

Practice Pointer: Assessment of an adolescent with a possible eating disorder

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Assessing young people with possible eating disorders can be complex for a variety of reasons, including managing confidentiality and risk (for example, a young person not wanting their parent to be involved, or a parent presenting with concerns about their child), the young person or parent not being aware of the severity of the illness, and difficulty in knowing how questions can be sensitively phrased. This Practice Pointer will offer advice on building therapeutic relationships in consultation with a child or young person, and with their parent(s), what information to gather and how to do so sensitively, and how to discuss the role of the parent or carer in treatment. We recommend that it is read alongside the accompanying Clinical Update for detailed notes on examination, investigations, when to refer, and risk. The advice is based on expert experience. We use the female pronoun throughout as eating disorders are more prevalent in females, but it should be noted that they can and do also occur in males.

Developing the therapeutic relationship:

- *How to approach a consultation with a child/adolescent presenting alone*

A non-judgemental and respectful manner is crucial in developing rapport. As in all appointments where you see a child or young person alone, it is important to be honest from the start about the limits of confidentiality. Begin by thanking her for being brave enough to tell you about this. It's really important to talk about it and think about how you can help her get better. You need to assess whether she has an eating disorder and the extent of risk to her health, plan follow-up and establish whether you need to let her parent(s) know what is happening. Make sure you can maintain contact with her – do you have her mobile number? Is she happy to have letters posted to her? Can you book a follow-up appointment before she leaves? Is there anyone else in the family or at school she might be happy to involve in her care?

Ideally, you will be able to agree with the young person that they, you, or both of you together, let her parent(s) know what is happening ('I think it's really important that we find a way to let your parent(s) know about what's going on – they are worried and want to help – can you think of a way we could do that? Could you tell her here with my support, or would you like me to tell her what's happening? Could we do that now, or should we make another appointment together?'). Depending on the severity, risks involved, and the young person's age, you may have to break confidentiality, balancing this against the risk of losing trust. It may be appropriate to prioritise establishing a relationship with her over a few meetings. A conversation with a colleague, or calling your local child and adolescent mental health team might help you make this decision. As well as being an important part of managing risk and helping the young person get better, the parent may offer useful collateral about behaviours around eating and weight, which may be minimised by the young person.

- *How to approach a consultation with a parent/carers*

Parent may present with concerns about their child or young person's eating and weight without bringing them to the appointment. Reassure the parent that he/she has done the right thing in coming to see you with their concerns. If the consultation reveals that the young person has lost

weight, is food restricting, vomiting/taking laxatives or exercising excessively, has physical problems or low mood, then the young person will need to be seen for follow-up. Your consultation may lead the parent to conclude that this is necessary; if not you need to share your concerns with them. Parents can become used to the “new normal” of disordered eating, and may need help understanding the risks.

Parents may want advice about how to get their child/young person to come and see you. You can let them know that although a young person may be angry with being required to seek help, they often feel reassured that parents care enough to insist on it. If the parent-child relationship is already tense, the parent(s) could build it up by focussing positively on neutral areas not related to food/weight. With regard to raising concerns about eating, it is difficult but important for parents to try to stay calm and authoritative even though they may feel very anxious and frustrated. They could open a conversation with something like “you haven’t seemed yourself recently – is there a problem we can talk about? – we need to keep you healthy and help you feel better about yourself”. If there are physical symptoms (e.g. periods stopping) this can be a good reason for seeking medical help; otherwise the parent can raise their worries about the risks of not eating enough. It may be helpful to let the young person decide whether they would rather visit the GP or the school nurse initially (school nurses can usually refer directly to Child and Adolescent Mental Health Services, and school perception of the child and her peer group provides useful information for specialist services).

Meeting a young person for the first time after having met alone with their concerned parent presents its own challenges. The young person might be unhappy that you have apparently formed an alliance with the parent. Some strategies to try include: open questions about current difficulties; what she thinks her parent is worried about and why; what her worries are about opening up to you; explaining why you are worried. Avoid commenting on weight. Focus ideas about treatment on helping her feeling better about herself.

Sensitive information gathering

Box: exploring extent and speed of weight loss

This can be difficult for the family to assess as they are seeing the person daily; you could ask whether clothes are now too big, and when she was last weighed. Practice records of previous weight and height can be useful for secondary services. Weight loss of 1kg or more per week is particularly worrying. Weighing and measuring height is useful; some young people may find this very challenging and it can be helpful to offer them the option not to look at the scales or be told their weight, and to remind them that weight fluctuates during the day with amount of fluid, and that different scales will often give different weights due to differences in calibration. Some young people may try to conceal the extent of their weight loss by drinking extra fluids before weighing or by carrying heavy things in pockets, so ideally weighing should be done after removing outer layers of clothing and shoes, and repeated weighing over several weeks can give a more accurate picture of true weight.

Box: exploring eating and food

These questions can help explore food restriction and binge eating. What did she eat yesterday? Has she changed what she eats? Is she trying to restrict the amount she eats, whether or not she

succeeds? Are there foods she will no longer eat? Has there been a change in her behaviour around food preparation, e.g. new interest in cooking? Does she ever eat until she feels uncomfortably full? Does it ever feel like her eating gets out of control?

Box: exploring weight-loss behaviours

What does she do in terms of exercise (type and frequency)? What happens if she can't exercise? (refusing to miss sessions when unwell/injured, or distress at other engagements interfering with exercise can indicate feeling driven to exercise rather than enjoying it) Has she been making herself sick, taking laxatives, diet pills or water tablets, or drinking excessive water to prevent hunger? (These can disturb electrolyte balance.) Has she been drinking excessive caffeine, smoking heavily or using weight-loss medications bought online? Has she stopped taking prescribed medication (e.g. steroids, anticonvulsants) for fear of weight gain side effects? (If binge eating and purging once a week or more for over 3 months then bulimia is likely; less frequent may indicate OSFED)

Ask for more detail about any weight loss behaviour you find, for example you may ask the following concerning vomiting: What is your main worry about the vomiting? How long has it been happening, and how often? When do you normally vomit, and why? (Shame may lead to her underestimating frequency).

Box: exploring motivations

It is important to try to establish the aims of restricting eating/vomiting/other weight loss behaviours (Begin with an open question around why they are engaging in the behaviour. Then probe further with questions like: Are you trying to lose weight? Do you feel like you're too fat? What would be your ideal weight? An unrealistically low target weight, or a belief that she is very overweight, would point towards a disorder. You could ask what she sees when she looks in the mirror).

Box: Physical complaints and differential diagnosis

Has she had any faints or funny turns? Does she feel the cold more than previously? Has she experienced abdominal pain, constipation, sore throat, bloating, lethargy, haematemesis? Does she still get/has she started her periods? (This is not in DSM 5 diagnostic criteria but remains an important marker of excessive weight loss/malnutrition). It is also important to screen for other possible causes of weight loss such as diabetes, hyperthyroidism, diarrhoea and vomiting, inflammatory bowel diseases

Box: Social history

Family relationships (Eating problems can be really stressful for parents and siblings - how are things in the family generally? How is everyone getting on? Is she withdrawing from others?)

Peers (Is she being bullied or picked on? Is she withdrawing from friends?)

School (How is her work at the moment? Does she find it hard to concentrate? Is she getting into any trouble at school? Are there current pressures, e.g. exams?)

Social media (What does she look at online? Pictures of models, advice on diet and weight loss? Is she in contact with people with eating disorders?)

Box: Family history

Is there a family history of eating disorders, dieting, overweight?

Box: Mood & risk of suicide

Eating disorders are often comorbid with anxiety or depression. Ask about mood, and ask directly about self-harm and suicidal ideation (How is she in herself? Have there been changes in mood or sleep? Is she still enjoying things? Has her sense of humour gone? Has she ever self-harmed? Has she ever felt so low that she's thought about killing herself? Can you tell me more about these thoughts/plans? Plans to end her life indicate a need for urgent psychiatric assessment).

Box: Safeguarding

It is always important to consider whether there are any safeguarding concerns when seeing a child or young person. Ask direct questions about any history of emotional, physical or sexual abuse, or neglect, explaining that this is part of your routine practice when you see a young person. This may not be appropriate in the first meeting, but should be raised once you have established a trusting and supportive therapeutic relationship.

Initial Management

If you think that a young person has an eating disorder you should promptly refer her to your local specialist child and adolescent eating disorder team, as early intervention is associated with improved outcome. Refer to the associated Clinical Update for guidance on determining the urgency of the referral and whether a simultaneous referral to Paediatrics is indicated. In the meantime, you can usefully share your concern about the risks of food restriction and weight loss behaviours for physical health. In the case of a young person who has been severely restricting their dietary intake, be cautious about advising an immediate return to normal eating as there is a risk of refeeding syndrome. Return to normal eating needs to be done carefully under the care of a specialist team. In the case of a young person who is binge eating and vomiting, you can highlight the ineffectiveness of vomiting, laxatives and diuretics in weight loss, and explain the usefulness of regular, normal meals and snacks to minimise risk of binges and vomiting. If she is prescribed an oral contraceptive, counsel her that vomiting will reduce its efficacy and if sexually active she will need to use another method of contraception. You should also arrange a follow up appointment, and for blood tests (as detailed in the associated Clinical Update) and an ECG.

The role of a parent or carer in treatment process

It can be helpful to for families to conceptualise the eating problems as separate from the young person, so that parent and child can team up against it; some young people find it helpful to think of the eating disorder as having a bullying "voice". This can be hard initially when the young person may not believe they are unwell. It is very challenging and stressful looking after a child with an eating disorder – encourage the parent(s) to look after themselves and ask for help of their own if they need it; recovery can take many months. An alliance of both parents can be more powerful

than one parent acting alone; if the other parent is not able to help, a lone parent might usefully seek support from a respected and supportive relative, or a professional in school. Specialist child and adolescent teams will be likely to want to involve the whole family, including siblings. The linked Clinical Update provides useful sources of information for parents and carers.

Case examples

Box: Clinical scenario 1

A mother presents to discuss her 13 year old daughter's changed eating patterns. The daughter spends significant time doing sport at school, and running cross-country for the county, but is no longer eating properly and seems withdrawn. She thinks she is losing weight, but her daughter does not want to be weighed and alludes to thinking she is fat. Her daughter doesn't know she has come to see you; the mother wants to know what she can do without you needing to see her daughter as she is worried her daughter will become upset and withdrawn if others are involved.

How to approach

Your aims in the consultation are to help the mother to find a way of discussing the issue with her daughter, plan how to facilitate a meeting with the daughter and assess immediate risk to health.

Box: Clinical scenario 2

A 15-year-old young person is brought to see you by her mother, who is concerned that she has seemed withdrawn and unhappy for the past 6 months. When you talk to her alone, she reveals that she has been making herself vomit after meals. She doesn't want her mother to know. She seems to be of normal weight.

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