EATING DISORDER ASSESSMENT

KEY POINTS

- Complete a thorough, individualised assessment of the young person and their situation (allowing clear and appropriate decisions about treatment).
- Aim to assess risk (medical and psychological).
- Be patient- and family-centred.
- A comprehensive assessment is generally achieved by involvement of the multidisciplinary team.
- Appropriately trained mental health staff should carry out the majority of the family and individual assessment.
- Questioning should be searching, detailed and sensitive. Aim to validate the young person's experience and demonstrate that you have heard what has been said by all family members.
- Attempt to gain some understanding of how the young person views their illness and what they feel will help or hinder their recovery.
- The interview will be difficult for many young people and will depend, in part, on their level of insight to the illness as well as their medical and psychological status at the time. Parent or carer input is required to validate or supplement some of the interview findings.
- Involve the patient and family in assessment, treatment and discharge planning.
- Adolescents are still growing and developing. Physical consequences of the eating disorder may be irreversible, though may be treatable if intervention is timely.
- See Appendix 5 for examples of psychometric assessment tools.

THE INDIVIDUAL INTERVIEW

The key aspects of the individual interview include consideration of the history of the presenting illness, the past and co-morbid psychiatric history, as well as social and family history.

HISTORY OF THE PRESENTING ILLNESS

1. Patient's perception of the problem and perceived impact on the patient and the family
2. Duration of illness
3. Description of the eating disorder symptoms (include onset, potential triggers and maintaining factors)
4. Weight controlling behaviours (restricting eating, vomiting, exercise, laxative use, and other substance misuse)
5. Current patterns of eating (including mealtime description, feelings associated with eating and binge eating episodes)
6. Presence of excessive exercise behaviours
7. Premorbid weight and growth
8. Degree of body image distortion; impact of potential weight gain
9. Insight into illness and motivation for change
10. Effects on school (e.g., academic progress, peer and teacher relationships, achievements, difficulties)

PAST AND CO-MORBID PSYCHIATRIC HISTORY

1. Past psychiatric history and treatment
2. Co-morbid conditions (mood and anxiety disorders are common)
3. Other psychological history including neglect, trauma, depression, self-harm, suicidal thoughts and bullying
4. Personality traits (e.g., perfectionism, obsessiveness)

SOCIAL AND FAMILY HISTORY

1. Personal interests (e.g., hobbies, sport, recreations) and strengths
2. History and details of family eating and dieting behaviours
3. Family history (e.g., mental illness)
4. Degree parents are working together consistently to care for the child
5. Relationships between family members
6. General atmosphere of the family (e.g., warmth, tension, closed)
7. Affective responses and communication processes between family members
8. Family strengths and weaknesses
9. Areas for consideration such as cohesion, adaptability, flexibility, hardiness, and problem solving
10. Cooperation, or willingness, of the family to work with the treating team

Note: HEEADSSS assessment is a useful tool in biopsychosocial assessment, although training is required (see Appendix 5).

MEDICAL INFORMATION

Collect information on pre-existing medical conditions, allergies, medications (including vitamins, minerals and complementary medicines), bowel function and a detailed menstrual history. The menstrual history should include age of menarche (if reached), regularity of menstrual periods, length of menstrual cycle, absence of any menstrual periods and date of last menstrual period.

PHYSICAL ASSESSMENT

Try to ensure that the physical examination is carried out sensitively. The patient will be exposing their body (a disliked aspect of themselves) to an unfamiliar person.

- **Weight and height**. Weigh without heavy clothing or shoes using calibrated scales (ideally those that will be used for future weighs). Measure height using a stadiometer.
- **Calculate BMI** (weight kg/height m^2).
- **Chart weight, height and BMI** using age appropriate percentile charts. Include any other available measures to help assess progress. Rapid weight changes even within the normal percentile range can cause severe symptoms.
- **Pulse, blood pressure (lying and standing) and temperature**
- **Assess for dehydration** (sunken eyes, dry lips and tongue, poor skin turgor, slow capillary return).
- **Skin inspection:** acrocyanosis (blue discolouration), jaundice, carotenaemia (orange skin), dry skin, lanugo hair (soft downy hair on back and arms), callused knuckles (repeated induced vomiting), skin infections and lesions from self-harm.
- **Oral examination:** dental erosions, pharyngeal redness and parotid enlargement may all occur with recurrent vomiting.
- **General systems examination** is required for all patients to assess any pre-existing illness. Other findings in patients with an eating disorder may include cardiac flow murmurs, oedema, evidence of significant constipation and hepatomegaly with rapid weight change.
- **Pubertal status** should be assessed using Tanner Stages.
- **Urinalysis** may show high specific gravity and ketones in fasting patients.

INVESTIGATIONS

- **ECG** is useful in all patients (provides a more accurate resting pulse and assesses for arrhythmias especially prolonged QTc which is common with severe weight loss).
- **Blood tests** - full blood count (FBC), electrolytes (UEC), liver function tests (LFTs), glucose, calcium, magnesium, and phosphate are mandatory in acute assessment especially if rehydration or refeeding is planned. These may all be normal even in very unwell patients. Thyroid stimulating hormone (TSH), Tri-iodothyronine (T3), Serum Thyroxine (T4), Follicle stimulating hormone (FSH), Luteinising Hormone (LH) and oestradiol should also be measured.
- **Bone densitometry** if available and amenorrhoea persists > 6-12 months.
- **Further investigations** to exclude other diagnoses & assess nutritional status may include: erythrocyte sedimentation rate (ESR), thyroid function, Ferritin, B12, folate, Anti-transglutaminase Antibodies, stool microscopy.
- **Pelvic ultrasound and bone age** may be considered.