

MENTAL HEALTH ASSESSMENT

Issues to cover in the initial interview

- The clients description of presenting problem/s
- History of the development of the problem/s
- Co-morbid psychiatric or psychological problems, previous treatments
- Personal, social and family history
- Mental state examination
- Provisional diagnosis and formulation

Presenting problems

How does the client perceive his/her problem? It is important that s/he state, in his/her own words why s/he has come to see you, and this should be recorded verbatim. Question clients gently if you suspect that there is an underlying eating problem. Some clients may become defensive and withdrawn but others will be relieved that someone has recognised that there are issues, other than those presented. Suggestions for dealing with this situation may include saying:

'I can't help noticing that since I last saw you, you've lost a lot of weight – what's been happening?' Alternatively, try to link some of the symptoms that a client has presented with, to the dieting problem e.g. *'You know, the disturbance to your periods, the tiredness, lethargy and poor concentration that you've been experiencing could be related to how you're eating...perhaps we should take a look at that issue more closely?'*

Drawing a link between physical problems and dieting behaviours can help to highlight the importance of returning to a normal diet and may assist in motivating the client. At this stage of the interview paraphrase and summarise what the client has said. Later, return to examine the problems in more detail.

Comorbid Psychological Problems

Clients with eating disorders are subjected to the same psychiatric problems as the general population. There is a tendency however for certain problems to be more common among the eating disorder group.

When assessing a person with an eating disorder from a psychiatric perspective, consider the effects of the metabolic imbalance or poor nutritional state before making an additional psychiatric diagnosis. If at all possible, consultation with a psychiatrist should be arranged if the psychiatric illness appears significant or is of chronic duration.

The conditions with which people with eating disorders are more often associated are:

- Depression
- Obsessive Compulsive Disorder
- Substance Abuse
- Borderline Personality Disorder

Depression

Depression is commonly seen in people with eating disorders. In part this is most probably due to their poor nutritional state, and in the case of anorexia nervosa that they are in a condition of chronic starvation. The depth of the depression can vary from mild unhappiness or dysthymia to severe suicidal ideation with social withdrawal. Symptoms of depression are often very similar to those of the eating disorder and it is for this reason that an

additional diagnosis should not be made until the eating disorder has been stabilised and the client has been seen over a period of several weeks.

Depressed mood can best be assessed using a mental state exam and by the way in which the client presents and describes their mood. The most important aspect of depression that needs to be assessed is suicidal thoughts and/or actions. Suicidality can be assessed using a series of questions that form a natural hierarchy - the assessor should go along this hierarchy as far as necessary. (Asking questions about thoughts of suicide or self harm does not increase the likelihood that these things will occur).

Have you thought about committing suicide/harming yourself in any way?

Have you made any plans to commit suicide?

Do you have the means at your disposal?

Have you made an attempt?

While occasional thoughts about suicide are fairly common, plans to commit suicide are to be treated seriously. If a client has a plan to commit suicide liaison with the local crisis team or community mental health team will be necessary, with a view to hospital admission.

Delay using antidepressants or major tranquillisers until observing the effects of starting in treatment and regaining weight. If depression appears to be pervasive and does not respond to an improvement in physical state, then a trial of antidepressant medication is warranted. The dosage should initially be low and be gradually built up over a period of several weeks to therapeutic levels. Avoid tricyclic antidepressants, which are dangerous in anorexia nervosa, instead use one of the newer ones (such as a SSRI or SNRI). If in doubt about the diagnosis or the management then referral to a psychiatrist is appropriate.

Obsessive Compulsive Disorder

This condition is seen to a mild degree in many people who have eating disorders. It may manifest itself in the form of counting calories, repetitious weighing or obsessional thinking about body shape, weight and/or food. At times it becomes extremely pathological.

Upon initial assessment, a general question like – ‘Are you a person who likes things done in a certain order or in a certain way?’ – can help determine degree of obsessiveness. Get the client to describe what sort of things s/he likes done in a certain way, the frequency, time taken, beliefs about and history of these symptoms. In your questioning target the non-cognitive compulsions like hand-washing, ordering and checking, that makes up the symptoms of OCD. If a client performs these compulsive behaviours, it is important to ask about the obsessions (repetitive thoughts, images or impulses) that lead to the compulsions. This can be done asking, ‘What concerns you if you do not do things that way or in that order’. This is a very general screen for OCD symptoms and will not capture the symptoms of OCD clients who use compulsive mental acts to deal with obsessions.

Generally, the obsessive compulsive ideation tends to resolve as the eating disorder comes under treatment, however in some instances it may continue. If the obsessive compulsive ideas and behaviour are generalised and involve other areas of the person’s life, it is more likely that a separate diagnosis of obsessive compulsive disorder can be made. In this case, symptoms should respond to specific medication such as tricyclic or SSRI antidepressants, or cognitive-behavioural treatments like exposure and response prevention therapy. Again, if in doubt about the diagnosis or management of obsessive compulsive disorder, referral to a psychiatrist or clinical psychologist is appropriate.

Substance Abuse

People with eating disorders, particularly bulimia nervosa, frequently abuse alcohol or drugs. The alcohol abuse may be binge-like as the eating disorder itself may be, or be used to control appetite and weight as in the case of amphetamine abuse. Certain appetite suppressant tablets have a mechanism of action similar to amphetamines and can cause a sensation similar in quality though less euphoriant. Abuse of those drugs can be associated with fluctuating mood states from mild elation to depression.

All clients, including those with eating disorders, should be asked about their alcohol consumption, their use of recreational or illegal drugs, and particularly cigarette smoking as this is commonly used to suppress appetite, assist dieting and prevent weight gain. When asking about substance use/abuse it is important to focus on the behaviour rather than the person.

If the substance abuse is prominent it may need to be managed in its own right and would ideally be brought under control before attempts are made to control the eating disorder. It is best to make a referral to a specific drug and alcohol clinic, or drug and alcohol counsellor.

Borderline Personality Disorder

Some people suffering from an eating disorder, particularly those with bulimia nervosa, also exhibit characteristics of a borderline personality disorder. Their history may include past sexual abuse, either during childhood or later, substance abuse, deliberate self harm, generalised impulsivity and considerable difficulties managing their interpersonal relationships. The eating disorder may present as only a part of this condition. Although the eating disorder needs to be managed in its own right, a person suffering from borderline personality disorder requires specialised psychotherapy as well. The eating disorder can usually be managed while that treatment is undertaken.

Previous Treatments

Some clients with anorexia nervosa may have had a previous period of illness, remitted or recovered, and are now presenting again. Others may have sought help for the presenting problem before coming to you. Where the client has had previous treatment note:

- duration of treatment
- type of treatment - who and what kind (psychologist, psychiatrist/CBT, psychotherapy)
- what did the client find helpful about the treatment
- what was not so helpful and
- how it could have been more helpful

This latter information is important for treatment planning and may also uncover any beliefs that a client has about his/her problem or treatment.

Personal and Social History

Employment history

Questions should cover:

- Age at first job.
- Number, duration and type of previous jobs. Note the frequency of job changes.
- Periods of unemployment and why.
- Current job and feelings about it. Ask if there are any problems or what they like and dislike about the job.

- Long-term ambitions and goals for work.

It is often important to discuss these issues in relation to the effect the eating disorder has had upon a client's employment history.

Childhood and Schooling/Education

Note place of birth, caregivers and nature and quality of care received. Ask the client to describe what it was like growing up in their family. Document any childhood difficulties. Record the age when the client left school and qualifications received. Difficulties with teachers or other students should be described. The client can be asked what they did best in at school.

Family relationships

It is helpful to get clients to describe their family of origin and their immediate family - detail names, ages and occupations of family members. Describe any important family events (e.g. major transitions like migration, relationship changes, losses and achievements) and establish the quality of the relationship between the client and various members of their family. Identify who in the family is aware of the eating problem and how the family is coping with it – are they supportive of a treatment plan? Obtain a family history of an eating disorder, affective disorder, substance abuse, anxiety or other mental illness and history of treatment.

Marital and Relationships History

The client should be asked to describe his/his/her current relationship and partner. Any current problems should be probed, including the quality of the client's sexual relationship. Is the partner aware of the dieting problem or not and if so, how they are dealing with it?

Ask about the number of previous relationships, get the client to describe these – how long they lasted and why they did not work. Whether previous partners were aware of the dieting problem and how they dealt with it will also be worth noting.

Social relationships

Assess the degree of social support the client has and the effect the eating disorder has had on their social relationships. Ask if friends are aware of the client's eating problem.

Interests

A client's interests, hobbies and achievements should be listed.

Forensic History

A history of arrest, assault or violence should be followed up. Eating disorder clients are rarely violent but an extensive legal history or history of violence may suggest a personality disorder and a potential for future violence.