# Using outcome and feedback tools in the treatment of children and young people with eating disorders.

CORC
Child Outcomes Research Consortium

An Anna Freud project

## Introduction

The guidance in this document is intended to support mental health practitioners in using outcome and feedback tools in the treatment of children and young people with eating disorders.

CORC facilitated a dedicated working group consisting of practitioners and researchers working to improve support for children and young people experiencing eating disorders. The purpose of this group was to identify key recommendations and considerations useful to anyone using outcome and feedback measures in their support of and treatment for those experiencing eating disorders. This document outlines the findings of the working group.

The group advise that specific measures of disordered eating be used alongside more general measures of symptoms of mental health difficulties or measures of life functioning or wellbeing.

They also recommend that goals-based measures be utilised to understand and track the individual needs of service users and that client feedback should be routinely captured and responded to.

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# Using outcome and experience measures with children and young people.

For all types of support for any mental health difficulty experienced by a child or young person, CORC recommends that suitable outcome and experience measures are used in ways that are **most meaningful to service users.**

CORC's **6 Steps to Good Practice** are based on the views and preferences of young mental health service users:

**Step 1.** Use a suitable measurement questionnaire.

**Step 2.** Be familiar with the measurement questionnaire.

**Step 3.** Prepare to introduce it.

**Step 4.** Use it to understand and to explore with the child or young person.

**Step 5.** Prepare to give feedback and discuss scores and responses.

**Step 6.** Plan ahead.

Young people working with CORC have said that questionnaires are only as useful as the way in which they are used. They have five messages for practitioners asking them to complete outcome measures:

- If I trust you and understand where you are coming from, then it will be more meaningful.
- Explain why you are asking me to fill it in, go through the results with me, and make the questionnaire feel like part of our sessions together.
- Think about what it will be like for me to fill it in, and be there to support or help me if that is what I need.
- Explore my questionnaire responses with me and be clear that a questionnaire score can only be a part of building a bigger picture of who I am, and how I'm feeling.
- Give me choice where you can, and don't make assumptions about how I will feel about the questionnaires.

The choice of measures used in the support provided to a child or young person, and the way that they are used, should reflect their specific needs - with reference, for example, to neurodiversity, learning difficulties or culture. When feasible it is also advised that self-reported measures are used alongside measures completed by parents and carers and measures completed by professionals, to ensure that the different perspectives on a child or young person's strengths and difficulties are considered in their treatment or support.

# Specific outcome measures for the treatment of eating disorders

Questionnaires have been developed and researched for eating disorders specifically, to capture important information on changes to eating disorder related behaviours such as eating habits, weight concern, body image and attitudes to eating. These measures each have their own intended purposes and background research.
The working group highlighted some of the available measures that are suitable for use with children and young people:

| Measure | Purpose | Completed by | Further information |
|---|---|---|---|
| Eating Disorder Examination Questionnaire (EDE-Q) | Designed to assess the range and severity of features associated with a diagnosis of eating disorder using four subscales (restraint, eating concern, shape concern and weight concern) and a global score. | Self-completed by those aged 14 and over. | Probably the most widely used and well-known measure of disordered eating. See below for considerations when using the EDE-Q as a measure of binge eating. |
| Adolescent version of the EDE (EDE-A) | A modified version of the EDE-Q with age-appropriate language and exploring experiences over a shorter time frame (14 days versus 28 days). | Self-completed by those aged 12 and over. | There is little available research on the validity of the EDE-A and there is also an omission with the response options (an 11 days option is not provided). |
| Youth Eating Disorder Examination-Questionnaire (YEDE-Q) | The YEDE-Q was also adapted from the EDE-Q and is designed to assess a range of eating disorder behaviours with children and adolescents in the younger age bracket (8-14 years). | Self-completed by those aged 8-14 years. | It has shown to be reliable for use with females aged 12-14 years[i]. However it remains in need of validation in younger child populations. |

[i] *Eating disorder examination questionnaire: norms for young adolescent girls, Jacqueline C. Carter a,*, D. Anne Stewart b, Christopher G. Fairburn, 18 February 2000*

| Measure | Purpose | Completed by | Further information |
|---|---|---|---|
| Child short form version of the Eating Disorder Examination (ChEDE-Q8) | Similar to the EDE-Q however, the ChEDE-Q does not assess symptoms of avoidant/restrictive food intake disorder. | Self-completed by those aged 7-18 years. | The ChEDE-Q8 has been shown to be a reliable self-report assessment tool of eating disorder psychopathology in children aged 7-18 years [ii]. |
| EDE short forms: EDE-QS and EDE-7 | 2 short versions of the EDE have been derived from the EDE-Q; the EDE-QS (short)[iii] which has 12 items, and the EDE-7[iv], which has 7 items. | Self-completed by those aged 14 and over (see Considerations). | Studies have validated these in adult populations and show that they are useful as screening tools for eating disorders. Since they are short forms, they lack the depth of understanding that the full versions provide. |
| Clinical Impairment Assessment (CIA) | A measure of the severity of psychosocial impairment due to eating disorder features. 16 items: impairment in domains of life affected by eating disorder(s): mood and self-perception, cognitive functioning, interpersonal functioning and work performance. | Self-completed by those aged 16 and above years | Designed to be completed immediately after filling in a measure of current eating disorders. |

[ii] *Kliem S, Schmidt R, Vogel M, Hiemisch A, Kiess W, Hilbert A. An 8-item short form of the Eating Disorder Examination-Questionnaire adapted for children (ChEDE-Q8). Int J Eat Disord. 2017 Jun;50(6):679-686. doi: 10.1002/eat.22658. Epub 2017 Jan 25. PMID: 28122128.*

[iii] *Prnjak, K., Mitchison, D., Griffiths, S. et al. Further development of the 12-item EDE-QS: identifying a cut-off for screening purposes. BMC Psychiatry 20, 146 (2020). https://doi.org/10.1186/s12888-020-02565-5*

[iv] *Jenkins PE, Davey E. The brief (seven-item) eating disorder examination-questionnaire: Evaluation of a non-nested version in men and women. Int J Eat Disord. 2020 Nov;53(11):1809-1817. doi: 10.1002/eat.23360. Epub 2020 Aug 6. PMID: 32767481.*

| Measure | Purpose | Completed by | Further information |
|---|---|---|---|
| PARDI-AR-Q | Self-report measure of the symptoms of avoidant restrictive food intake disorder (ARFID). | Self-completed by those aged 14 and over. | A parent and carer version is available for children aged 4 or over. Both versions consist of 32 items. |
| Binge Eating Scale (BES) | A questionnaire assessing the presence of certain binge eating behaviours. | Self-completed by ages 18 and above. | 16 items: to identify behaviours, emotions and attitudes related to binge eating episodes among those at risk of developing binge eating disorders. |
| Accommodation and Enabling Scale (AES-ED) | To measure accommodating and enabling behaviour in the contex of having a relative with an eating disorder. | Completed by parents and carers. | 33 items: exploring and helping to improve carers' coping strategies and examining the effectiveness of family-based interventions. |

The lists are not intended to be an exhaustive. Other suitable measures may be available.

We welcome your suggestions and experiences of using other eating disorder specific measures.

## The EDE-Q as a measure of binge eating

It can be difficult to assess self-reported binge eating in children and young people with the EDE-Q (including those adaptations described above) given the ambiguity of terms such as “large amount of food” and “loss of control”. Therefore, supplementing the EDE-Q with additional instructions is necessary for children and young people to reliably report such behaviours.

In adult samples, studies have shown that providing brief detailed instructions improves the performance of the EDE-Q when evaluating binge eating in patients with Binge Eating Disorder [i]. Such detailed explanations of ambiguous terms may assist children and adolescents in correctly classifying episodes of binge eating as well.

# Other measurement tools relevant to working with children and young people with eating disorders

Using eating disorder specific measures alongside measures of life functioning, wellbeing or mental health, means that emotional factors and impacts on function associated with an eating disorder can be monitored.

Research shows that significant proportions of young people experiencing eating disorders also have co-occurring mental health difficulties such mood disorders, generalised anxiety disorder, post-traumatic stress disorder, and specific phobia[i].

The Working Group identified several useful measures that could be considered for use alongside an eating disorder specific measure:

| Measure | Purpose | Completed by | Further information |
|---|---|---|---|
| The Revised Child Anxiety and Depression Scale (RCADS) | Includes six subscales: separation anxiety disorder, social phobia, generalised anxiety disorder, panic disorder, obsessive compulsive disorder, and low mood (major depressive disorder). | Self-completed by those aged 8-18 years. | The full version is made up of 6 subscales and includes 47-items. Shorter versions have been developed – the RCADS-25 and RCADS-11. A parent and carers version is available to complete (RCADS-P). |
| YP-CORE | Consists of items covering anxiety, depression, trauma, physical problems, functioning and risk to self. | Self-completed by young people aged 11-18. | Consists of 10 statements. The clinically validated cut-off score is dependent on age and gender. |

[i] *Binx Yezhe Lin, Angela Liu, Hui Xie, Sarah Eddington, Dominic Moog, Kevin Y. Xu, Co-occurring psychiatric disorders in young people with eating disorders: A multi-state and real-time analysis of real-world administrative data, General Hospital Psychiatry, Volume 90, 2024.*

| Measure | Purpose | Completed by | Further information |
|---|---|---|---|
| The Generalised Anxiety Disorder Assessment (GAD-7) | A 7 item instrument that is used to measure or assess the severity of generalised anxiety disorder (GAD). | Self-completed by young people aged 11-18. | GAD-7 scores may be used to differentiate between mild, moderate and severe GAD in adolescents. |
| Patient Health Questionnaire-9 (PHQ-9) | A 9 item questionnaire used to measure the severity of depression. | Self-completed by young people aged 13-17 years. | The PHQ-9 is from the PHQ group of measures which also measures: depression, anxiety, somatoform, alcohol and eating. |
| Me and My Feelings | A 16 item measure of child mental health, covering two broad domains: emotional difficulties and behavioural difficulties. | Self-completed by those 8+ years. | The first 10 items comprise the Emotional Difficulties subscale. Items 11-16 comprise the Behavioural Difficulties subscale. |
| Child Outcome Rating Scale (CORS) | A simple 4 item session-by-session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention. | Self-completed by those 6-12 years. | For young people aged 13 and above the Outcome Rating Scale can be used. |

| Measure | Purpose | Completed by | Further information |
|---|---|---|---|
| SCORE-15 | Designed to indicate crucial aspects of family life that are relevant to the need for therapy and for therapeutic change. | It records perceptions of the family from each member over the age of 11 years. | The SCORE-15 should be administered to each family member individually at or just before the start of the relevant sessions.<br><br>For children 8 to 11 years the Child SCORE should be used. |
| Strengths and Difficulties Questionnaire Parent version (SDQ-P) | A measure of a child's emotional and behavioural difficulties. | Completed by parents or carers of children aged 2-17 years. | Different versions and scoring instructions are provided for parents of children aged 2-4 years and those aged 4-17 years. |
| The Children's Global Assessment Scale (CGAS) | A rating of general functioning for children and young people aged 4-16 years old. | Practitioner rated. | The clinician assesses a range of aspects of psychological and social functioning and gives the child or young person a single score between 1 and 100. |
| HoNOSCA | Focuses on general health and social functioning. | Practitioner rated. | 15 item questionnaire, to be completed by practitioners, to indicate the severity of each problem, on a scale of 0-4. |

# Emotional self-regulation and disordered eating

There is some evidence that the eating disorders anorexia nervosa, bulimia nervosa, binge eating disorder and obesity are associated with a reduced abilities in emotion and impulse regulation in childhood, adolescence, and adulthood[i]. This suggests that emotional regulation is a crucial factor in the treatment of many children and young people with disordered eating and this therefore is important to measure and monitor as part of that treatment.

There are a few outcome measures related to emotional regulation including:

| Measure | Purpose | Completed by | Further information |
|---|---|---|---|
| Trait Emotional Intelligence Questionnaire (TEIQue) - ASF | Includes a self-regulation subscale that measures short, medium, and long-term control of one's own feelings and emotional states. | Self-completed and recommended for those aged 13-17 years. The form has been used successfully with children as young as 11. | The TEIQue-ASF is a simplified version, in terms of wording and syntactic complexity, of the adult short form of the TEIQue. It comprises 30 short statements. |
| Adolescent Self-Regulatory Inventory (ASRI) | Measures both short and long term self-regulation. | Self-completed by 10-17 year olds. | It comprises 36 short statements. |

[i] *Weinbach N, Sher H, Bohon C. Differences in Emotion Regulation Difficulties Across Types of Eating Disorders During Adolescence. J Abnorm Child Psychol. 2018 Aug;46(6):1351-1358. doi: 10.1007/s10802-017-0365-7. PMID: 29101588; PMCID: PMC6014925.*

# Eating disorders and neurodiversity and trauma

Eating disorders commonly coexist with neurodevelopmental conditions, physical health difficulties and trauma related difficulties.

Practitioners treating children and young people with eating disorders report significant proportions of their clients also experiencing challenges including attention-deficit and hyperactivity disorder (ADHD), autism, learning disabilities, intellectual disability, conduct disorders, cerebral palsy, and impairments in vision and hearing[i].

Early or childhood trauma and associated trauma-related neurodevelopment is also prevalent in eating disorder populations[ii].

It is therefore important to consider the individual needs of children and young people and their context, when using measures as part of their emotional and mental health support.

Please see **CORC guidance** on developing practice and approaches to using measures considerate of cultural differences, learning disabilities and neurodiversity.

[i] *Cobbaert, L., Millichamp, A.R., Elwyn, R. et al. Neurodivergence, intersectionality, and eating disorders: a lived experience-led narrative review. J Eat Disord 12, 187 (2024). https://doi.org/10.1186/s40337-024-01126-5*

[ii] *Groth T, Hilsenroth M, Boccio D, Gold J. Relationship between Trauma History and Eating Disorders in Adolescents. J Child Adolesc Trauma. 2019 Jul 10;13(4):443-453. doi: 10.1007/s40653-019-00275-z. PMID: 33269044; PMCID: PMC7683676*

# Set and monitor goals collaboratively

This working group advises that an important aspect of any support and treatment of children and young people with eating disorders is the **setting and routine monitoring of their goals**.

It is recommended that the focus in goal-setting with children and young people with eating disorders is not on their eating disorder or aspects associated with it e.g. body weight or shape, eating routines, relationship with food. Instead, it is recommended to take a holistic focus on the child or young person and their wider life or underlying needs. By working towards goals associated with the wider mental health and wellbeing, needs of a child or young person and their progress can be monitored alongside the impact on their eating disorder, measured in the ways discussed in the previous section.

# Actively seek feedback – and respond to it

Research shows that feedback on client progress and the quality of the therapeutic relationship is among the most effective ways to improve outcomes[i].

## Why?

- Feedback works because mental health professionals use tools to monitor their performance.
- Feedback helps mental health professionals select the most effective treatment options
- Feedback enhances the therapeutic relationship

This guidance recommends using tools that routinely capture feedback from children and young people being treated for eating disorders, such as the Session Rating Scale (SRS), CARE Patient Feedback Measure[ii], or Session Feedback Questionnaire (SFQ). It is important to give space as part of treatment, to listen to the feedback provided and to respond in appropriate ways.

[i] *de Jong, K. orcid.org/0000-0002-7621-9290, Douglas, S., Wolpert, M. et al. (16 more authors) (2025) Using progress feedback to enhance treatment outcomes: a narrative review. Administration and Policy in Mental Health and Mental Health Services Research, 52 (1). pp. 210-222. ISSN 0894-587X*

[ii] *https://caremeasure.stir.ac.uk/*

# Working Group

The guidance included in this document is derived from the contributions of the members of the CORC working Group ‘children and young people with eating disorders’.

Our thanks to the energy and input from:

- Eating Disorders Association Northern Ireland
- East London Foundation Trust
- Birmingham Women’s and Children’s NHS Foundation Trust
- SWEDA
- First Steps ED
- Royal College of Psychiatrists

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on behalf of the CORC Working Group.

The Child Outcomes Research Consortium (CORC) brings together organisations and individuals committed to using and improving evidence to improve children and young people’s mental health and wellbeing. We are experts in measuring mental health outcomes.

Founded in 2002 by a group of mental health professionals determined to understand the impact of their work, today our network includes mental health providers, education settings, cultural and community services, local authorities, professional bodies and research institutions from across Europe and beyond.

We hold data relating to mental health and wellbeing outcomes of more than 400,000 children and young people in the UK. We support others to gather and understand their own data. We build expertise about using this information to improve support.

CORC is a project of Anna Freud.

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