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The Questionnaire on Eating and Weight Patterns-5 (QEWP-5): An Updated Screening Instrument for Binge Eating Disorder

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Binge eating disorder (BED) recently has been included as a feeding and eating disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),¹ and consequently, there is a need for assessment measures that reflect the DSM-5 criteria. Therefore, we have revised and updated the widely used Questionnaire on Eating and Weight Patterns (QEWP), which was developed for use in the original field trials of the proposed criteria for BED. These criteria were included in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV)² and DSM-IV TR in an appendix for further study. In the sections that follow, we provide a background for the development and use of this instrument and describe modifications made to accommodate the DSM-5 criteria, with the hope that provision of the QEWP-5 will stimulate research to document its utility in clinical and research settings.

Behaviors consistent with BED, primarily in persons with obesity, were first described by Stunkard in 1959.³ Beginning in the 1980s, an increasing number of studies confirmed that recurrent binge eating characterized a distinct phenotype among obese individuals. The great majority of these individuals did not purge (or use other compensatory behaviors) after binge eating, thus differentiating their behavior from that of individuals with bulimia nervosa (BN).

In 1992, Spitzer and colleagues, in consultation with the American Psychiatric Association's Workgroup on Eating Disorders for the DSM-IV, proposed preliminary criteria for a new eating disorder, BED, as a distinct diagnosis.⁴ The collaborative group developed the Questionnaire on Eating and Weight Patterns (QEWP), which screened respondents for BED and also assessed demographic and behavioral characteristics, weight history, and other eating-disordered behaviors. The QEWP was administered by self-report or telephone in multisite field trials in a variety of settings, including university-based and commercial weight loss clinics, self-help groups, and community settings.^{4,5}

The initial multisite field trial established that BED was common in those attending specialized obesity treatment programs (30.1 percent), but far less prevalent in community samples (2.0 percent).⁴ BED also was more common in women than men, although the gender discrepancy was not as marked as that seen in anorexia nervosa or BN. Finally, providing evidence of face validity, BED was strongly associated with obesity, as well as a history of weight fluctuation, in both the treatment-seeking and community samples. A second large multisite study that included weight-control, community, and college-student samples, as well as patients with bulimia nervosa, confirmed the prevalence of BED observed in the first trial, as well as the disorder's association with obesity, weight fluctuation, functional impairment, and numerous demographic characteristics (as assessed by an expanded version of the original QEWP). BED also was found to be distinct from BN.⁵

In 1993, the QEWP was revised (QEWP-R) to focus primarily on assessing diagnostic criteria for BED, with continued inclusion of questions for research purposes (such as temporality of binge eating and dieting).⁶ This version also included revised decision tools for making a tentative diagnosis of BED based on responses to the questionnaire. The QEWP and QEWP-R have been further revised by others to include Adolescent and Parent Report versions and translated into multiple languages, including Spanish and Portuguese. In addition, some investigators have adapted the QEWP to capture episodes of loss of control (LOC) eating that do not involve the consumption of an objectively large amount of food (i.e., subjective bulimic episodes). This inclusion is potentially important because evidence suggests that the experience of LOC eating may be a fundamental characteristic of BED, independent of the amount of food consumed.⁷

The QEWP has been shown to have reasonable agreement with interview-based measures such as the SCID and the EDE. However, the QEWP generally is more sensitive and less specific, suggesting that the QEWP should only be used to screen for BED, with its confirmation by interview.

BED in the DSM-5

Based on a large number of studies confirming that BED has distinct behavioral and psychopathological features, which differentiate it from other eating disorders⁸ or obesity,⁹ BED was included in the DSM-5 as a diagnosis in the feeding and eating disorders chapter.¹ DSM-5 criteria for BED differ slightly from those included for research purposes in the DSM-IV and DSM-IV TR, and include: 1) a change from assessing binge days to binge episodes; 2) a reduction in binge frequency threshold from two to one episode per week; and 3) a reduction in minimum duration of symptoms from 6 months to 3 months, consistent with the thresholds for BN.¹ Table 1 compares diagnostic criteria for BED in the DSM-IV TR and DSM-5.

With the change in the DSM-5 diagnostic criteria for BED (as well as for BN), we have revised the QEWP-R to capture the new diagnostic criteria, including ruling out inappropriate compensatory behaviors consistent with BN (see Appendix-QEWP-5). The QEWP-5 may be used by investigators and clinicians without cost, although the source

should be cited and copyright observed. If an investigator or clinician wishes to adapt the QEWP-5 (for example, for administration to children or translation to another language), permission should be requested from Dr. Marsha Marcus at the University of Pittsburgh (marcusmd@upmc.edu). The QEWP-5 includes the following modifications to the QEWP-R:

1. Frequency of behavior: Assessment of the frequencies of binge eating and compensatory behaviors has been revised to correspond to those used to assess diagnostic threshold and severity criteria (for BED and BN) in the DSM-5.
2. Compensatory behaviors: The frequency of compensatory behaviors required for a diagnosis of BN is established in the DSM-5. However, with the exception of vomiting, specific operational definitions of other purging or non-purging behaviors are not provided. Because taking more than the recommended dose of medications -- such as obesity drugs, diuretics, or laxatives -- specifically to avoid weight gain after binge eating can be considered misuse, we revised the threshold for inappropriate compensatory use from "more than twice the recommended dose" (as stated in the QEWP-R) to "more than the recommended dose." For assessing exercise as an inappropriate compensatory behavior, we used a criterion of functional impairment (i.e., exercise despite being injured or interfering with important activities), as recommended in the DSM-5,¹ rather than a specified length of time (e.g., more than 1 hour), as used in the QEWP and QEWP-R. The instrument does not capture levels of inappropriate compensatory behaviors that do not meet criteria for BN but which may reflect partial or subsyndromal BN.
3. Questions eliminated: Questions that were not related to diagnostic criteria were eliminated, including temporality of dieting and binge eating onset.
4. Loss of control eating/subjective bulimic episodes: We have added questions to assess loss of control eating, in the absence of consuming an objectively large amount of food (i.e., subjective bulimic episodes), so that this information can be used for research purposes. These items also include frequency criteria so that severity can be assessed.
5. Revised decision rules: We have revised the decision rules for scoring the QEWP-5 to make them consistent with current diagnostic criteria for BED and BN. Because the QEWP and QEWP-R are sensitive but not specific for a diagnosis of BED, we also have noted that the QEWP-5 is a screening instrument. It should not be used to make a diagnosis, a task that requires a clinical interview.

In order to assess the readability and clarity of the QEWP -5, the questionnaire was administered to a convenience sample of adults, including scientific and nonscientific staff members at the authors' sites. Feedback from individuals who completed the revised questionnaire, as well as investigators with expertise in BED and BN, was incorporated in developing the final version of the QEWP-5.

Conclusion

The QEWP-5 is a screening tool that can be used in research or clinical settings to identify persons who may have BED. With the publication of DSM-5, there is a compelling need for updated screening instruments for use in clinical and research settings. Thus, we encourage the use of the questionnaire to examine its reliability and validity and document its utility in clinical and non-clinical populations.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

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TABLE 1

Comparison of Diagnostic Criteria for Binge Eating Disorder in DSM-IV TR and DSM-5 Research Criteria for Binge-Eating Disorder

DSM-IV TR	DSM-5
A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:	SAME
1 eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances	
2 a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)	
B. The binge-eating episodes are associated with three (or more) or the following:	SAME
1 eating much more rapidly than normal	
2 eating until feeling uncomfortably full	
3 eating large amounts of food when not feeling physically hungry	
4 eating alone because of being embarrassed by how much one is eating	
5 feeling disgusted with oneself, depressed, or very guilty after overeating	
C. Marked distress regarding binge eating is present	SAME
D. The binge eating occurs, on average, at least 2 days a week for 6 months	D. The binge eating occurs, on average, at least once a week for 3 months
E. The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa .	E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa . Specify if: <ul style="list-style-type: none"> In partial remission In full remission Specify current severity <ul style="list-style-type: none"> Mild: 1–3 binge episodes per week Moderate: 4–7 binge episodes per week Severe: 8–13 binge episodes per week Extreme: 14 or more binge episodes per week

Source: Reproduced with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (Copyright 2000) and the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (Copyright 2013). American Psychiatric Association. All rights reserved. DSM-IV TR criteria were considered research criteria.