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ORIGINAL PAPER

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Comparing self- and expert rating: a self-report screening version (SIAB-S) of the Structured Interview for Anorexic and Bulimic Syndromes for DSM-IV and ICD–10 (SIAB-EX)

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Abstract *Objective:* Carrying out structured interviews in larger numbers by well-trained interviewers is costly and time consuming. Therefore, we developed parallel to the existing Structured Interview for Anorexic and Bulimic Syndromes (SIAB-EX) a similarily designed questionnaire for symptoms of disordered eating and related areas (SIAB-S). *Method:* 377 treated eating disordered patients were assessed within a two-week time period using both the SIAB-EX and SIAB-S. *Results:* Generally, self-ratings based on the SIAB-S were quite similar to expert ratings. Cohen's kappa showed good agreement between self- and expert ratings. Factor structure based on principal component analyses of expert ratings or self-ratings led to rather similar results confirming the robustness of the subscales in self- and expert ratings. Using expert rating as a criterion, the self-rating (SIAB-S) – which can more easily be used for screening purposes – had a sensitivity of 0.70, a specificity of 0.80 and a PPV = 0.91 for the DSM-IV diagnoses of AN and/or BN (worst ever condition). Diagnostic sensitivity (79/73 %) and specificity (66/63 %) were in an acceptable range (past/current). If we focus on the differences between the two approaches the following was found: self-rating (compared to expert-rating) resulted in lower scores for items inquiring about binges and inappropriate compensatory behaviour, attitudes towards food and eating, and social interaction. On the other hand, self-rating (compared to expert-rating) led to higher scores for items measuring general psychopathology and atypical bingeing. *Conclusion:* Compared to the "gold standard" of data obtained with investigator-based standardised or structured interviews, data based on self-rating with items formulated clearly and concisely can lead to reliable and valid results. While complex issues (what is a binge) are difficult to assess in self-ratings, some (very personal) questions may even be better asked in a self-report questionnaire.

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Introduction

For the assessment of eating disorders for clinical research purposes the following measures have been used: 1) structured investigator-based interviews, 2) self-rating scales, 3) objective measures such as the Stroop color naming task (Fairburn et al., 1991), 4) behavioural observations and 5) structured daily diaries filled out by the patient. Objective measures so far have not been found useful as a method to confirm diagnosis or to measure symptomatic change and outcome (Ben-Tovim & Walker, 1991). Structured diaries (protocols) can only be reliable when the patient is reliable as well as willing and able to fill it out hour by hour, day by day. Cooper & Fairburn (1987) have argued that eating disorders are most effectively evaluated with an interview format. In 1991 the Structured Interview for Anorexic and Bulimic Syndromes (SIAB-EX) was first introduced (Fichter et al., 1991). It not only covers eating specific signs and symptoms, but also non-eating specific psychopathology, which is frequently associated with eating disorders (e. g. depression, anxiety, substance use). The present version of the SIAB-EX[1)] uses operationalised criteria for the diagnosis of anorexia and bulimia nervosa including their subtypes (according to DSM-IV and ICD–10). The SIAB-EX also offers a computer algorithm for the diagnosis of binge eating disorder according to DSM-IV criteria and for further eating disorder syndromes not described in DSM-IV. For each SIAB-EX item there exists a clear definition of symptoms and criteria as well as case examples, which supply anchoring points. However, a

1) A sample of the SIAB-EX interview and manual in English Language can be obtained from the senior author. A German version has appeared in print (see references). A Spanish version is in preparation.

major drawback in using a structured clinical interview such as the SIAB-EX (Fichter et al., 1998) and the EDE (Fairburn & Cooper, 1993) is that it is time consuming and requires training of personnel. It is therefore a logical step to evaluate the use of self-report questionnaires as a less costly and less time consuming method of assessment of eating specific and more general psychopathology. If reliable and valid, self-report questionnaires are much easier to use. A number of studies have begun to tackle the issue of reliability and validity of self-report measures in comparison to expert interviews in eating disorders. Fairburn & Beglin (1993) reported close agreement between self- and expert ratings for self-induced vomiting and laxative misuse, dietary restraint, somewhat more disagreement in the assessment of concerns about body weight and more disagreement in the assessment of concerns about shape and binge eating (objective bulimic episodes). Loeb et al. (1994) compared the EDE interview with data obtained from self-report inventories and concluded that essential features of bulimia nervosa can well be evaluated with self-report measures once the diagnosis has been established. Steinhausen & Seidel (1993) concluded from follow-up data that self-reports and interview measures "tackle different facets of the eating disorders and, therefore, both should be used in outcome studies" (p. 367) and that self-report measures such as the EAT and the EDI do not discriminate outcome groups. However, other self-report measures more specifically designed to discriminate certain groups may effectively do that. De Zwaan et al. (1993) assessed diagnostic agreement between patient rating and expert rating with regard to the presence or absence of binge eating disorder and reported a modest kappa value of .57. Discrepancies were mainly observed for ratings of loss of control, marked distress regarding binge eating and the frequency of binge eating episodes. More recently Grilo et al. (1998) reported an acceptable level of convergence between interview and self-report measures in the assessment of BED.

In particular, self-report measures have been developed for the two major expert interviews for eating disorders, the Eating Disorders Examination (EDE) (self-rating form EDE-Q) and the Structured Interview for Anorexic and Bulimic Syndromes SIAB-EX. (self-rating version SIAB-S). The SIAB self-rating version contains basically the same items as the SIAB-EX However, the SIAB-S items are phrased in a way that they are more easily understood by lay people. In comparing data obtained with costly and time consuming structured clinical interviews with self-report measures, which can much more easily be administered, the critical issue is whether the latter sacrifies accuracy for convenience.

Several studies were done to compare the results of self-report versus interview measures in binge eaters. Gladis et al. (1998) defined several cut-off scores for the Binge Eating Scale (BES) and compared them to diagnoses of binge eating disorder defined by the Questionnaire on Eating and Weight Patterns (QEWP), which was extended to a quasi expert rating by reviewing the answers to the QEWP with each subject individually. Results showed moderate agreement, the BES especially giving a high rate of false positives and many false negative binge eaters. Greeno et al. (1995) compared the EDE with the BES in persons with binge eating disorder and found that self-report did identify non-binge eaters but did not accurately identify binge eaters. In this study, the BES also showed a high rate of binge eaters which could not be confirmed by the EDE. Wilfley et al. (1997) and Black & Wilson (1996) compared the expert rating and the self-rating form of the EDE. Both studies reported higher levels of disturbance found with self-reports, Black & Wilson concluding that self-reports may be better suited for assessing purging behaviour than binge eating or dietary restraint. Again unconfirmed high rates of binge eating were found in the self-report. The study of French et al. (1998) confirmed the results of Black & Wilson finding an over-estimation of weight control practices in adolescents by a questionnaire developed by the authors. The interview used was also developed by French et al. based on the EDE.

In the present study structured interview data and self-report data (SIAB-EX and SIAB-S) obtained from the same eating disordered patients are compared. Since previous studies have shown that some symptoms can more easily be assessed in a reliable and valid way by self-rating than others (Fairburn & Beglin, 1994), we made comparisons for each of the single items of the SIAB as well as for the SIAB subscales. This paper also presents data on the sensitivity and specificity of the SIAB-S questionnaire in diagnosing eating disorders according to DSM-IV using the SIAB interview as the criterion.

Method

Sample characteristics and procedure

The sample consisted of 377 inpatients (11 males, 366 females) at Klinik Roseneck, a 360-bed hospital for behavioural medicine in Bavaria, Germany. All patients received treatment between January 1994 and May 1997 for eating disturbances. The average age at assessment was 29.1 years (SD + 9.3 years). At the time of assessment the sample had an average BMI of 25.7 (SD + 11.7). On admission, 60 (16%) of these 377 patients were classified as suffering from anorexia nervosa (30 binge/purging type and 30 restrictive type) and 97 (25.7%) as suffering from bulimia nervosa (9 non-purging type and 88 purging type) according to the Diagnostic and Statistical Manual, fourth edition (DSM-IV) criteria (American Psychiatric Association, 1994). The remaining 220 patients were suffering from a severe eating disorder but did not fulfill all criteria for anorexia nervosa or bulimia nervosa according to the DSM-IV.

Patients filled out the self-report SIAB-S immediately after being admitted for treatment. Within two weeks after admittance and after filling out the SIAB-S they were interviewed by the expert-rating SIAB-EX. The interviewers were blind concerning the results of the SIAB-S.

Measures of eating disturbance

The latest (third) revision of the Structured Interview for Anorexic and Bulimic Syndromes for Expert Rating (SIAB-EX; Fichter et al., 1998) consists of 87 items. Of these 87 items 20 items were exclusively formulated for an exact diagnostic classification according to DSM-IV or ICD-10. Sixty-seven items assess severity or duration of

eating disturbance on a five point scale from 0 (symptom not present) to 4 (very severe symptom). Part of these items are used for diagnostic classification. For this purpose a value of 0 or 1 is considered indicating no disturbed behaviour, while the values 2, 3 or 4 indicate a clinically relevant disturbance. The SIAB-EX consists of six factor-analytically derived subscales. For more details concerning the factorial structure of the SIAB-EX see Fichter et al. (1998). The self-rating version of the SIAB (SIAB-S) contains the same items as the expert version, but items are formulated in a way appropriate for self-rating. (Example: "I experienced distress regarding binge eating". Answer code 0 = no, 1 = slightly, 2, = markedly, 3 = strongly, 4 = very strongly (even desperation), 8 = no eating binges.) The expert interview (SIAB-EX) served as the basis for diagnoses of anorexia nervosa and bulimia nervosa. Expert ratings and self-ratings were conducted for the current status and for the maximum pathology in the previous years (past symptom expression). Subscales of the SIAB-S were defined following the factor structure of the SIAB-EX as well as following factor analyses reported in this paper.

Statistical analysis

Sum scores for the six subscales and total scale containing 65 items (all items coded 0–4 excluding two items) of the SIAB-EX and for the SIAB-S were computed according to the standard computer algorithm for the SIAB. Correlations (Pearson's R) and pairwise t-tests were calculated between SIAB-EX and SIAB-S scales and between items. The Kappa coefficients of agreement between SIAB-EX and SIAB-S were assessed after recoding the items from 0 to 4 into dichotomous variables with the values 0 (before recoding 0 and 1: no clinical significance) and 1 (previous codes 2 to 4: clinically relevant). Discriminant analyses were calculated to distinguish patients with bulimia or anorexia nervosa from each other and from patients with other eating disorders on the basis of the self-rating subscales. All diagnoses were made by using the computer algorithm for SIAB-EX. The cut off value of the overall self-rating score to identify full diagnoses of anorexia nervosa or bulimia nervosa in a population of eating disordered patients was calculated with regard to optimising both sensitivity and specifity. Principal component analysis (PCA) with varimax rotation was conducted for the SIAB-S current and past measures analogous to the SIAB-EX. Means and standard deviations of these new subscale structures are reported.

Results

Table 1 shows mean and standard deviations and pairwise comparisons (correlations; t-tests; kappa values) for the subscales and items of the Structured Interview for Anorexic and Bulimic Syndromes for patients treated for an eating disorder. In the table past and current symptom expression is listed and expert (SIAB-EX) and self-ratings (SIAB-S) are compared.

Considering overall the pairwise comparisons, the data show a moderate association (Pearson's R between 0.3 and 0.6). Cohen's kappa showed fairly good agreement values ranging mainly between 0.4 and 0.8.

For eating disordered patients who sought treatment, higher scores were obtained by expert ratings as compared to self-ratings for some items, while for other items higher scores were obtained by self-ratings as compared to expert ratings. A very clear pattern was observed on the basis of our data using SIAB-EX and SIAB-S: 1) Higher expert ratings as compared to self-ratings were obtained for eating disordered patients a) for behaviours of disordered eating (quantitative and qualitative reduction of food intake, bingeing (subjectively and objectively), frequency of bingeing, inappropriate compensatory behaviours to reduce weight (self-induced vomiting, excessive fasting, laxative abuse, alcohol abuse), and b) disturbed attitudes towards food and eating (body image disturbances, preoccupation with food and eating, denial of seriousness of low body weight), and c) items referring to social interactions (avoidance of social contacts, social withdrawal, objective impairment, sexual anxieties, partner relationship, quality of social contacts). 2) On the other hand, eating disordered patients showed higher self-rating scores than expert-ratings a) in items assessing the more general psychopathology (lack of self-confidence, depressive thoughts, depressed mood, anxieties, phobias, obsessive ruminations, compulsive checking), and b) items referring to disturbed eating behaviours frequently associated with binge eating disorder (frequency of atypical binges, stress-induced eating, feeling uncomfortably full after eating, distress in association with bingeing). Some behaviours (qualitative reduction of food, frequency of binges, sleep disturbance, leisure activities, social withdrawal) are reported differently for current and past: there are higher expert ratings for past and higher self-ratings for current. Thus, a general pattern was observed: some data are more willingly reported in self-ratings (general psychopathology, atypical binges) and some are reported more in investigator-based interviews, such as bingeing and purging behaviours, disturbed attitudes towards food and eating and items related to social interactions.

Response patterns of self- vs. expert rating were in the opposite direction for AN as compared to BN patients for two items: 1) weight phobia (higher expert rating for AN and higher selfrating for BN), and 2) frequency of binge attacks (three months) (higher self-rating for AN and higher expert-rating for BN). For both items this was true for the current symptom expression only, and not for the past symptom expression.

Both AN and BN showed higher past expert than self-rating for bulimic behaviour (bingeing and compensatory behaviour) as well as for sexuality and social integration, and showed lower current expert than self-rating for items covering general psychopathology.

When we compared AN to BN patients in the total scale current assessment, both tended to have higher self-rating scores than expertrating scores (AN 1.6 vs. 1.4; BN 1.7 vs. 1.4 average score total scale SIAB). In particular, AN in comparison to BN patients tended to have higher expert ratings than self-ratings in a number of items from SIAB subscale I body image and slimness ideal covering lack of self-esteem and self-confidence, and social withdrawal.

For the further development of the classification of eating disorders a detailed differentiation of the major eating disorders (AN, BN) is of interest. On the basis of the self-rating subscales constructed after the subscale structure of the expert rating, discriminant analyses were calculated in order to test for the ability of the SIAB-S to differentiate major eating disorders from each other and from eating disorders not otherwise specified.

The five SIAB self-rating components, on which these

Table 1 Means (M), standard deviations (SD) and pairwise comparison of expert rating and self-rating (correlations; t-Test, Kappa) for the subscales and items of the Structured Interview for Anorexic and Bulimic Syndroms (SIAB-EX: Expert Rating and SIAB-S: Self-Rating, range 0–4) for Roseneck inpatients (past and current) (N=377)

Item No.		N	Expert Rating M (SD)		Self-Rating M (SD)		Correlation Pearson's R		t-Test		Kappa[1]	
		Past	Past	Current	Past	Current	Past	Current	Past	Current	Past	Current
	I Body Image and Slimness Ideal (BI)	**370**	**1.9 (0.8)**	**1.2 (0.6)**	**1.9 (0.8)**	**1.4 (0.6)**	**.69****	**.71****	**n.s.**	**–10.6****	**.49****	**.40****
16	Body image disturbance	358	2.2 (1.5)	1.6 (1.4)	1.5 (1.7)	0.9 (1.4)	.52**	.50**	8.4**	8.8**	.38**	.36**
7	Weight phobia	365	2.6 (1.3)	1.9 (1.2)	2.6 (1.4)	2.4 (1.4)	.40**	.37**	n.s.	–6.1**	.33**	.32**
61	Ideal of slimness	367	2.7 (1.2)	2.0 (1.3)	2.9 (1.4)	2.5 (1.4)	.30**	.32**	–2.5*	–5.7**	.24**	.28**
(1)	Underweight (modified)/deviance from normal weight	355	1.9 (1.7)	0.9 (1.4)	1.8 (1.7)	1.0 (1.4)	.98**	.95**	2.5*	–3.3**	.95**	.90**
12	Qualitative reduction of food intake	363	2.6 (1.3)	1.3 (1.4)	2.4 (1.6)	1.6 (1.5)	.35**	.51**	2.2*	–4.0**	.26**	.48**
59	Compulsive behaviour concerning food and eating	366	1.2 (1.2)	0.9 (1.1)	1.3 (1.6)	1.1 (1.4)	.37**	.50**	n.s.	–4.0**	.29**	.41**
42	Excessive exercising	364	1.7 (1.5)	0.6 (1.0)	1.8 (1.4)	0.9 (1.2)	.55**	.45**	n.s.	–5.2**	.44**	.35**
60	Preoccupation with food and eating	367	3.1 (1.3)	2.3 (1.5)	2.6 (1.5)	2.2 (1.5)	.36**	.48**	5.7**	n.s.	.28**	.41**
14	Chewing and spitting out food	364	0.5 (1.1)	0.2 (0.8)	0.7 (1.3)	0.6 (1.3)	.41**	.29**	–3.0*	–5.9**	.37**	.29**
3	Internal achievement orientation	359	1.8 (1.3)	1.3 (1.2)	3.1 (1.1)	2.4 (1.3)	.36**	.26**	–18.2**	–13.0**	.09**	.06
10	Dependence of self-esteem on figure and weight	222	2.8 (1.0)	2.4 (1.1)	2.9 (1.3)	2.5 (1.4)	.30**	.42**	n.s.	n.s.	.26**	.37**
13	Setting limits for caloric intake	355	2.0 (1.7)	0.5 (1.2)	1.9 (1.6)	0.8 (1.2)	.50**	.52**	n.s.	–5.1**	.46**	.45**
19	Amenorrhea (modified)	357	1.3 (1.0)	0.9 (1.0)	1.2 (1.2)	0.9 (1.1)	.48**	.66**	2.2*	n.s.	.54**	.71**
55	Constipation	362	1.6 (1.6)	0.8 (1.4)	1.6 (1.5)	1.2 (1.4)	.59**	.65**	n.s.	–6.4**	.55**	.57**
15	Regurgitation of food	365	0.2 (0.7)	0.1 (0.5)	0.2 (0.8)	0.1 (0.6)	.74**	.54**	n.s.	n.s.	.74**	.51**
17	Denial of the seriousness of the low body weight	83	2.0 (1.9)	0.7 (1.4)	1.4 (1.8)	1.0 (1.4)	.45**	.45**	3.0**	n.s.	.42**	.41**
63	Reduced perception of internal stimuli	–	– –	2.0 (1.0)	– –	2.1 (1.5)	–	.48**	–	n.s.	–	.37**
83	Denial of illness	–	– –	0.7 (1.0)	– –	1.7 (1.6)	–	–.08	–	–9.3	–	.04
	II General Psychopathology (Gen Psy) (past) General Psychopathology and Social Integration (GenPsySoc) (current)	**370**	**1.5 (0.7)**	**1.1 (0.7)**	**1.6 (0.9)**	**1.5 (0.7)**	**.68****	**.77****	**–2.5***	**–13.9****	**.43****	**.37****
66	Lack of self-confidence	367	2.2 (1.2)	1.7 (1.3)	2.4 (1.5)	2.0 (1.4)	.48**	.53**	–3.2**	–5.2**	.37**	.44**
65	Depressive thoughts	367	2.2 (1.2)	1.5 (1.3)	2.6 (1.4)	2.2 (1.4)	.40**	.37**	–4.7**	–8.3**	.30**	.30**
64	Depressed mood	366	2.4 (1.1)	1.6 (1.2)	2.6 (1.4)	2.2 (1.4)	.33**	.54**	–2.7**	–9.2**	.25**	.46**
67	Lack of self-esteem	365	2.5 (1.3)	1.9 (1.5)	2.5 (1.4)	2.2 (1.4)	.46**	.54**	n.s.	–4.0**	.29**	.40**
4	Anxieties	365	1.4 (1.2)	1.1 (1.1)	2.0 (1.3)	2.1 (1.2)	.43**	.43**	–8.8**	–14.8**	.26**	.23**
6	Sleep disturbances	365	2.1 (1.6)	1.6 (1.5)	1.6 (1.5)	1.8 (1.4)	.52**	.59**	5.9**	–3.7**	.38**	.51**
62	Feelings of insufficiency	366	2.4 (1.2)	1.8 (1.4)	2.2 (1.5)	2.1 (1.4)	.24**	.38**	n.s.	–4.0**	.13**	.35**
58	Obsessive ruminations	360	0.5 (0.9)	0.4 (0.8)	0.9 (1.3)	0.8 (1.2)	.39**	.31**	–6.4**	–7.2**	.33**	.25**
68	Suicidal thoughts	366	2.1 (1.5)	0.6 (1.1)	1.4 (1.4)	0.8 (1.2)	.63**	.53**	9.9**	–4.3**	.53**	.52**
5	Phobias	365	1.2 (1.1)	1.0 (1.0)	1.7 (1.5)	1.5 (1.4)	.42**	.42**	–6.0**	–6.5**	.31**	.37**
56	Compulsive checking	364	0.5 (0.9)	0.4 (0.7)	0.9 (1.3)	0.9 (1.2)	.47**	.54**	–6.9**	–9.7**	.28**	.35**
69	Suicidal acts	367	0.7 (1.1)	0.0 (0.2)	0.6 (1.0)	0.2 (0.5)	.80**	.13*	2.4*	–5.1**	.66**	–.01
70	Autoaggressive behaviour	366	0.7 (1.2)	– –	0.6 (1.1)	– –	.75**	–	2.1*	–	.61**	–
57	Obsessions about cleanliness	364	0.6 (1.0)	0.4 (0.8)	0.6 (1.1)	0.5 (1.0)	.57**	.50**	n.s.	n.s.	.42**	.39**
82	Social withdrawal	(365)	– –	1.3 (1.4)	– –	1.5 (1.4)	–	.53**	–	–3.2**	–	.48**
79	Leisure activities	(359)	– –	1.9 (1.5)	– –	2.3 (1.3)	–	.48**	–	–5.1**	–	.36**

Item No.		N	Expert Rating M (SD)		Self-Rating M (SD)		Correlation Pearson's R		t-Test		Kappa[1]	
		Past	Past	Current	Past	Current	Past	Current	Past	Current	Past	Current
80	Extent of social contacts	(363)	– –	1.3 (1.3)	– –	2.0 (1.3)	–	.62**	–	–12.4**	–	.49**
53	Objective impairment	(357)	– –	2.2 (1.4)	– –	1.7 (1.4)	–	.47**	–	6.2	–	.34**
72	Tranquillizer abuse	(365)	– –	0.1 (0.4)	– –	0.4 (0.9)	–	.29**	–	–6.7	–	.06
81	Quality of social contacts	(364)	– –	0.7 (1.3)	– –	0.8 (1.0)	–	.35**	–	n.s.	–	.33**
	III Sexuality and Social Integration (SexSoc) (past) Sexuality (Sex) (current)	**368**	**2.3 (0.8)**	**2.1 (1.3)**	**1.9 (0.9)**	**1.9 (1.3)**	**.48****	**.83****	**10.7****	**5.5****	**.70****	**.16****
78	Avoidance of sexual contacts	344	1.8 (1.8)	2.3 (1.8)	1.5 (1.7)	2.1 (1.8)	.29**	.73**	3.0**	2.6*	.24**	.68**
76	Sexual anxieties	359	2.0 (1.6)	1.7 (1.6)	1.8 (1.5)	1.7 (1.6)	.50**	.63**	3.2**	n.s.	.45**	.51**
79	Leisure activities	364	2.6 (1.4)	– –	2.0 (1.4)	– –	.27**	–	6.5**	–	.24**	–
82	Social withdrawal	361	2.1 (1.4)	– –	1.8 (1.5)	– –	.40**	–	3.3**	–	.30**	–
75	Reduction of libido	359	2.7 (1.7)	2.3 (1.7)	1.6 (1.6)	1.6 (1.6)	.38**	.64**	11.7**	8.8**	.23**	.55**
77	Partner relationship	363	1.9 (1.5)	2.1 (1.7)	1.5 (1.3)	2.0 (1.8)	.46**	.82**	5.7**	n.s.	.36**	.78**
81	Quality of social contacts	359	1.8 (1.8)	– –	1.5 (1.3)	– –	.43**	–	3.5**	–	.44**	–
83	Denial of illness	356	2.8 (1.4)	– –	2.6 (1.6)	– –	.09	–	n.s.	–	–-	–
84	Global evaluation of symptoms	351	3.4 (0.8)	– –	2.6 (1.4)	– –	.18**	–	10.7**	–	.08**	–
80	Extent of social contacts	363	2.0 (1.3)	– –	2.0 (1.3)	– –	.43**	–	n.s.	–	.34**	–
53	Objective impairment	347	2.5 (1.3)	– –	1.3 (1.4)	– –	.26**	–	13.3**	–	.14**	–
63	Reduced perception of internal stimuli	367	2.3 (1.0)	– –	2.1 (1.6)	– –	.36**	–	n.s.	–	.18**	–
	IV Bulimic Symptoms (Bul)	**369**	**2.4 (1.2)**	**1.9 (1.2)**	**2.0 (1.4)**	**2.0 (1.2)**	**.70****	**.81****	**7.2****	**n.s.**	**.69****	**.58****
21a	Bingeing (objectively)	355	2.6 (1.5)	1.8 (1.7)	1.8 (1.4)	1.6 (1.3)	.57**	.64**	11.8**	3.4**	.51**	.57**
23	Frequency of binge attacks (3 months)	361	2.5 (1.5)	1.8 (1.6)	2.2 (1.6)	2.0 (1.6)	.60**	.73**	4.7**	–4.1**	.53**	.68**
24	Frequency of binge attacks (6 months)[2]	208	2.5 (1.4)	1.8 (1.6)	2.1 (1.6)	2.1 (1.6)	.62**	.77**	3.5**	–3.1**	.53**	.70**
21b	Bingeing (subjectively)	364	2.8 (1.5)	2.0 (1.7)	2.2 (1.6)	1.8 (1.6)	.58**	.68**	8.4**	2.3*	.48**	.63**
26	Loss of control	322	2.3 (1.2)	1.8 (1.4)	2.2 (1.7)	2.0 (1.7)	.49**	.48**	n.s.	n.s.	.43**	.36**
28	Bingeing and distress	209	2.1 (1.5)	1.7 (1.6)	2.4 (1.6)	2.2 (1.7)	.50**	.60**	–3.0**	–5.0**	.44**	.54**
35	Induced vomiting	364	2.1 (1.9)	1.5 (1.8)	1.7(1.8)	1.5 (1.7)	.78**	.89**	7.3**	n.s.	.72**	.83**
34	Craving for food	220	2.5 (1.4)	1.9 (1.5)	2.3 (1.7)	2.0 (1.7)	.43**	.54**	n.s.	n.s.	.39**	.51**
22	Course of binge eating	80	2.1 (1.7)	–	1.9 (1.4)	–	.69**	–	n.s.	–	.61**	–
84	Global evaluation of symptoms		– –	3.3 (0.8)	– –	3.1 (0.9)	–	.35**	–	2.7**	–	.19**
	V Inappropriate Compensatory Behaviours to Counteract Weight Gain, Fasting, Substance-Abuse (Compensatory Behaviour)	**367**	**1.0 (0.6)**	**0.4 (0.3)**	**0.8 (0.6)**	**0.4 (0.3)**	**.70****	**.56****	**7.0****	**n.s.**	**.29****	**.56****
38	Appetite suppressants	363	0.6 (1.1)	0.1 (0.5)	0.6 (1.2)	0.1 (0.4)	.67**	.41**	n.s.	n.s.	.51**	.54**
37	Abuse of diuretics	363	0.3 (0.8)	0.1 (0.3)	0.3 (0.9)	0.0 (0.5)	.60**	.54**	n.s.	n.s.	.44**	.39**
41	Excessive fasting/dieting	219	1.5 (1.6)	0.3 (0.9)	1.0 (1.3)	0.3 (0.8)	.55**	.36**	5.3**	n.s.	.49**	.37**
72	Tranquilizer abuse	363	0.4 (0.9)	– –	0.7 (1.2)	– –	.44**	–	–4.7**	–	.23**	–
73	Abuse of illegal drugs	364	0.3 (0.7)	0.03 (0.2)	0.3 (0.8)	0.04 (0.2)	.74**	.41**	n.s.	n.s.	.72**	.50**
36	Laxative abuse	362	1.2 (1.5)	0.4 (1.0)	0.9 (1.3)	0.4 (1.0)	.72**	.81**	6.2**	n.s.	.60**	.81**
11	Quantitative reduction of food	362	3.1 (1.2)	1.5 (1.6)	2.4 (1.5)	1.3 (1.4)	.35**	.54**	8.6**	2.6*	.13**	.44**

Item No.		N	Expert Rating M (SD)		Self-Rating M (SD)		Correlation Pearson's R		t-Test		Kappa[1]	
		Past	Past	Current	Past	Current	Past	Current	Past	Current	Past	Current
71	Alcohol abuse	362	1.3 (0.9)	0.7 (0.7)	1.1 (1.0)	0.7 (0.7)	.64**	.59**	3.7**	n. s.	.51**	.51**
39	Abuse of thyroid medication	363	0.1 (0.4)	0.0 (0.1)	0.1 (0.6)	0.1 (0.5)	.28	.22	n. s.	–3.1**	.14**	–
43	Enemas	84	0.1 (0.4)	0.1 (0.4)	0.1 (0.3)	0.0 (0.1)	.38**	1.0**	n. s.	n. s.	–.01	––
44	Ipecac abuse	84	0.0 (0.0)	0.0 (0.0)	0.0 (0.2)	0.0 (0.0)	–	–	n. s.	n. s.	–	–
70	Autoaggressive behaviour	(368)	–	– 0.2 (0.8)	–	– 0.3 (0.7)	–	.45**	–	n. s.	–	.30**
	VI Atypical Binges (Atyp. Binge)	**84**	**1.1 (1.1)**	**0.8 (1.0)**	**1.6 (1.1)**	**1.4 (1.1)**	**.47****	**.62****	**–4.3****	**–5.5****	**.47****	**.45****
31	Frequencies of atypical binges (3 months)	83	1.1 (1.4)	0.8 (1.3)	1.8 (1.7)	1.6 (1.6)	.30**	.49**	–3.5**	–4.8**	.34**	.45**
32	Frequencies of atypical binges (6 months)[2]	82	1.0 (1.4)	0.8 (1.3)	1.6 (1.6)	1.6 (1.6)	.28**	.47**	–2.8**	–4.9**	.29**	.42**
29	Atypical binges	83	1.6 (1.8)	0.9 (1.6)	1.7 (1.5)	1.3 (1.5)	.45**	.50**	n. s.	–2.3*	.35**	.34**
33	Stress-induced eating	84	1.6 (1.7)	1.4 (1.7)	2.1 (1.6	1.9 (1.6)	.57**	.61**	–3.2**	–3.2**	.56**	.54**
30	Feeling comfortably full after eating	82	0.1 (0.6)	0.1 (0.5)	0.9 (1.3)	0.6 (1.2)	–.01	.17	–4.7**	–4.3**	–.2	.07
Total Scale		**370**	**1.7 (0.5)**	**1.2 (0.5)**	**1.6 (0.7)**	**1.4 (0.5)**	**.66****	**.80****	**3.6****	**–12.7****	**.56****	**.35****

M=Mean; SD=Standard deviation; ** $p < 0.01$, * $p < 0.05$; n. s.= not significant; – statistics cannot be computed
1 Kappa was computed on the basis of recorded items (0 and 1 = 0, clinically not significant; 2–4 = 1, clinically significant)
2 item additionally reported (not included in any subscale)

analyses were based, were I body image and slimness ideal, II general psychopathology (and social integration), III sexuality (and social integration), IV bulimic symptoms, and V measures to counteract weight gain, fasting, and substance abuse. One set of analyses was done to see how well patients with either AN or BN (at admission, SIAB-EX diagnoses) can be distinguished from other patients of the sample. For the current symptom expression, correct allocation of these two groups was possible in 70.5 %. Correctly classified were 70.1 % of the AN/BN patients and 70.7 % of the other patients. Based on the self-rating data of past expression, 62.7 % were correctly classified (59.4 % of the AN/BN patients and 65.1 % of other eating disordered patients (current SIAB-EX diagnoses)).

Another set of analyses was applied to discriminate patients with a current diagnosis of AN from patients with current BN. Using current symptom expression of the self-rating data 81.2 % (71.7 % of the AN and 87.2 % of the BN patients) were correctly classified. The same diagnostic group could be correctly allocated in 71.6 % (61.7 % AN, 77.9 % BN) of all AN/BN cases (current diagnosis) using the past symptom expression.

In order to obtain an overview of the structure of the SIAB-S, principal component analyses (PCA) were conducted. All items used in the PCA of the SIAB-EX (see Fichter et al., 1998) were used. Items which were added more recently to the SIAB (atypical binges (items 29, 30, 31 and 33)) were not included. Forced five- and six-factor solutions were analysed. For the past symptom expression a rotated six factor solution was the most sensible solution which was well interpretable. The six factors were: I Bulimic Symptoms (Bul; N = 367, mean = 2.2, SD = 1.2); II General Psychopathology (GenPsy; N = 370, mean = 1.8, SD = 0.9); III Slimness Ideal (Slim; N = 369, mean = 2.3, SD = 0.9); IV Sexuality and Social Integration (SexSoc; N = 368, mean = 1.7, SD = 1.0); V Body Image (BI; N = 370, mean = 1.3, SD = 0.8); VI Inappropriate Compensatory Behaviours to Counteract Weight Gain, Substance Abuse, Fasting, and Other Autoagressive Behaviour (Compensatory Behaviour; N = 367, mean = 0.7, SD = 0.6). A seventh factor with the items refering to atypical binges was added (N = 84; mean = 1.6; SD = 1.1). The total score (N = 370) was on the average 1.7 points on a range from 0–4 (SD = 0.7). For the current symptom expression a rotated five-factor solution was considered the best (Table 2). For the current state a factor was also added (not shown in Table 2) with the items refering to atypical binges (N = 86; mean = 1.4; SD = 1.1). A few items were moved from the factor with the highest loading to another factor on conceptual considerations.

On the basis of the newly established self-rating subscale structure, discriminant analyses – analogous to those mentioned above – were calculated. The analyses were based on five (current; cf. Table 2) and six (past) factors excluding atypical binges from analyses. For the current symptom expression, correct allocation of AN or BN versus other eating disorder was possible in 72.6 %, while 72.1 % of the AN/BN patients and 73 % of the other patients were correctly classified. Based on the data of past

Table 2 Factor loadings of SIAB self-rating items for the current symptom expression[1) 2)]

Item No.		Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
	I General Psychopatholgy and Social Integration (GenPsySoc) (N = 370, Mean = 1.5; SD = 0.7)					
67.	Lack of self-esteem	.66				
64.	Depressed mood	.65				
62.	Feelings of insufficiency	.65				
82.	Social withdrawal	.64				
66.	Lack of self-confidence	.64				
4.	Anxieties	.63				
80.	Extent of social contacts	.61				
65.	Depressive thoughts	.60		.35		
68.	Suicidal thoughts	.59				.41
79.	Leisure activities	.59				
53.	Objective impairment	.57				
5.	Phobias	.56				
63.	Reduced perception of internal stimuli	.45	.42			
58.	Obsessive ruminations	.45				
56.	Compulsive checking	.44				
81.	Quality of social contacts	.42				
6.	Sleep disturbances	.39				.30
83.	Denial of illness	.36				
57.	Obsessions about cleanliness	.34				.33
69.	Suicidal acts	.32				
72.	Tranquilizer abuse	.26				
	II Bulimic Symptoms (Bul) (N = 369, Mean = 2.0; SD = 1.2)					
23.	Frequency of binge attacks (3 months)		.89			
21B.	Bingeing (subjectively)		.89			
21A.	Bingeing (objectively)		.86			
28.	Bingeing and distress		.80			
34.	Craving for food		.79			
26.	Loss of control		.68			
35.	Induced vomiting		.65			.43
84.	Global evaluation of symptoms		.49			
22.	Course of binge eating	–	–	–	–	–
	III Body Image and Slimness Ideal (BI) (N = 370, Mean = 1.7; SD = 0.8)					
11.	Quantitative reduction of food			.74		
12.	Qualitative reduction of food			.70		
13.	Setting limits for caloric intake			.67		
61.	Ideal of slimness		.38	.59		
7.	Weight phobia	.31		.57		
10.	Dependence of self-esteem on figure and weight	.44		.50		
60.	Preoccupation with food and eating		.41	.50		
16.	Body image disturbance			.44		.32
3.	Internal achievement orientation			.41		
42.	Excessive exercising			.31		
17.	Denial of the seriousness of the low body weight	–	–	–	–	–

Table 2 Continued Factor loadings of SIAB self-rating items for the current symptom expression[1) 2)]

Item No.		Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
	IV Sexuality and Body Weight (SexWeight) (N = 370, Mean = 1.5; SD = 1.0)					
78.	Avoidance of sexual contacts				.67	
19.	Amenorrhea (modified)				.65	
(1).	Underweight (modified) /deviance from normal weight				.64	
77.	Partner relationship				.59	
76.	Sexual anxieties	.43			.55	
75.	Reduction of libido	.46			.46	
59.	Compulsive behaviour concerning food and eating			.39	.40	
	V Measures to counteract weight gain, fasting and substance abuse (Counteract) (N = 369, Mean = 0.4; SD = 0.3)					
36.	Laxative abuse					.49
70.	Autoaggressive behaviour	.30				.47
55.	Constipation					.41
38.	Appetite suppressants					.35
41.	Excessive fasting					.32
14.	Chewing and spitting out food					.29
37.	Abuse of diuretics					.26
73.	Abuse of illegal drugs					.22
15.	Regurgitation of food					.21
39.	Abuse of thyroid medication					–.16
71.	Alcohol abuse					.21
43.	Enemas	–	–	–	–	–
44.	Ipecac abuse	–	–	–	–	–
	Total Score (N = 370, Mean = 1.4, SD = 0.5)					

Notes: [1)] For each item the loading on the factor to which the item is attributed is shown. Loadings on other factors are shown only if they are .30 or higher.
[2)] A complete listing of all loadings and a table with a complete listing on the factor structure for the past symptom expression is available from the senior author.

expression, 67.8 % were correctly classified (61.9 % of the AN/BN patients and 72.1 % of the other patients) (current SIAB-EX diagnoses). Discriminating AN (current) patients from BN (current) patients resulted in 86.4 % (83.3 % of AN and 88.3 % of BN) correctly classified for current symptom expression and for 73.6 % (73.3 % of AN and 73.7 % of BN) successfully allocated for the past symptom expression of SIAB-S subscales.

A score of 1.3 of the SIAB-S total scale (past symptom expression) was found as the cut off that discriminated best between patients with a past diagnosis of anorexia or bulimia nervosa and other eating disorders. Diagnostic sensitivity (patients with anorexia or bulimia nervosa) was 0.79 and diagnostic specifity (other eating disordered patients) was 0.66. Positive predictive value was 0.86. For the current symptom expression, a total score of 1.3 was also the best discriminating cut-off for differentiating present state anorexia or bulimia nervosa from other present state eating disorders. Diagnostic sensitivity (patients with anorexia or bulimia nervosa) was 0.73 and diagnostic specifity (other eating disordered patients) was 0.63 and positive predictive value was 0.58 for the present state.

A reliable and valid questionnaire, which can easily be administered to larger samples, is very desirable for screening purposes using two stage studies in which those addressed are then verified by interview. In order to test the SIAB-S as an instrument for diagnostic screening for a major eating disorder (AN, BN), DSM-IV diagnoses were computed from the SIAB-S and were then compared to those derived from the interview (SIAB-EX). For diagnostic purposes only 35 items of the SIAB-S are required. Thus, diagnoses may be made economically by using only these items. The following procedure was used for calculations so as not to lose true cases through a screening criteria with a questionnaire set wider than for the interview. For the questionnaire codes between 1 and 4 were considered as fulfilling the criterion for the items covering criteria B and C for anorexia nervosa and criteria A, B, and D of bulimia nervosa. This procedure was used to compensate for possible down-playing symptoms through self-report. Of 279 persons with a major eating disorder (AN or BN) according to the expert interview (SIAB-EX; worst ever = past and present state combined) 194 were correctly diagnosed by the SIAB-S, while 78 of the 98 persons without a major eating disorder (72 % of the total group) were correctly identified. This results in a sensitivity of 0.70, a

specificity of 0.80 and a positive predictive value of 0.91. For the present state and for past diagnoses (resp.), the sensitivity of the SIAB-S was 0.52 and 0.56, specificity was 0.86 and 0.82, and positive predictive value was 0.72 and 0.90, while 72 % and 63 % of the total group were correctly identified. Prediction was improved by dropping criterion C for anorexia nervosa (body image disturbance and denial of illness) and criterion C for bulimia nervosa (frequency of binges and inappropriate compensatory behaviour). These criteria appear to be more difficult to assess by self-rating. When criteria C for AN or BN resp. are deleted, the sensitivity of the SIAB-S with a diagnosis of AN and/or BN was 0.72, the specificity was 0.76 and the PPV was 0.89 for the worst ever condition; accordingly for the present state the sensitivity was 0.60, the specificity was 0.81, and PPV was 0.70; for the past sensitivity was 0.59, the specificity was 0.78, and PPV was 0.88. All calculations concerning the SIAB-EX interview diagnosis referred to scores in the relevant items of 2, 3 or 4 points. Regarding diagnostic misclassification of the 194 patients who were correctly diagnosed by the SIAB-S, 94 % of the AN patients were correctly classified as having AN, and 82 % of the BN patients were correctly classified as having BN. This results in an overall rate of 90 % correct diagnostic classification for AN and BN.

Discussion

Some clinicians and researchers have regarded individuals with an eating disorder as "notoriously unreliable informants" (Crowther & Sherwood, 1997, p. 38) and it has been noted by Vitoussek, Daly & Heiser (1991) that "the challenge of getting eating disordered clients to tell us what they think and feel – and the difficulty of trusting them, when they do – have long figured prominently among the concerns of clinicians and researchers who work with this population" (p. 647). On the other hand, Loeb et al. (1994) concluded that "once the diagnosis has been established and the patients have been instructed in the construct of binge, the essential features of bulimia nervosa (frequency of binge eating and purging and overconcern with body shape and weight) can be evaluated with self-report measures" (p. 75).

The general concept that self-report data might be less accurate or less reliable does not appear to be true – at least not for persons who identify themselves as eating disordered patients and who have sought treatment. If a person binges in secrecy and wants to hide this from others, she may do so effectively in self-reports as well as investigator-based interviews. In fact, a person is more likely to feel comfortable in reporting very intimate, personal things in the more anonymous context of self-report questionnaires, rather than having to look into the interviewer's eyes.

On the other hand, as Fairburn & Beglin (1994) have pointed out, a complex concept like bingeing, which takes into account a number of aspects (amount of food consumed, frequency of bingeing, speed of eating, loss of control over eating etc.) can be assessed more appropriately in structured clinical interviews done by well-trained and clinically experienced interviewers. For such training purposes the SIAB-EX has an extensive manual defining in detail what is meant by each item and item score. A major finding of the present study was that (except for atypical binges and related items) attitudes and behaviours specific for eating disorders and social fears and interactions resulted in higher expert rating scores, while the general psychopathology which usually accompanies eating disorders (depression anxieties etc.) resulted in relatively higher self-rating scores. Our study compares a number of different areas of psychopathology assessed by self-report or expert rating. Previous studies by others using the EDE cover only few of these areas. Also, the EDE covers only the current state, so that comparisons between EDE and SIAB are restricted to that. On the basis of the SIAB we found higher self-report ratings for the factor body "image" and the items "ideal of slimness", "weight phobia", and "excessive exercising". Similarily, Fairburn & Beglin (1994) as well as Black & Wilson (1996) using the EDE interview and EDE questionnaire in BN patients reported higher self-report ratings for "shape concern" and "weight concern". Neither of these two studies nor our study found significant differences between self- and expert rating for vomiting and laxative abuse. There was, however, one difference concerning self- and expert rating of "objective binges". Fairburn & Beglin (1994) and Black & Wilson (1996) as well as Greeno et al. (1995) reported higher self-rating scores for objective binges. Our SIAB data on the other hand revealed higher expert than self-ratings for objective binges. Probably the detailed operationalised definition of objective binges in the SIAB manual and in the self-report questionnaire account for these differences. Both versions of the SIAB rely on the caloric content consumed in a binge as the definitional criterion. As a conclusion the ratings of simple constructs like vomiting or laxative abuse seem to show no differences while the ratings of more complex constructs like problems with weight and shape or objective binges vary with the type of assessment and the definition of the constructs.

Comparing the SIAB-S PCA factor structure described in this manuscript with that of the SIAB-EX (Fichter et al., 1998), we found that the same factors were generally derived from self-rating as has been described for interviewer rating. Past analysis showed a factor for bulimic symptoms, general psychopathology, slimness ideal, sexuality and social integration, body image, and inappropriate compensatory behaviours to counteract weight gain; the items for atypical binges, which constituted the sixth factor of the SIAB-EX were not entered for the SIAB-S factor analysis and is a factor with relatively low Eigenwert. Body image focussing on deviance from normal weight, body image, amenorrhea, compulsive behaviour concerning food and eating and excessive exercising (past) is separated from slimness ideal in the SIAB-S factor structure. For the current symptom expression for SIAB-EX as well as SIAB-S the following very similar factors were derived: body image and slimness ideal, general psychopathology and social integration, bulimic symptoms, sexuality, and inappro-

priate compensatory behaviours to counteract weight gain; as for the past data, items from the SIAB-EX factor atypical binges were not entered. Thus, very similar or almost identical results were obtained for a 5 or 6-factor structure based on self-ratings as compared to expert rating data. Discriminant analyses successfully discriminated patients with a DSM-IV major eating disorder (AN, BN) from eating disordered patients who did not fulfill all criteria for AN or BN, and – in separate analyses – AN from BN.

Correlations and Kappa values between expert ratings and self-ratings differed widely, the majority being greater than .40. This is a moderate but acceptable result. Most results of the t-tests for dependent samples, comparing the means of self-rating and expert rating, were significant. This may be due to the great sample size as there are only minor differences of the means for many items.

According to our data the SIAB-S can be a valuable instrument for screening purposes. Using the SIAB-EX expert rating as the criterion, the SIAB-S self-rating had a sensitivity of 0.70, a specificity of 0.80, and a positive predictive value of 0.91 with a diagnosis of anorexia and/or bulimia nervosa (worst ever condition). In comparison Johnson-Sabine et al. (1988) reported for the EAT-26 a sensitivity of 0.88, a specificity of 0.96 and a rather low positive predictive value of 0.53 for full or partial syndromes of an eating disorder in pupils. In two-stage studies, in which the SIAB-S is used at the screening stage and the SIAB-EX at the interview stage, it appears advantageous that both scales have the same items, in one case formulated for experts and in the other case for lay persons. There are, however, a number of caveats in interpreting sensitivity, specificity, and PPV. First, the diagnoses reported by Johnson-Sabine et al. included partial syndromes, while our data refer exclusively to full diagnoses. Second, in a non-clinical population base rates of eating disorders are low and eating disorder symptomatology is rather different from usual behaviour. Therefore, persons with high screening values have a high probability to have a full diagnosis of an eating disorder; therefore, higher sensitivity and specificity must be expected. Third, vice versa positive predictive value (that is the percentage of true cases in those who are identified as probable cases by the screening instrument) can be expected to be higher in clinical populations with a high rate of eating disorder symptomatology.

There are two approaches to use the SIAB-S questionnaire for screening purposes. Similar to the approach used by Johnson-Sabine et al., a SIAB-S sum score cut-off can be used, e. g. to identify persons at risk for an eating disorder in population studies. Alternatively, SIAB-S diagnoses may be especially suited for identifying clearly defined eating disorders according to DSM-IV and ICD-10 in (semi) clinical samples.

The approach using a sum score cut-off implies higher sensitivity and lower specifity compared to using SIAB-S-diagnoses. For the current state PPV was considerably increased by using SIAB-S diagnoses (72 % vs. 58 %). The usefulness of SIAB-S diagnoses may even be enhanced by the application of a diagnostic short form of the SIAB-S. This short form comprises only 35 items and includes all information necessary for deciding on eating disorder diagnoses according to DSM-IV. Thus, several options for the use of the SIAB-S are available from which the researcher may choose the one which suites the purposes best. Besides being an efficient screening instrument the SIAB-S provides a descriptive profile of eating disorder symptoms on other areas of psychopathology (depression, anxiety, obsessive-compulsive symptoms) and sexual as well as social impairment. These are important areas of clinical evaluations as well as follow-up studies.

Using categorical diagnoses as well as discriminant analysis resulted in about the same proportion of patients correctly classified by the SIAB-S for the current state. The converging results of these two very different methodological approaches confirms the stability of the findings on the predictive power of the SIAB-S.

Results of our study are of practical relevance, because carrying out structured interviews with well-trained interviewers is costly and time-consuming and self-report data can be fairly easily obtained. It is our experience that eating disordered patients are quite willing to fill out even long self-report forms, in some cases to an extent that it can be understood as self-injurious behaviour or at least a difficulty in saying no. We should not flood patients with questionnaires, but should use them very sensibly. Our results show that at least in identified eating disorderd patients, good data can be obtained using appropriate self-report questionnaires without sacrificing too much accuracy for convenience. At times and with certain items, self-report data may even be more reliable and valid if the item is straight forward and can be easily understood. There are a couple of limitations of this study. Our sample was not an unselected representative community sample but rather a selected sample (consecutively admitted inpatients of one hospital). Also, for reasons of practicality, we did not systematically change the sequence of administration of self- and expert rating. However, administering the self-report for an in-depth interview is the procedure used in two stage designs. The sequence applied in the present study thus corresponds to the usual sequence in which SIAB-S and SIAB-EX will be used. Since the interviewers were blind to the results of the SIAB-S a most likely effect of this procedure was that a patient was made more familiar with the questions later asked in the interview.

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