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A Self-rating Scale for Bulimia
The 'BITE'

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A new brief questionnaire, the Bulimic Investigatory Test, Edinburgh (BITE), for the detection and description of binge-eating is described. Data from two separate populations demonstrate satisfactory reliability and validity. The scale has measures of both symptoms and severity. All items in the DSM-III definition of bulimia and Russell's definition of bulimia nervosa are covered but the questionnaire is more than just an operationalised checklist of these diagnostic criteria.

Over the past few years, there has been increasing interest in the prevalence of binge-eating (bulimia nervosa). One study (Halmi *et al*, 1981) found a prevalence rate of 13% in a population of American college students. In order to identify binge-eaters the authors used a short questionnaire, which included items on all the DSM-III (American Psychiatric Association, 1980) criteria for bulimia and for bulimia nervosa as described by Russell (1979).

A more recent study by Pyle *et al* (1983) used a slightly more sophisticated questionnaire to look at the incidence of binge-eating among college freshmen. This study found a prevalence of 4.5% in women, which is substantially lower than the figures found by Halmi *et al* (1981). This questionnaire also used DSM-III criteria, with the inclusion of questions about behaviour in the past as well as at the time of completion. In addition, Pyle *et al* defined what they meant by the term 'binge-eating', something that Halmi *et al* did not.

Hawkins & Clements (1980) have produced a questionnaire designed to provide descriptive and quantifiable information about behaviour and attitudes in binge-eating. This is a small 19-item questionnaire, of which only nine items are used in the calculation of the score. Although it could be used as a method of quantifying binge-eating behaviour, it is not comprehensive enough for epidemiological work. Nor would it be sensitive enough to enable identification of those with less severe pathology.

Much descriptive work has been completed on bulimia nervosa (e.g. Russell, 1979; Palmer, 1979; Wardle & Beinhart, 1981; Fairburn, 1983). It would seem more appropriate, when designing a questionnaire concerned with a particular disorder, to incorporate all the currently acknowledged symptoms and behaviour associated with that disorder. However, all the previous studies have relied on the American DSM-III diagnostic criteria and have used these as a basis for the wording of the individual items. Often no attempt is made to define what is meant by such terms as 'binge-eat'. Such questionnaires were all designed for the individual studies of which these were part and were often not tested for reliability or validity on separate populations before use. In a comprehensive review of the available questionnaires for use with binge-eaters, Gandour (1984) concludes that those currently available have been little used and they lack data on their reliability and validity. However, she indicates that a reliable self-report instrument would have a number of important potential uses.

These methods of questionnaire design are likely to lead to an overestimate of the incidence rate through misinterpretation of the questions, and/or a loss of information about those suffering from a less severely disordered eating pattern. The present authors felt that there was a need for a more sensitive questionnaire that would allow such people to be identified. In addition, there was a need for a tried and tested tool that explored fully the symptoms and behaviour associated with bulimia nervosa.

A questionnaire of this type has been developed for anorexia nervosa by Garner & Garfinkel (1979), the Eating Attitudes Test (EAT). The EAT has been used successfully as a screening tool to identify both clinical (Garner & Garfinkel, 1979) and subclinical cases of anorexia nervosa (Button & Whitehouse, 1981). Although the EAT is a proven, reliable questionnaire, it was not designed for use with binge-eaters: the questions are specifically concerned with the behaviour and feelings associated with anorexia nervosa. A more

References for this paper have been combined with those for the following paper and can be found on page 31.5. Similarly, all authors' affiliations are given at the end of the following paper, on page 29.

comprehensive measure of eating behaviour is the Eating Disorders Inventory (EDI) Garner *et al*, 1983*a*). This is a questionnaire designed to assess a broad range of attitudes and behavioural aspects of anorexia nervosa and bulimia. It consists of eight subscales measuring dimensions such as drive for thinness, body dissatisfaction, bulimia and maturity fears. This instrument is a major advance in the comprehensive assessment of anorexia nervosa. However, it was not designed for use with binge-eaters. The population on which it was validated consisted of 129 anorexic subjects and did not include a group of binge-eaters that met DSM-III criteria. Furthermore, it is too cumbersome for use as a quick screening instrument.

Although binge-eaters share some common features with anorexics, they differ in many ways (Russell, 1979). Binge-eating is a very secret behaviour, and it is helpful to subjects completing a questionnaire if they can see that the questions are relevant to their problem.

In summary, the aim of the present study was to design and validate a questionnaire which would identify binge-eaters, provide clinical information on cognitive and behavioural aspects of the disorder and have properties similar to those of the EAT. The questionnaire was to include the most pertinent signs and symptoms associated with binge-eating described currently in the literature. This could then be used both as an epidemiological tool for identifying cases and subclinical cases in a given population and as a screening device for use in outpatient clinics. In addition, it would serve as a useful tool in a treatment setting, allowing severity to be quantified as well as being a measure of the response to treatment.

Method

Questionnaire design

An initial list of all the symptoms and behaviour associated with binge-eating was compiled from the current literature. In particular, those symptoms described by Palmer (1979), Russell (1979) and Bruch (1975) were included, as well as those listed in DSM-III. From these symptoms a preliminary list of questions was devised, which was given to a group of subjects, both normal controls ($n = 10$) and binge-eaters ($n = 7$). The binge-eaters were all currently receiving treatment from one of the authors.

After discussion with the subjects, all those items that were either misinterpreted or found to be ambiguous were deleted or reworded. A final list of 40 questions was then drawn up, the Bulimic Investigatory Test, Edinburgh (BITE). This list contained seven items concerned with dieting behaviour, 27 concerned with symptoms and behaviour associated with binge-eating and six concerned with more specific information on the frequency of the most significant behaviour.

For the pilot studies, a further section of questions intended to elicit information about eating patterns and demographic factors, e.g. height, was included in the BITE.

Pilot studies

Two independent groups of binge-eaters and normal controls were used to test the validity of the BITE. An important test of the cross-validity of a questionnaire is its ability to predict a case when it is applied to a new group not involved in its original preparation. Accordingly, two separate studies were undertaken. The first study was designed to test the face validity of the questionnaire and its acceptability to subjects. Following statistical analysis, the results from this study were used to decide which items should be included in the final form. The second study was designed to test the validity of the BITE as a sensitive and reliable measure of binge-eating, and its ability to identify cases accurately. Scoring was designed to be carried out by computer, using the SPSS system (Nie *et al*, 1975). However, scoring by hand can also be done quickly and easily.

First study subjects

For the first study the subjects were 15 female binge-eaters (Binge 1) and 40 normal controls (Control 1) (13 males, 27 females). The binge-eaters were all at various stages of treatment by one of the authors. The control group included various members of the hospital staff and a group of third-year medical students.

First study results

The BITE was given to both groups of subjects and then scored. On the basis of the scores on the 27 questions on symptoms, the subjects were divided into two groups, high scorers (total score >20) and low scorers (total score <20). Sixteen subjects were high scorers (mean score = 33.73, s.d. = 8.14) and 39 low scorers (mean score = 5.9, s.d. = 5.37).

The high-scoring group contained 14 subjects from the Binge 1 group and two from the Control 1 group. In the low-scoring group there were 38 from the Control 1 group and one from the Binge 1 group. It seemed clear that the questionnaire had succeeded in identifying the bulimic cases. Statistical analysis confirmed that this result was highly significant ($\chi^2 = 95.69$, $P < 0.00001$, 1 d.f.). The one bulimic patient who scored below 20 was at the end of treatment.

The individual items in the BITE were then analysed to determine whether they were significant determinants of group membership, again using the chi-squared test. All but three of the items concerning symptoms were significant at the level $P < 0.05$ (1 d.f.), while 19 were significant at a level of $P < 0.0001$. On the basis of this analysis, it was decided to include three items from the dieting questions in the calculation of the total score. The three non-significant items were retained as it was felt they provided important clinical information.

Following the results of the first study, we subdivided the questionnaire into two subscales. The first subscale is

TABLE I
Comparison of subjects and controls for the first and second studies

Group	n	Age (years, mean ± s.d.)	Height (cm, mean ± s.d.)	Weight (kg, mean ± s.d.)
Binge 1	15	24.3 ± 5.7	163.3 ± 6.2	59.5 ± 11.7
Control 1	40	24.2 ± 5.5	168.2 ± 9.9	61.3 ± 9.8
Binge 2	32	25.3 ± 6.0	163.5 ± 3.4	62.1 ± 10.1
Control 2	32	24.8 ± 5.0	165.2 ± 7.3	57.4 ± 5.8

made up of 30 items relating to symptoms, behaviour and dieting, and is called the Symptom Subscale. The second subscale contains the six items measuring the severity of behaviour as defined by its frequency, and is called the Severity Scale.

The Symptom Subscale has a maximum possible value of 30, with a score of 20 as the criterion score. The Severity Subscale has a maximum score of 39 and a score of five or above is considered to be clinically significant. A total combined score of 25 or above is considered to be indicative of the presence of a severely disordered eating pattern.

Second study subjects

The subjects were 32 female binge-eaters (Binge 2), each of whom fulfilled DSM-III criteria for bulimia. These women took part in the study before commencing treatment. The control group (Control 2) comprised 32 normal females, including members of the hospital staff and psychology students. Demographic data on the subjects from both studies are presented in Table I.

Second study results

The BITE was completed by the second group of binge-eaters and normal controls. None of the normal control group produced a Symptom Score (mean = 2.94, s.d. = 2.94) or a Severity Score (mean = 0.44, s.d. = 0.29) above the cut-off points (20 and 5 respectively). All the binge-eaters scored above the cut-off on the Symptom Subscale (mean = 26.03, s.d. = 2.25), (see Fig. 1). All the binge-eaters scored above the cut-off score of 25 for the total score (mean = 36.19, s.d. = 4.47). Two subjects had a Severity Score of 4, the rest scored 5 or above (mean = 10.16, s.d. = 3.63). A total of 20 (62.5%) of the control subjects scored a Severity Score of 0. There is a highly significant difference between the total scores of the two groups ($t = 31.68$, $P < 0.001$, 62 d.f.) and also between both the Symptom Subscale and the Severity Subscale scores ($t = 35.29$, $P < 0.05$, 62 d.f. and $t = 14.65$, $P < 0.05$, 62 d.f. respectively).

Reliability

The inter-item reliability coefficient for all items on each subscale was calculated using the α reliability coefficient. Using both the subjects and the controls from the second study, α was 0.96157 for the Symptom Subscale and 0.62342 for the Severity Subscale. Thus, the items in both subscales demonstrate a high degree of internal consistency.

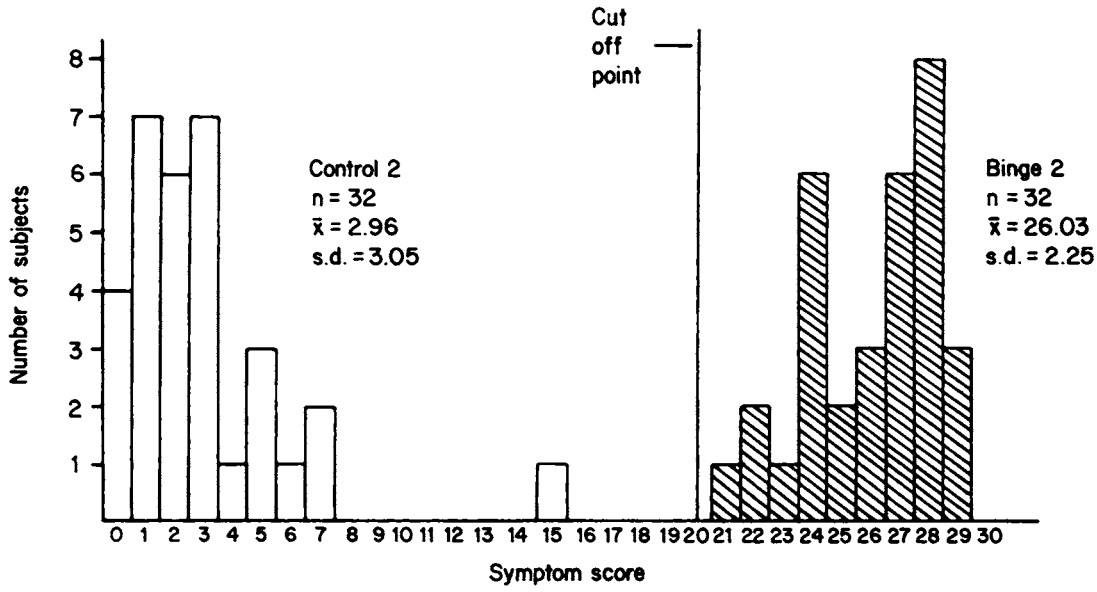

FIG. 1 This figure shows the scores of the Control 2 and Binge 2 subjects on the Symptom Subscale.

TABLE II
Correlation between BITE and EDI, EAT scores

Measure correlated with BITE		*Pearson's correlation coefficient R*	*No. of subjects N*	*Significance P<*
EDI	Drive to thinness	0.589	57	0.001
	Binge-eating	0.678	57	0.001
	Body dissatisfaction	0.352	57	0.01
	Ineffectiveness	0.506	57	0.001
	Perfectionism	0.143	57	NS
	Interpersonal distrust	0.227	57	NS
	Interoceptive awareness	0.519	57	0.001
	Maturity fears	0.438	57	0.001
EAT	Total	0.697	72	0.0001
	Diet subscale	0.621	72	0.0001
	Binge subscale	0.681	72	0.0001
	Oral control	0.232	72	NS

Relationship between the BITE and other measures

Scores on the BITE from the second group of binge-eating subjects (Binge 2) were compared with their scores on the EAT and the EDI (Garner & Garfinkel, 1982). The mean scores for the Binge 2 subjects on the EAT was 43.5 and the mean score on the bulimia subscale of the EDI was 10.5. The correlations are shown in Table II.

Third study subjects

Twenty-seven subjects in a treatment study completed the BITE before treatment, 8 weeks into treatment and at the end of 15 weeks treatment, to assess whether the questionnaire was sensitive to change. These subjects were all female, all met DSM-III criteria for bulimia and were bingeing at the rate of at least four times per month at the start of the study. The mean rate of bingeing was 7.2 times per week, at the start of the treatment study. The age-range of these subjects was 16–42 years, with a mean age of 22 years. The study involved a comparison of behaviour therapy, cognitive therapy and group psychotherapy. The preliminary results have been reported elsewhere (Freeman *et al*, 1985).

Third study results

Table III shows the scores on the BITE for these 27 subjects before starting treatment for bulimia, after 8 weeks and at the end of therapy. Significant reduction in scores occurred between 0–8 weeks and 8–15 weeks, showing that the BITE is highly sensitive to change.

Fourth study subjects (test–retest reliability)

To assess test–retest reliability, 30 non-case female controls completed the BITE on two occasions separated by at least 1 week. These subjects were members of hospital paramedical staff and mothers whose children attended a university day nursery. In addition, ten women who were DSM-III bulimia cases completed the BITE on two occasions separated by 15 weeks. These were subjects who were part of a waiting-list control group for another study. All ten subjects met DSM-III criteria at the end of the waiting-list period as well as at the beginning.

TABLE III
Change of BITE scores with treatment

	n	*Mean*	*s.d.*	*t value*	*2-tail P*
Pre-treatment	27	33.85	5.97		
				8.24	0.000
Mid-treatment	27	15.03	8.60		
				3.78	0.001
End-treatment	27	8.29	6.02		

Fourth study results (test–re-test reliability)

Mean scores for the 30 non-case women who completed the BITE on two occasions were as follows: first occasion 3.33 (s.d. 2.57, range 0–9), second occasion 3.22 (s.d. 2.27, range 0–9). A Pearson coefficient of $R = 0.86$ ($P < 0.0001$) shows a high positive correlation between the two sets of scores. Mean scores for the ten bulimic women who completed the BITE on two occasions were as follows: first occasion 34.4 (s.d. 3.13, range 29–38), second occasion 31.8 (s.d. 5.39, range 21–42). A Pearson coefficient of $R = 0.6825$ ($P < 0.05$) shows a high positive correlation.

Discussion

It is important that a questionnaire of this type should be easy to administer, acceptable to subjects and simple to score. The BITE meets all these requirements. It is self-explanatory and can easily

be given to large numbers of subjects for completion. Those subjects who have significant scores can be identified easily. The average time for completion of the questionnaire is less than 10 min. Those subjects who took part in the pilot studies reported that the BITE was very acceptable and many commented on the pertinence of the questions.

The sensitivity of any new screening instrument is very important. The results clearly indicate that the modified BITE produces neither false positives nor false negatives. It is able to distinguish binge-eaters clearly from normal subjects while at the same time picking up less severe levels of pathology.

As can be seen in Fig. 1, one subject from the Control 2 group had a Symptom Score of 15. This score would suggest that the subject had a disturbed, but not clinically significant eating pattern. This subject was interviewed and it became clear that she had unusual eating habits, but not of sufficient severity to be classified as a binge-eater. Similarly, two of the Control 1 subjects were found to have disordered eating patterns, again not clinically significant. The presence of subjects with eating problems in groups of randomly selected controls illustrates the problem of finding 'normal' control subjects. Binge-eating is not a discrete clinical state; there are many intermediate subclinical stages between normality and a DSM-III diagnosis of bulimia nervosa. A shorter questionnaire relying on a few key questions is unlikely to have been sensitive enough to identify and classify correctly such subclinical cases.

Furthermore, the BITE would appear to be sensitive to changes in both symptoms and behaviour during and after treatment. In this capacity it should serve an invaluable role as a measure of response to treatment and allow comparison of the effectiveness of different treatment methods.

Unlike other questionnaires used to identify binge-eaters, the BITE does not differentiate subjects in an all-or-none fashion. There is a large range of possible scores, and subjects suffering from binge-eating of various degrees of severity can be detected. Those scoring less than the criterion score of 25, but more than a proposed lower cut-off of 10, are likely to reflect a subclinical group of subjects who have a disordered eating pattern.

The use of frequency of behaviour as a measure of severity is open to criticism. However, the authors feel that it will serve as an alerting sign to those using the questionnaire. A high score on this scale (10 or above) indicates that the subject is binge-eating and fasting or engaged in purging behaviours more than once a week. It is acknowledged that frequency of behaviour alone does not automatically imply a case. A possible diagnosis of binge-eating should only be made when the subject scores above 25 on the two scales combined. There are groups of patients, e.g. psychogenic vomiters, as described by Fairburn (1979), who may well score highly on the question concerning self-induced vomiting, but who would not meet the criteria for a diagnosis of binge-eating.

The BITE is put forward as a tested, valid questionnaire, designed specifically for use by those interested in binge-eating. There is a need for such an instrument for use in the field of eating disorders, which will allow workers to look at binge-eating in a systematic way. The EAT has been used widely. However, it is of limited use when looking at the symptoms of binge-eating. It is hoped that the introduction of the BITE will provide as useful a measure of binge-eating tendencies as does the EAT of anorexia nervosa.

The significant positive correlation between the EAT and BITE scores for the Binge 2 subjects does not mean that the two questionnaires are measuring the same clinical dimension. Both instruments are measures of abnormal eating patterns and attitudes to eating, but the behaviour with which each is concerned differs significantly. It would not be possible to assign a DSM-III diagnosis of bulimia to a subject on the basis of their score from the EAT. The BITE provides such information as well as detailed clinical information concerning a subject's individual difficulties. In addition, it allows the clinician a method of quantifying the severity of the problem as defined by frequency of behaviour and the presence or absence of different purging behaviours.

Until now, all those concerned with eating disorders have had to design their own questionnaires. These are often not tested for reliability and validity on a separate population before use. The BITE is put forward as a tried and tested alternative that can be used easily for a range of different purposes. It can be used in epidemiological studies concerned with incidence rates in various populations; it can also be used as a measure of severity of symptoms and response to treatment by both psychiatrists and GP's in outpatient work. Its ease of administration and scoring makes it ideally suited to these tasks.

There is still a great deal of ignorance concerning both the incidence and prevalence rates of binge-eating. Fairburn (1983) states that bulimia nervosa may well be an important undetected source of psychiatric morbidity. The BITE should go some way to help us gain a better understanding of the true prevalance rate of binge-eating.

Appendix 1

BITE instructions for administration and scoring

Uses

The BITE is a 33-item self-report measure, designed to identify subjects with symptoms of bulimia or binge-eating. It can be used to identify binge-eaters in a given population or as a screening instrument for use in a clinical setting. In addition, it serves as a useful measure of severity and response to treatment. The BITE consists of two subscales: the Symptom Scale, which measures the degree of symptoms present, and the Severity Scale, which provides an index of the severity of bingeing and purging behaviour as defined by their frequency. Scores on the Symptom Scale can be subdivided into three groups: high, medium and low scores. Those subjects achieving a high score have a high probability of meeting the DSM-III criteria for bulimia and Russell's (1979) criteria for bulimia nervosa. An additional front data sheet accompanies the BITE, which provides useful demographic data relevant to the study and treatment of binge-eating. Use of this data sheet is optional; it does not contribute to the subject's final score.

Administration

When the BITE is used as a screening instrument or in survey work, the subjects should be asked to complete the questionnaire based on their feelings and behaviour over the past 3 months. Where the BITE is to be used as a measure of response to treatment, only the past month should be considered.

Scoring

Symptom Scale

All the questions, with the exception of the three starred (6, 7 and 27), make up the Symptom Scale. The underlined questions (1, 13, 21, 23, and 31) score one point for a 'No' response. The remaining 25 items score one point for a 'Yes' response. The maximum possible score is 30.

Severity Scale

The three starred items (6, 7 and 27) comprise the Severity Scale. The total score is the sum of the numbers corresponding to the circled responses.

Interpretation of results

Symptom Scale

In general the scorers on this scale can be subdivided into three main groups; high scorers with a score of 20 or more, medium scorers with a score of 10–19 and low scorers with a score below 10.

A symptom score of 20 or more indicates a highly disordered eating pattern and the presence of binge-eating. There is a high probability that a subject who achieves such a score will fulfil DSM-III criteria for a diagnosis of bulimia.

A symptom score in the medium range (10–19) suggests an unusual eating pattern, but not to the extent that a subject in this range would meet all the criteria for a diagnosis of bulimia. An example of this might be a compulsive eater who eats excessively but does not binge-eat. A score in the 15–19 range should certainly be followed up by an interview. Subjects in this category may well reflect a subclinical group of binge-eaters, either in the initial stages of the disorder or recovered bulimics.

A symptom score in the low range (0–10) falls within normal limits. Such a score indicates the absence of both compulsive eating and binge-eating.

Severity Scale

The severity scale measures the severity of bingeing and purging behaviour, as defined by its frequency. A score of 5 or more on this scale is considered clinically significant. A score of 10 or more indicates a high degree of severity. A significant score on this scale should ideally be followed up by interview, regardless of the symptom score.

A high score on this scale alone may identify the presence of psychogenic vomiting, or laxative abuse, in the absence of binge-eating.

Any score on the severity scale should be checked against the relevant question in order to check for this type of behaviour.

Appendix 2

Bulimic Investigatory Test, Edinburgh (BITE)

Optional front data sheet

1. What is your sex? MALE 1 FEMALE 2 (*please circle number*)
2. Are you:
   MARRIED 1 SINGLE 2 DIVORCED 3 SEPARATED 4 WIDOWED 5
3. What is your occupation? _____
4. If married, what is your spouse's occupation? _____
5. What is your age? _____years
6. What is your height? _____feet _____inches, or _____cm
7. What is your weight? _____stone _____pounds, or _____kg
8. What is the most that you have ever weighed?
   _____stone _____pounds, or _____kg
9. What is the least that you have weighed at your present height?
   _____stone _____pounds, or _____kg
10. What would your ideal weight be if you could choose it?
    _____stone _____pounds, or _____kg
11. Do you feel yourself to be VERY OVERWEIGHT 5
    OVERWEIGHT 4 (*please*
    AVERAGE 3 *circle*
    UNDERWEIGHT 2 *number)*
    VERY UNDERWEIGHT 1
12. Do you have regular periods? (if applicable) YES 1 NO 2
13. How often, on average, do you eat the following meals?

	EVERY-DAY	5/7 DAYS	3/7 DAYS	1/7 DAYS	NEVER	
BREAKFAST	1	2	3	4	5	
LUNCH	1	2	3	4	5	(*circle*
DINNER	1	2	3	4	5	*number)*
BETWEEN MEAL SNACKS	1	2	3	4	5	

14. Have you ever consulted someone in a professional capacity for advice on dieting/eating? YES 1 NO 2

15. Have you ever been a member of a slimming club? YES 1 NO 1

16. Have you ever suffered from any type of eating disorder? YES 1 NO 2
. . . . . if yes, please give details over:

Bulimic Investigatory Test, Edinburgh

1. Do you have a regular daily eating pattern? YES NO

2. Are you a strict dieter? YES NO

3. Do you feel a failure if you break your diet once? YES NO

4. Do you count the calories of everything you eat, even when not on a diet? YES NO

5. Do you ever fast for a whole day? YES NO

*6. . . . If yes, how often is this?
EVERY SECOND DAY 5 2–3 TIMES A WEEK 4
ONCE A WEEK 3 NOW AND THEN 2 HAVE ONCE 1

*7. Do you do any of the following to help you lose weight? (*circle number*)

	Never	Occasionally	Once a Week	2–3 Times Week	Daily	2–3 Times a Day	5+ Times a Day
TAKE DIET PILLS	0	2	3	4	5	6	7
TAKE DIURETICS	0	2	3	4	5	6	7
TAKE LAXATIVES	0	2	3	4	5	6	7
MAKE YOURSELF VOMIT	0	2	3	4	5	6	7

8. Does your pattern of eating severely disrupt your life? YES NO

9. Would you say that food dominated your life? YES NO

10. Do you ever eat and eat until you are stopped by physical discomfort? YES NO

11. Are there times when all you can think about is food? YES NO

12. Do you eat sensibly in front of others and make up in private? YES NO

13. Can you always stop eating when you want to? YES NO

14. Do you ever experience *overpowering* urges to eat and eat and eat? YES NO

15. When you are feeling anxious do you tend to eat a lot? YES NO

16. Does the thought of becoming fat *terrify* you? YES NO

17. Do you ever eat large amounts of food rapidly (not a meal)? YES NO

18. Are you ashamed of your eating habits? YES NO

19. Do you worry that you have no control over how much you eat? YES NO

20. Do you turn to food for comfort? YES NO

21. Are you able to leave food on the plate at the end of a meal? YES NO

22. Do you deceive other people about how much you eat? YES NO

23. Does how hungry you feel determine how much you eat? YES NO

24. Do you ever binge on large amounts of food? YES NO

25. . . . If yes, do such binges leave you feeling miserable? YES NO

26. If you do binge, is this only when you are alone? YES NO

*27. If you do binge, how often is this?
HARDLY EVER 1 ONCE A MONTH 2
ONCE A WEEK 3 2-3 TIMES A WEEK 4
DAILY 5 2-3 TIMES A DAY 6

28. Would you go to great lengths to satisfy an urge to binge? YES NO

29. If you overeat do you feel *very* guilty? YES NO

30. Do you ever eat in secret? YES NO

31. Are your eating habits what you would consider to be normal? YES NO

32. Would you consider yourself to be a compulsive eater? YES NO

33. Does your weight fluctuate by more than 5 pounds in a week? YES NO