CHAPTER 1

Diagnostic Issues

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Patients with eating disorders may present in a variety of settings with complex histories and a range of symptoms. While the two most well-defined syndromes, anorexia nervosa (AN) and bulimia nervosa (BN), are readily recognizable if a full history is available, patients frequently do not provide a complete description of their difficulties. They may describe symptoms that suggest the presence of other diagnoses, and they may fail to meet all criteria for AN or BN. The goal of the clinical assessment is to elicit information that will permit the accurate description of presenting symptoms, the identification of specific syndromes, and appropriate treatment recommendations. This chapter reviews the evaluation and assessment of patients with disordered eating in a general clinical setting. The clinician may also wish to consider the use of structured diagnostic and assessment instruments routinely employed in research settings. These are described elsewhere in this volume.

We first provide a broad description of the clinical assessment of the symptoms and signs associated with eating disorders. We then identify specific issues particularly relevant to the different eating disorder categories as identified by DSM-IV (the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*; American Psychiatric Association, 1994). We thereby hope to provide a useful introduction to the evaluation of patients with disordered eating.

PSYCHIATRIC INTERVIEW

The clinical assessment of individuals with eating disorders should follow the standard approach to the assessment of any emotional or behavioral problem, but the content and specific questions should be tailored to focus on eating disorders. One major goal of the initial assessment is to allow the patient to provide a description of the development of his/her difficulties from his/her perspective. Opportunities to corroborate aspects of this story can be pursued by consulting the patient's family, if possible and appropriate, the referring clinician, and previous treatment providers. A primary focus of the evaluation should be the patient's weight and eating history and associated emotional and behavioral problems.

Reason for the Assessment (Chief Complaint)

The assessment should begin by determining, from the patient's perspective, what prompted the evaluation. One of the difficult aspects in treating individuals with eating disorders, especially with AN, is patients' ambivalence about making changes in their eating, coupled with a tendency to deny the potentially serious nature of their disorder. Clarification of whether the patient initiated the appointment or was persuaded by another party to come for an evaluation can assist the clinician's assessment of the patient's insight and level of commitment to change. This discussion also provides an opportunity for the patient to express his or her feelings about the assessment. If the patient denies any understanding of the reason for an evaluation, expresses annoyance at having to speak with the clinician, or does not perceive a significant clinical problem, the assessment may be particularly challenging. In such instances, the clinician should display empathic support by assuring the patient that the clinician is not making any value judgments about the patient or the patient's behavior, and that together they can better understand why other people are concerned about the patient's health and well-being. Even if the clinician views the presenting symptoms differently from the way the patient does, as is often the case, the opportunity for an empathic dialogue may assist in the formation of an alliance.

History of the Current Illness

Once the patient's understanding of the reason for the assessment has been established, the clinician can begin to elicit the history of the development of eating symptoms. Because concerns about body image and cog-

nitive disturbances regarding shape and weight are virtually universal among individuals with eating disorders, it is important to obtain a history of changes in weight and dieting as well as current eating patterns. This can begin with open-ended questions about changes in eating habits and weight in the recent past or during the current disordered eating episode. The clinician should also ask for descriptions of events or experiences (e.g., emotional or environmental) that the patient believes may have contributed to the development or exacerbation of the problem. As the onset of an eating disorder is frequently associated with a significant life change or interpersonal event, the clinician should ask the patient to describe what was going on at the time that symptoms began, and to consider whether personal life events may have had a direct or indirect influence on the evolution of eating symptoms.

In assessing individuals with disordered eating, it is very important to obtain a picture of the patient's current eating habits by asking the patient to describe the frequency and content of meals and snacks on a recent, typical day. The clinician should also specifically inquire about several eating-related behaviors:

1. The degree to which the individual restricts calorie intake, and whether he or she avoids specific foods and/or categories of foods. Many individuals with eating disorders avoid foods they believe to be high in calories, such as desserts and red meats. A smaller number develop vegetarianism or other restrictive eating patterns during the course of their disorder. The clinician should also inquire about religious food restrictions (e.g., keeping kosher) and reported allergies to foods.
2. The occurrence and frequency of binge eating. Although the definition of a binge in DSM-IV explicitly requires the consumption of an objectively large amount of food, many individuals refer to the consumption of a modest or even small amount of food they had not intended to eat as a binge. The clinician should ascertain what is consumed during a typical episode of binge eating.
3. The occurrence and frequency of purging behaviors, such as self-induced vomiting and laxative or diuretic abuse. The clinician may also inquire about less common methods such as the use of syrup of ipecac, which is employed by some individuals to help induce vomiting, the omission of hypoglycemic agents (e.g., insulin) by diabetics, and the practice of chewing and spitting out food without swallowing.
4. The frequency and intensity of exercise, and how exercise patterns have changed in relation to changes in eating habits and weight.

In obtaining a history of the development of eating symptoms, several other topics should at least briefly be raised as they are often of importance in the development of the disorder. These include the highest and lowest weights, at least at the current height, and (for females) the age at which menstruation started. The clinician should inquire about any sustained (longer than 3 months) episodes of amenorrhea, and the association of such episodes with weight changes. This information is important not only in establishing the onset and duration of illness but also in putting into context the patient's current presentation. Because the patient's experience of his or her shape and weight are important in both the onset and maintenance of eating-disordered thoughts and behaviors, the clinician should ask what weight the patient thinks would be ideal, and the patient's view of him- or herself at the current weight.

Two other areas warranting attention are the patient's family history of eating attitudes and behaviors and the patient's occupational and social history. Often the family's attitudes toward eating and accompanying behaviors (e.g., dieting), especially if taken to an extreme, can play a significant role in the formation of patients' attitudes and behaviors. The clinician should inquire about these family patterns, if not already volunteered by the patient, and their effect on his or her relationship to food. Similarly, the emphasis on shape and weight within the family structure and its influence on the patient's perceptions of shape and weight should be discussed.

Patients with eating disturbances frequently engage in occupations in which shape and weight are highly emphasized (e.g., personal trainer) or food is the focal point (e.g., waitress). Whether the pursuit of such careers is a contributing factor to or a by-product of the eating disturbance undoubtedly varies, but the relationship of these occupations to the chronology of changes in eating and dieting practices should be reviewed. Such information may prove valuable in treatment planning when a consideration of career plans can be more thoroughly evaluated.

Medical Complications

Eating disorders, especially AN, are associated with significant medical problems. The clinician should ask whether the patient has experienced any physical problems as a consequence of the eating disturbance, and specifically inquire about any emergency room visits or less acute medical care, and about the existence of complications such as osteoporosis and dental disease.

Treatment History

Most assessments of individuals presenting for an evaluation will uncover symptoms of a possible eating disorder. If so, the clinician should obtain information about any treatments attempted. A range of treatment settings (e.g., inpatient, day-program, outpatient), modalities (e.g., behavioral, cognitive, interpersonal, family-oriented, psychopharmacological, medical) and intensity are currently employed in the treatment of eating disorders. Often, these are difficult for the patient (or clinician) to characterize accurately. Furthermore, for a patient with a long history of illness, the complete history of treatment may be too lengthy to obtain in a single assessment. It is important to ascertain whether and how often the patient has been hospitalized for treatment of the eating disorder or its complications, what psychological strategies and medication interventions have been attempted, and what the patient has found to be most and least helpful. It is also useful to determine the reason for termination of treatment. For example, did insurance coverage expire? Did the patient leave treatment against medical advice? Such information can often be used to help judge the severity of the disorder and the patient's willingness to engage in treatment.

Coexisting Conditions

Because of the frequent occurrence of disturbances of mood and of substance abuse among individuals with eating disorders, symptoms of these disorders should be explicitly reviewed. Specific questions about the lifetime usage of alcohol and recreational drugs should be posed. The clinician should be mindful about patients' potential reluctance to disclose such information, but should inquire directly, in a nonjudgmental fashion ("Have you ever tried marijuana, cocaine, or other recreational drugs?"). The clinician should also be alert for indications of personality disorders, which are commonly present among individuals with eating disturbances.

Physical Assessments

The approach just described should provide a description, largely based on the patient's report, of the current eating difficulties and their history and development, a description of other major psychological and medical problems, and an outline of current and past treatments. An important additional component of the assessment is the acquisition of more objective measures of current health status. These include (1) height and

weight, (2) vital signs (pulse, blood pressure), (3) general physical examination, and (4) laboratory tests. Some or all of these measures can be obtained by the clinician assessing the history, if he or she has the requisite training and experience, or from a physician who serves a general medical role. How imperative it is to obtain these assessments depend on the nature of the presenting problem and the clinician's observations of the patient. For example, a patient with a history of substantial weight loss or of frequent purging is in more urgent need of physical assessment than one with a normal and stable weight but psychological overconcern with shape and weight. Additional details regarding the medical complications specific to each disorder are provided later in this chapter.

Patient Reluctance to Provide Information

For a variety of reasons, patients may be reluctant to provide accurate information about their difficulties. In some instances, patients are ashamed of beliefs or behaviors that they recognize as abnormal but feel unable to control. Patients may deny that they purge or that they use recreational drugs, or they may claim to weigh more than they do do—and consume excessive amounts of liquids or carry concealed objects when they are weighed. No approach to such denial and subterfuge is universally effective. However, it may be useful for the clinician to note that individuals with eating problems commonly find it difficult to be open about all aspects of their problems, and, in a nonconfrontational manner, ask if there are issues the patient has difficulty admitting. The clinician should avoid criticizing the patient for not being open, as such maneuvers are unlikely to yield more accurate information and will undermine the development of a therapeutic alliance.

DIFFERENTIAL DIAGNOSIS

Before concluding that the patient's difficulties are best ascribed to the existence of an eating disorder, the clinician should consider two other possibilities: that the eating disturbances are better considered as symptoms of another psychiatric disorder or that the symptoms are secondary to a general medical condition. For example, episodes of overeating (binge eating episodes) may occur in association with major depressive disorder, and weight loss is a prominent symptom of a variety of medical illnesses. When a complete history is available, typical cases of AN and BN are usually easy to recognize. However, when the history is unclear or

the features are unusual, the clinician should seriously consider the possibility that another diagnosis is warranted. The following sections provide some specific considerations about the differential diagnosis of AN and BN.

Anorexia Nervosa

Diagnosis

DSM-IV specifies four major criteria for the diagnosis of AN. The most prominent is a refusal to maintain a minimally acceptable body weight for a person's height and age. DSM-IV recommends a guideline of 85% of ideal body weight (IBW) but does not provide a more specific standard. The 10th edition of the *International Classification of Mental and Behavioural Disorders* (ICD-10; World Health Organization, 1992) requires that patients have a body mass index (BMI) equal to or below 17.5 kg/m^2, a criterion considerably more stringent than that of DSM-IV, especially in light of current recommendations for desirable body weight (Metropolitan Life Insurance Company, 1983). This variability, and the fact that DSM-IV explicitly describes the 85% of IBW only as an example, indicate that clinical judgment should be exercised in determining whether the patient is sufficiently underweight to meet this criterion. This is particularly true in the assessment of children and adolescents whose normal weight goal is influenced by the demands of growth and the stage of pubertal development. It is also important to consider the patient's weight history and, for females, the weight at which menses were regular in assessing the relative "normality" of the current weight.

The clinician should be aware that severe malnutrition itself is associated with profound psychological and cognitive disturbances. Underweight patients may exhibit delays in speech, illogical thought patterns, and a limited range of affect. It may be useful to draw the patient's attention to some of these consequences of maintaining an undernourished state as a way to help foster greater insight. Similarly, it may be helpful to note how the eating disturbance has interfered with other facets of the patient's life.

For the diagnosis of AN, DSM-IV requires that there be an intense fear of gaining weight. In classic cases, this fear is overt and acknowledged by the patient. However, other individuals with AN deny that they are afraid of gaining weight, and may even describe attempts to increase calorie consumption. On the other hand, focused questioning about what foods the patient actually consumes and about the patient's emotional re-

action to increases in weight often suggests a deeply seated concern about weight gain. Similarly, the accounts of family members regarding the patient's attitudes and eating behavior may yield evidence of strong fears of weight gain. A patient's insistence, even in the face of persuasive accounts of behaviors that suggest the contrary, that he or she is not afraid of gaining weight may raise questions about whether this DSM-IV criterion for AN is satisfied. The clinician should exercise clinical judgment and assign the diagnosis of AN if all other criteria are met and there is substantial, even indirect, evidence of fear of gaining weight.

DSM-IV also requires evidence of what is usually described as a distortion of body image. This may be manifested in a variety of ways, including the patient's feeling that, despite being underweight, a part of the body is too fat, or by denying how serious the currently low body weight actually is. Sufficient information to assess these psychological characteristics will usually have been obtained during the discussion of the current illness described earlier.

DSM-IV requires that, for the diagnosis of AN, postmenarchal women have amenorrhea for at least 3 months, a requirement that highlights the importance of obtaining a menstrual history during the evaluation. It should be noted, however, that considerable debate continues regarding the appropriateness of this criterion in making a clinical diagnosis of AN (Garfinkel et al., 1996a; Cachelin & Maher, 1998; Watson & Andersen, 2003).

DSM-IV suggests that individuals with AN be classified into one of two mutually exclusive subtypes: the restricting subtype (AN-R) and the binge–purge subtype (AN-BP). In most eating disorders centers, one quarter to one half of patients with AN are classified as having the binge–purge subtype. Because of uncertainty about the characteristics of binge eating associated with AN, DSM-IV does not specify a frequency and duration criteria for binge-eating episodes. DSM-IV also does not indicate whether what constitutes an "unusually large amount of food" should take into account the patient's low weight. There is considerable empirical support for this subtype distinction, as individuals with the AN-BP subtype report more mood disturbances and impulsive behaviors than those with the AN-R subtype (see DaCosta & Halmi, 1992, for review). However, it is common for someone who initially presents with the AN-R subtype to develop binge eating and purging if the illness persists for several years and therefore for his or her subtype classification to change. If this behavioral change is also accompanied by an increase in weight to within a normal range, a change in the diagnosis from AN to BN may be warranted.

Physical Examination

The underweight state that is a defining characteristic of AN is associated with significant findings on physical examination. The most striking is often the obvious wasting. Blood pressure, pulse, and body temperature can be impressively low. The hair may be thin and brittle, and "lanugo"—fine, downy hair—may be present on the trunk, face, and extremities. Enlarged salivary glands may make the face appear disproportionately full in light of the degree of malnutrition. The hands and feet may be cold and blue (acrocyanosis), and there may be peripheral edema.

Laboratory Abnormalities

Virtually all the body's physiological systems are disrupted by the undernutrition of AN, and laboratory assessments of these systems will typically show abnormalities. The assessment of the patient's physical state (see Chapter 7) is an important part of the evaluation. For other reviews of this topic, see Walsh (2001) and Halsted (2001).

Differential Diagnosis

Before concluding that the symptoms of disordered eating are best ascribed to AN, the clinician should consider other Axis I psychiatric disorders and general medical conditions. Many serious medical illnesses are associated with substantial weight loss, but relatively few typically occur in adolescents and young adults. Examples of general medical conditions that should be considered include gastrointestinal illnesses such as Crohn's disease, brain tumors, malignancies, and AIDS. The intense psychological reward associated with losing weight and the fear of weight gain, which are prominent in typical AN, are not characteristic of these conditions. However, the presence of atypical psychological features should prompt a greater concern about the possibility that the weight loss is not due to AN.

Other Axis I mental disorders, such as major depressive disorder and schizophrenia, may occasionally be associated with weight loss and disturbances in eating behavior. However, these disorders are not associated with the concerns about shape and weight characteristic of AN. Some of the psychological characteristics of individuals with social phobia, obsessive–compulsive disorder (OCD), and body dysmorphic disorder (BDD) resemble those of AN. However, individuals with these disorders do not exhibit the unrelenting drive for thinness and the low body weight that are defining characteristics of AN. There is great similarity between

the psychological features of AN and those of BN. However, in the DSM-IV system, a diagnosis of BN is not made in the presence of AN, which results in a distinction that is often based on body weight: below normal in AN, normal or above normal in BN.

Bulimia Nervosa

Diagnosis

The salient diagnostic feature of BN is the repeated occurrence of episodes of binge eating followed by inappropriate behavior aimed at preventing weight gain. To determine whether the patient's symptoms fulfill this criterion, it is crucial to obtain a good description of current eating behavior. DSM-IV requires that a binge comprise an amount of food "definitely larger than most people would eat during a similar period of time and under similar circumstances" (American Psychiatric Association, 1994, p. 594). Clearly, this is not a precise definition, and it requires the clinician to exercise judgment in deciding whether or not the criterion is met. The second DSM-IV requirement for a binge is that the eating during a binge must be associated with a sense of loss of control over the eating. The assessment of this feature is reasonably straightforward, as it only requires an inquiry into the patient's subjective state while binge eating. In fact, several studies (e.g., Beglin & Fairburn, 1992; Gleaves, Williamson, & Barker, 1993) have found that most individuals associate a sense of loss of control over the eating as a more important characteristic of a 'binge' than the amount of food consumed, emphasizing the need for the clinician to assess both characteristics.

The DSM-IV criteria for a binge also require that it occurs within a discrete period of time and suggest a period of less than two hours. Therefore, the consumption of a large amount of food over the course of a day achieved by continuous snacking on small amounts of food would not meet criteria for a binge-eating episode.

DSM-IV requires that the episodes of binge eating (as well as the inappropriate compensatory behaviors) must occur at a minimum average frequency of twice weekly for the 3 months prior to the evaluation. There is concern that this frequency threshold is too demanding, as data suggest that individuals who engage in binge eating and purging once a week share many clinical characteristics with those who engage in such behaviors more frequently (Crow, Agras, Halmi, Mitchell, & Kraemer, 2002).

The most common compensatory behaviors described by patients with BN presenting to eating disorder clinics are self-induced vomiting

and, much less frequently, laxative abuse. Uncommonly employed methods include diuretic abuse, and, among individuals with Type I diabetes mellitus, the omission of insulin. All these examples are considered methods of purging, as they result, to a variable degree, in a loss of nutrients from the body.

Within the definition of inappropriate compensatory behavior, DSM-IV also includes nonpurging behavior such as fasting or excessive exercise. Examples might include engaging in physical activity after a binge that the patient would not ordinarily pursue or consuming no food for 24 hours following a binge. While such nonpurging behavior has been described, it is difficult to distinguish excessive from normal exercise and fasting from strict dieting. For these reasons, relatively little is known about the characteristics of nonpurging behaviors, or of individuals with BN who employ only nonpurging methods to compensate for binge eating.

On the basis of whether or not the individual employs purging methods to compensate for binge eating, DSM-IV suggests that patients with BN be classified as belonging to one of two mutually exclusive subtypes, purging or nonpurging. Patients with the purging subtype have greater levels of comorbid psychopathology and a higher risk of physical complications, such as electrolyte imbalances, than patients with the nonpurging subtype (Garfinkel et al., 1996b).

In addition to these behavioral disturbances, DSM-IV requires that individuals display an overconcern with body shape and weight, very similar to that of individuals with AN. While body image plays an important normal role in the regulation of self-esteem, individuals with BN overvalue shape and weight compared to individuals without eating disorders.

Medical Complications

Self-induced vomiting over many years may lead to softening and erosion of dental enamel, especially on the lingual surfaces of upper front teeth. In some patients, binge eating and vomiting is associated with enlargement of salivary glands. The development of calluses on the dorsum of the hand has been described among individuals who, in manually stimulating the gag reflex, rub the hand against the teeth.

Laboratory Abnormalities

Frequent purging is associated with fluid and electrolyte abnormalities, including hypokalemia, hyponatremia, and hypochloremia (American Psychiatric Association, 1994).

Differential Diagnosis

Individuals with BN share many psychological and behavioral characteristics with those who have the binge–purge subtype of AN. The major distinguishing feature is the abnormally low weight of patients with AN. However, the line between the binge–purge subtype of AN in partial remission and current BN is very unclear.

Other medical and neurological conditions such as Kleine–Levin syndrome are associated with binge eating but are not accompanied by the inappropriate compensatory behavior and the overconcern with shape and weight that characterize BN. Similarly, overeating sometimes occurs in association with major depressive disorder with atypical features and with borderline personality disorder, but is usually not associated with the other behavioral and psychological characteristics of BN. On the other hand, if criteria both for BN and for another mental disorder are met, both diagnoses should be given.

Binge Eating Disorder

While not an official DSM-IV diagnostic category, binge eating disorder (BED) has received considerable attention in recent years, prompted at least in part by the alarming rise in the prevalence of obesity. BED is characterized by recurrent binge eating episodes in the absence of the compensatory behaviors that characterize BN. In clinical samples, BED has generally been described among middle-aged men and women (the male to female ratio is approximately 2:3) who are overweight or obese. BED appears to affect a more an ethnically diverse subset of the population, unlike AN and BN, which occur among Caucasians much more frequently than among other ethnic groups.

Specific Features

The definition of binge-eating episodes associated with BED is identical in DSM-IV to the definition of such episodes in BN. However, the frequency criterion for BED is altered in two subtle ways. While the criteria for BN require a minimum average of two binge episodes per week for three 3 months, the criteria for BED require a minimum average of 2 days per week on which binge eating occurs over 6 months. Clinical experience and some objective data indicate that, during binges, individuals with BED consume a wider range of foods than do individuals with BN, whose binges are often confined to sweet, high-fat foods (Walsh &

Boudreau, 2003). Thus, the binge of a patient with BED more typically resembles a normal meal, except that it is much larger than normal in size. Another difference between individuals with BED and those with BN is that individuals with BED do not describe the extreme dietary restraint between binge eating episodes characteristic of BN. These differences in eating behavior highlight the importance of obtaining detailed information about eating habits during the evaluation.

Like individuals with AN and BN, individuals with BED express psychological concern regarding shape and weight, and the level of such concern is greater than that of similarly obese individuals without BED. Individuals with BED usually present for treatment not only because of a desire to stop binge eating, but also because they wish to lose a substantial amount of weight.

Medical Complications

BED is associated with significant medical morbidity, such as diabetes mellitus and hypertension, primarily related to the accompanying obesity (Bulik & Reichborn-Kjennerud, 2003).

Differential Diagnosis

Issues surrounding differential diagnosis are complicated by the uncertain status of BED in the psychiatric nomenclature. For example, the location of the boundary between BED and the nonpurging subtype of BN is unclear. Currently the distinction between nonpurging BN and BED hinges on an assessment of whether individuals' attempts to avoid weight gain are of sufficient frequency and inappropriateness to merit satisfying criteria for BN. Another disturbance characterized by binge eating and associated with obesity is night eating syndrome (NES), which is discussed later in this chapter. The characteristic difference between NES and BED is that, in NES, the overeating episodes occur primarily at night, including during awakenings from sleep (Birketvedt et al., 1999; Stunkard & Allison, 2003b). However, the literature comparing and contrasting the features of BED and NES is, as yet, modest.

As was noted regarding BN, major depression is sometimes associated with overeating, and a diagnosis of a mood disturbance should be considered when evaluating individuals with BED. In fact, a critical unresolved issue in the diagnostic nomenclature is whether BED would be better conceptualized as an indicator of mood disturbance among obese individuals (Stunkard & Allison, 2003a).

Eating Disorder Not Otherwise Specified

DSM-IV formally identifies only two eating disorders, AN and BN. All other clinically significant syndromes in which a disturbance of eating is the salient feature—including BED—are grouped in the broad and heterogeneous category of eating disorder not otherwise specified (EDNOS). In fact, a substantial fraction of individuals presenting for treatment of eating problems fall into this category.

Subthreshold Eating Disorders

Many individuals whose symptoms fall into EDNOS can reasonably be viewed as having subthreshold or atypical AN or BN. For example, this might include an individual who meets all the criteria for AN but who continues to menstruate, or an individual who meets all the criteria for BN but whose average frequency of binge eating and vomiting is only once per week over the last 3 months.

Night Eating Syndrome

A more distinct category within EDNOS is night eating syndrome (NES). NES is a disorder characterized by morning anorexia, evening hyperphagia, emotional distress, and insomnia, and may be viewed as a combination of an eating disorder, a sleep disorder, and a mood disorder. NES was originally described several decades ago, but has recently begun to receive increased attention (Stunkard & Allison, 2003b).

Childhood Eating Disorders

The description and study of eating disorders arising before puberty have received relatively little attention. However, there is no question about the potentially serious nature of behavioral abnormalities such as food refusal and idiosyncratic food selection, and investigators have recently begun to characterize such phenomena (Bryant-Waugh & Lask, 1995; Lask & Bryant-Waugh, 2000; Nicholls, Chater, & Lask, 2000).

SUMMARY

This chapter presented an overview of the essential components required in a thorough clinical assessment of individuals with eating disorders. To

arrive at a valid diagnosis, the clinician should obtain a full description of the patient's eating behavior and the psychological and emotional concomitants of that behavior. The clinician should attempt to understand how these disturbances began and have evolved, and to estimate the patient's commitment to changing them. Other mental and general medical disorders that might account for some or all of the eating disturbances should be considered, and possible physical complications should be assessed. A thorough assessment should yield the likely diagnostic possibilities and provide a firm basis for treatment planning. Carrying out the assessment in a thorough but empathic fashion should also begin to build an alliance with the patient, which will increase the likelihood that treatment will be successful.

Finally, it should be noted that the assessment approach described in this chapter is a semistructured method that can be applied in most general clinical settings. A range of more structured assessment methods, both interview-based and self-report, are also available (Pike, Wolk, Gluck, & Walsh, 2000). These are routinely used in research settings, but may also be usefully employed in routine clinical practice to obtain more objective measures of the patient status.

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