Assessment of eating disorders

Aims of assessment

- An ability to draw on knowledge that the primary aims of an assessment are to identify:
  - whether the individual has an eating disorder
  - whether there are significant physical or psychological comorbidities that interact with the eating disorder
  - the most appropriate treatment for that person
  - whether the individual is motivated to change/engage, and, if not, whether it is likely that motivation can be enhanced
  - any physical and/or psychological risks

- An ability to use judgment to:
  - ensure that the assessment process is consistently collaborative, so that the client remains engaged
  - adapt the pace and duration of assessment sessions to support engagement
  - ensure that the client (and, where appropriate, their significant others) feels able to give their perspective on current problems with eating

Content of assessment

- An ability to identify, administer and interpret appropriate standardised measures
- An ability to integrate information from standardised measures into the assessment by discussing information gleaned from these measures with the client
- An ability to integrate information from any medical risk assessments into the assessment (such as rate of weight loss or abnormal blood test results)

- An ability to gain a detailed account of eating problems
  - the current state of the problem over the last few months, e.g.:
    - eating habits on a typical day (and on ‘good’ and ‘not so good’ days)
    - methods used to control eating, weight and shape, e.g.:
      - dietary restraint, dietary rules (and reactions to breaking these rules)
      - self-induced vomiting, use of laxatives, diuretics or appetite suppressants, other medicines (e.g. thyroxin), insulin purging, over-exercising (and any relationship to perceptions of overeating)
    - extent of any dietary restriction (undereating)
    - extent of overeating (bingeing, grazing), including the amount eaten, relevant triggers and any sense of loss of control
    - other eating habits (such as ritualistic eating)
    - drinking, smoking and substance use (and any connection to eating problems)
    - ability to eat socially

- An ability to help the client discuss their fear of uncontrollable weight gain and its impact on their efforts at control
- An ability to identify the history of any uncontrollable weight gain, and alternative reasons for this, e.g.:
  - starvation-based binges, yo-yo dieting
  - as a response to emotional triggers or specific environmental cues

- An ability to discuss the client’s concerns about eating, weight and shape, and the centrality of these issues in self-evaluation

An ability to discuss and evaluate the extent of eating-related behaviours that maintain a negative body image, e.g.:
excessive weighing or avoiding weighing
calorie-counting/weighing food
behaviours related to social media and apps (e.g. taking selfies, browsing food and body images, viewing/engaging with thinspiration/fitspiration content)
An ability to assess the client's weight history, before and after the eating problem emerged, including:
the client's highest and lowest weight
patterns of weight change (e.g., gradual increase or a 'yo yo' pattern of gains and losses)
An ability to discuss the impact of the eating disorder on psychosocial functioning, e.g. its effect on their:
mood
family and romantic relationships
capacity for study/work
activities, interests and spirituality
financial situation (e.g. overdrafts, debts)

An ability to discuss the development of the eating problem, e.g.:
its onset, and any triggers
how the problem evolved
any periods of sustained remission (whether spontaneous of as a result of treatment)

An ability to discuss the outcomes and experience of any previous interventions

An ability to discuss the client's personal and family history, e.g.:
their experience of their family as they grew up, along with current experience and contact
their educational and occupational history
any coexisting psychological difficulties (e.g., anxiety, depression, low self-esteem, self-harm, substance use, indicators of excessive perfectionism)
any significant traumatic events or experiences (e.g., emotional, physical or sexual abuse, bullying, major bereavements)
An ability to discuss the client's interpersonal history, from childhood to the present (including friendships and relationships)

An ability to discuss the client's family history, e.g.:
any family psychiatric history (particularly depression and substance abuse)
any family history of eating disorder and obesity

An ability to discuss the client's physical health, and present and past medical history
An ability for non-medical specialists to draw on a working knowledge of areas of medical concern in people with eating disorders, e.g.:
features directly associated with the eating disorder, such as marked undereating, self-induced vomiting, over-exercising while underweight, rapid weight loss or significantly low weight
physical symptoms or signs, such as feeling faint, disoriented, chest pains, muscle spasms, shortness of breath, weakness, traces of blood in vomit
An ability to refer the client to an appropriate physician/nurse when there are areas that give rise to medical concern

An ability to discuss the client's attitude towards the eating problem and to treatment, e.g.:
their sense of what maintains the problem
their motivation for seeking and starting treatment
their goals (what they would like to be different)
their concerns about treatment and the prospect of change

Formulation and intervention planning

Knowledge

- An ability to draw on knowledge that the aim of a formulation is to explain the development and maintenance of the client's difficulties, and that formulations:
  - are tailored to the client
  - comprise a set of hypotheses or plausible explanations that draw on theory and research to explain the details of the clinical presentation obtained through an assessment
  - can be at the level of the overall presentation or addressed to specific behavioural patterns (e.g. cycles of safety behaviour)
- An ability to draw on knowledge that formulations should be reviewed and revised as further information emerges during ongoing contact with the client

- An ability to draw on knowledge that a case formulation usually includes consideration of:
  - factors that might predispose to the development and maintenance of the eating disorder (causes)
  - factors that might trigger the onset or exacerbation of difficulties (triggers)
  - factors that might perpetuate unhelpful coping strategies (maintenance), including:
    - factors that might moderate the impact of causal, triggering and maintaining factors, such as a supportive relationship
  - factors that explain the links between causes and the development of the specific eating disorder features (e.g. the development of poor self-esteem)
  - protective factors that might prevent a problem from becoming worse or may be enlisted to ameliorate the presenting problems (e.g. good family communication)
- An ability to draw on knowledge that one of the main functions of a case formulation is to help guide the development of an intervention plan
  - an ability to draw on knowledge that the intervention plan usually aims to reduce the effects of identified maintaining factors, and to promote protective factors

- An ability to draw on knowledge that to assure the utility of case formulations, they should be:
  - based on commonly used models of eating disorder or behaviour, where possible
  - 'sense-checked' as far as possible with the client, significant others and other clinicians
  - parsimonious
  - open to review (during assessment, treatment and post-treatment)

- An ability to draw on knowledge that the rationale for a formulation of a specific (unhelpful) behaviour is:
  - to help the client identify the risk of using that problem behaviour, and so reduce the likelihood of using it
  - understanding the short- and long-term function of the behaviour, especially safety behaviours (e.g., binge-eating for short-term emotional relief)
  - identifying and implementing more helpful ways of fulfilling that function

Ability to construct a formulation

An ability to draw on background knowledge when constructing the formulation, including theory and research that identifies biological, developmental, psychological and social factors that help to understand the development and maintenance of eating disorders

An ability to evaluate and integrate assessment information obtained from multiple sources and methods, and to identify salient factors that significantly influence the development and maintenance of the eating disorder, including:	
	the client's perception of the most significant issues
	the client's interpretation of their eating disorder, and the impact this has on the ways in which they manage their condition and their motivation for treatment
	family/carer/significant others' perspectives on the significant issues
An ability to construct a collaborative case or behaviour formulation that:	
	clearly acknowledges the client's perceptions of the factors pertinent to their presentation
	provides the client with a rationale for considering alternative perspectives that may lead to more adaptive eating patterns
An ability to share the formulation with the client in an open and accessible way that invites their feedback, and to modify it in the light of their comments	

An ability to draw on the formulation in order to identify the most appropriate intervention for the client
An ability to use the formulation to explain the most appropriate intervention to the client, family, significant others and other clinicians

Ability to collaboratively engage the client in an intervention plan

An ability to engage the client in a collaborative discussion of the treatment options open to them, informed by the information gleaned through assessment, the formulation emerging from the assessment, and the client's aims and goals
An ability to convey information about treatment options in a manner that is tailored to the client's capacities and that encourages them to raise and discuss queries and/or concerns
An ability to provide the client with sufficient information about the treatment and intervention options open to them, so that they are:
aware of the options available to them
in a position to make an informed choice from among these options

An ability to ensure that clients have a clear understanding of the approach being offered to them (e.g. its broad content and the way it usually progresses)

While maintaining a positive stance, an ability to convey to the client (and significant others) a realistic sense of:
the effectiveness and scope of the intervention if the client engages fully with it
the limitations of the intervention (i.e. what may change, and what is unlikely to change as a consequence of the intervention)
any challenges associated with the intervention

An ability to use clinical judgement to determine whether the client's agreement to pursue an intervention is based on a collaborative choice (rather than being a passive agreement, or an agreement that they experience as imposed on them), and:
an ability to identify when the client's understanding of their condition is at odds with the proposed intervention model, and to maintain a collaborative discussion in order to reach agreement over how to proceed