Centre for Integrative Health

■ Psychology ■ Nutrition ■ Movement

To weigh or not to weigh

A decision-making framework for weighing practices in the treatment of eating disorders

Virtual ICED 2020 (ANZAED and AED)

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Acknowledgement of country

I acknowledge the First Nations people as the Traditional Owners of the land on which I am presenting today.

I recognise the country north and south of the Brisbane River, as the home of both the Turrbul and Jagera people and I pay deep respects to all Elders past, present and emerging.

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Virtual ICED2020

TAKING A DIFFERENT PERSPECTIVE

Disclosures

I, Kate Lane, have no commercial relationships to disclose.

A note on weighing for weight-control in ED treatment

Aside from Anorexia Nervosa (and its "atypical" variants), weight and weight changes are not a criterion by which severity of eating disorder or remission of illness are defined in the DSM-5. (American Psychiatric Association, 2013).

Patients who are experiencing psychological distress in relation to their weight and shape should not be weighed for the purpose of further enhancing weight control (i.e. achieving weight loss as a primary outcome) as this perpetuates the harmful pre-existing cultural narrative around the imperative for weight-control as social currency, (thus maintaining the core mechanisms of the disorder) and it is unnecessary to achieve clinical remission as per the DSM-5 criteria.

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The debate

Weighing of eating disorder patients is widely regarded as a pertinent component of treatment in many leading therapy models. (Mulkens et al., 2018; Waller et al., 2012; Waller & Mountford, 2015)

In practice, clinicians vary significantly in their views on weighing their patients and how they do it (if at all). (Forbush et al., 2015))

There remains no empirical evidence regarding the impact of weighing procedures alone on the outcomes of eating disorder treatment to date.

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What are clinicians doing?

Between 28-39% of clinicians are routinely weighing their patients in-session. (Mulkens et al., 2018; Waller et al., 2012; Wisniewski et al., 2018)

Between 17- 43% of clinicians rarely or never use routine weighing in their treatment of patients with eating disorders. (Couturier et al., 2013; Mulkens et al., 2018; Waller et al., 2012; Wisniewski et al., 2018)

More than half of clinicians who weigh their patients report "generally using" blind-weighing practices. (Forbush et al., 2015))

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Why do clinicians vary in their weighing practices?

Clinicians may be more inclined to blind weigh than to open weigh patients when:

- The patient is perceived to be significantly cognitively or emotionally impaired due to malnutrition. (Forbush, 2015)
- The clinician perceives that they or the patient are unable to tolerate and/or regulate the patient's distress. (Daglish & Waller, 2019; Waller & Mountford, 2015)
- The clinician typically endorses treatment approaches that do not specify open weighing. (Forbush et al., 2015)
- If weighing is anticipated to lead to disengagement from therapy. (Waller & Mountford, 2015)

Clinicians may be less inclined to weigh at all when:

- There is confusion regarding roles within the treatment team (Couturier, 2013).
- The patient's weight has been unduly influenced by factors external to treatment (Daglish & Waller, 2019; Waller, 2016).
- The patient refuses or threatens disengagement (Wisniewski, 2018).
- The clinician is concerned about exposing the patient to weight-based shame or stigmatisation (Waller & Mountford, 2015).
- The clinician is delivering an eclectic or non-specific intervention. (Cowdrey & Waller, 2015)

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Aims of decision-making framework development

The weighing debate requires a more nuanced perspective in which different weighing practices might be advantageous over others under certain circumstances.

Aimed to develop a decision-making framework to support consistent and collaborative weighing practices amongst clinicians within the field of eating disorders that takes individual case circumstances into account.

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Assumptions

Basic knowledge of eating disorders:

- Neuro-bio-psycho-social basis of the illness.
- Clinician understanding of current evidence-based practice guidelines.
- Ability of mental health clinicians to develop an appropriate formulation and evidence-based treatment plan.

Definition of open-weighing:

Weighing the patient, either with the patient viewing the number on the scale or advised of their weight, and/or the patient's weight being plotted onto a weight chart which is shared with them.

Definition of blind-weighing:

Weighing the patient without them viewing or being advised of the exact weight (eg client standing on the scale backwards or the clinician covering the scale display).
Non-specific feedback (eg "trending up", "moved down a band", "within range") may be given if required as part of the specific clinical intervention.

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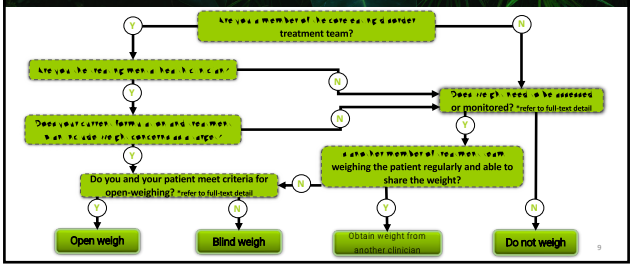
Decision-making Framework



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Case Example 1

Lucy is a 23-year-old female with Other Specified Feeding and Eating Disorder (Atypical Anorexia Nervosa, binge/purge subtype). She has lost 12.5kg in 6 weeks and is currently at a BMI of 24kg/m².

Lucy's GP has referred her for outpatient treatment with a clinical psychologist and dietitian who work in different locations.

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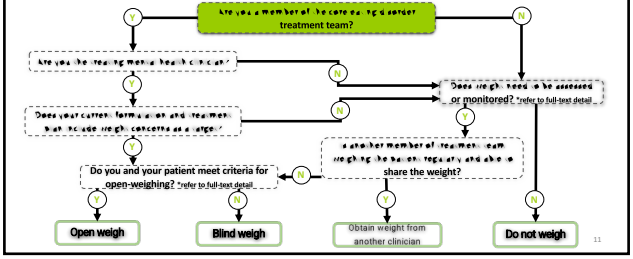
Decision-making Framework



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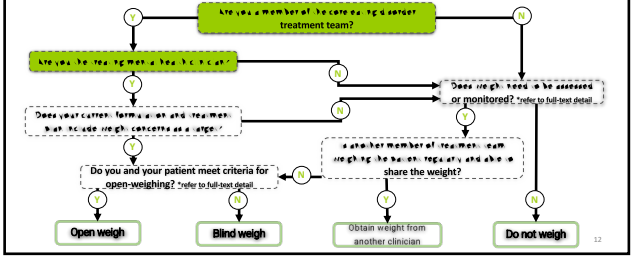

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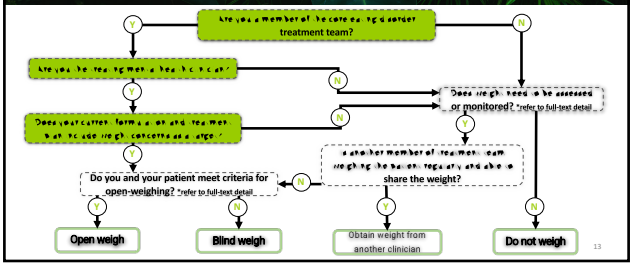

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Psychological considerations

Weighing serves many functions within evidence-based psychological therapies for eating disorders:

- Outcome measure indicative of therapy progress for patients below their healthy weight (Eisler et al., 2007; Fairburn, 2008; D. Garner & Bemis, 1982; Simon G. Gowers et al., 2007; Lock & Le Grange, 2012; Lynch et al., 2013; McIntosh et al., 2006; Mulkens et al., 2018; Pike et al., 2003; Schmidt et al., 2014)
- Proxy measure for the frequency and severity of target behavioural symptoms (American Psychiatric Association, 2013; Chen et al., 2008; Fairburn, 2008; Kroger et al., 2010; Le Grange et al., 2007; Safer et al., 2001; Waller et al., 2007; Wisniewski & Kelly, 2003).
- Tool for cognitive and behavioural interventions (eg exposure, experiments) (Fairburn, 2008; D. Garner & Bemis, 1982; D. M. Garner & Garfinkel, 1997; Goss & Allan, 2014; Gowers & Green, 2009 as cited in Waller & Mountford, 2015; Waller et al., 2007)
- In-vivo stimulus to address emotional responses to weight and weighing (Goss & Allan, 2014; McIntosh et al., 2006; P. Robinson et al., 2016; Schmidt et al., 2014).
- Address life and therapy-interfering behaviours (Lynch et al., 2013; Wisniewski & Kelly, 2003).
- Develop therapist-patient attunement (Lock & Le Grange, 2007; Lock & Le Grange, 2012; Loeb et al., 2015).
- Provide an opportunity to coach parents in managing eating disorder behaviour or tolerating the young person's distress (Lock & Le Grange, 2007; Lock & Le Grange, 2012; Loeb et al., 2015).

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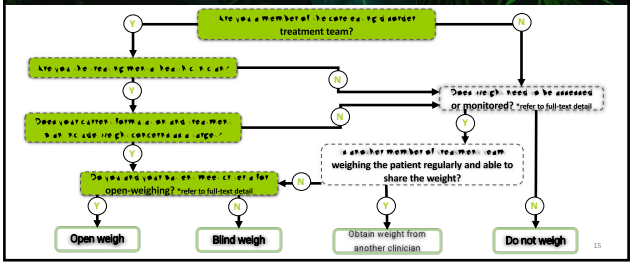

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Clinician and patient criteria for open weighing

Clinician	Patient
1) Possess a set of calibrated medical scales with a maximum weight capacity suited to all body sizes and preferably accurate to only 0.5kg. (Fairburn, 2008; Waller & Mountford, 2015)	**1)** Has been informed of the clinician's rationale for open weighing, the process by which this will occur, the possibility of adverse outcomes of the intervention (e.g temporary increase in distress) and how this will be managed to meet the requirements for informed consent. (Australian Psychological Society Ltd, 2007).
2) Have capacity for regular sessions with weighing occurring at the start of the appointment and have ample time available to debrief or contain the patient's distress. (Eisler et al., 2007; Fairburn, 2008; Le Grange et al., 2007; Lock & Le Grange, 2012; Pike et al., 2003; P. Robinson et al., 2016; Schmidt et al., 2014; Waller et al., 2007)	**2)** Patient distress and eating disorder behaviours can be contained such that weighing does not result in repeated medical or psychiatric compromise that prevents further engagement in treatment. * As supported by evidence for neurobiological impairments implicated in the inhibition of neuroplasticity, learning, emotion regulation, perception and fear extinction, resulting from malnourishment. (Brandys et al., 2011; Forbush et al., 2015; Guarda et al., 2015; Koskina et al., 2013; Maren & Holmes, 2016; Milad et al., 2014; Murray et al., 2018).
3) Hold an explicitly weight-neutral stance. (R. M. Puhl et al., 2014; R. Puhl & Suh, 2015).	
4) Formal training or supervision on open weighing procedures. (Fairburn, 2008; Waller et al., 2007).	

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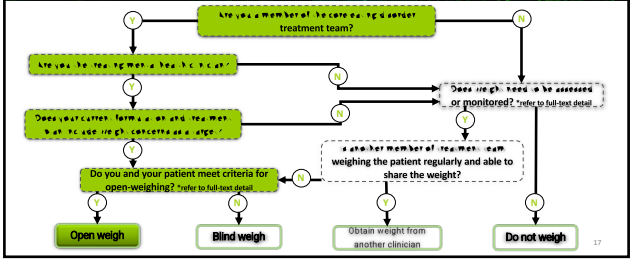

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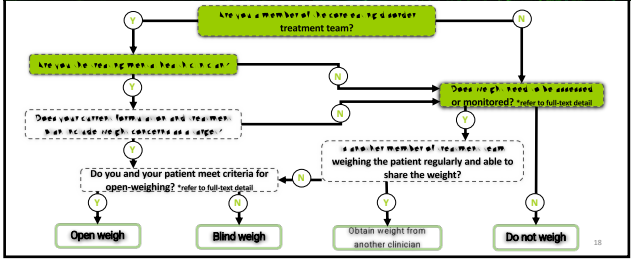

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Medical Considerations for ED

- Medical
  - Safety and medical risk: Total weight lost, degree of weight suppression and/or recency of the weight loss which are implicated in medical compromise, risk of refeeding syndrome and severity of eating disorder symptoms independent of BMI. (Garber, 2018; Kerrem et al., 2017; Lavender et al., 2015; Whitelaw et al., 2018) (Currin et al., 2007; Hay et al., 2014; National Institute for Health and Care Excellence, 2017; Schmidt et al., 2014)

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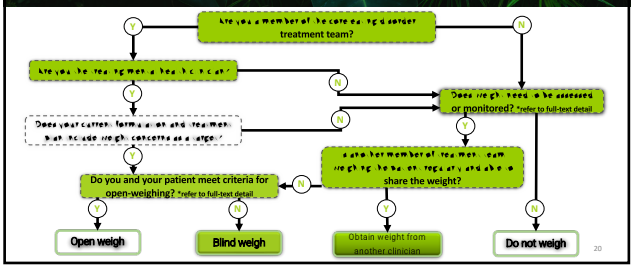

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Dietetic considerations

- Nutritional
  - Monitor for risk of refeeding syndrome or complications of malnutrition (in the setting of recent or rapid weight loss). (Garber, 2018; Kerrem et al., 2017; Lavender et al., 2015; Whitelaw et al., 2018) (Currin et al., 2007; Hay et al., 2014; National Institute for Health and Care Excellence, 2017; Schmidt et al., 2014)
  - Monitor outcomes of nutrition interventions to restore sufficient body fat, fat-free mass and nutritional status in those who are malnourished or weight suppressed. (Krause et al., 2012).
    - There are limitations to the weight or BMI as accurate reflections of percentage fat mass, body cell mass or nutritional status in undernourished patients (Hannan & Wrate, 1994; Kerruish et al., 2002; María Teresa García De Álvaro et al., 2007; Mattar et al., 2011; Trocki et al., 1998).
    - Alternative anthropometric measures taken in concordance with weight measures over time (eg tricipital skinfold thickness and/or mid-upper arm circumference, dual-energy x-ray absorptiometry or bioimpedance analysis may offer more accurate measures of nutritional rehabilitation (Becker et al., 2014; Elia, 2003; Kerruish et al., 2002; Krause et al., 2012; Lam et al., 2016; Martín et al., 2009; Mattar et al., 2011; Powell-Tuck, 2003; Preedy, 2012; Van Tonder et al., 2019).
  - Provide stimulus for psychoeducation, nutrition education and supportive counselling with respect to beliefs about food and weight and the effectiveness of eating disorder behaviours, where appropriate. (Fairburn, 2008; Herrin, 2015; Krause, 2012).

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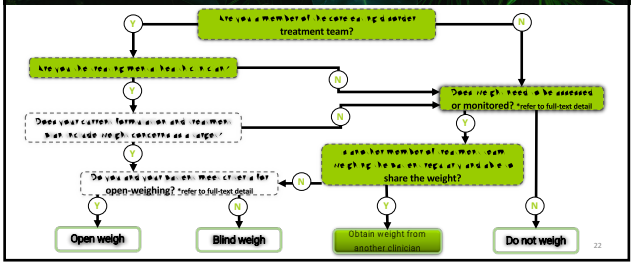

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Other considerations for weighing

- Insurance, where weight is required during assessment of claim eligibility or treatment progress.
  Centre for Discovery, n.d.-a, n.d.-b; National Eating Disorder Association, n.d., n.d.).
- Sport, where athletes participate in weight-sensitive or weight-class sports, or their performance is judged on aesthetic features, thus requiring assessment and monitoring of their weight or body composition. (Reardon et al., 2019)
- Other medical considerations including but not limited to, poor blood sugar control or insulin omission in type 1 diabetes mellitus, cancer cachexia, advanced organ failure, for dosing of some medications, or during pregnancy.
  (Davidson, 2014; Franko, 2006; Krause et al., 2012; Sánchez-Lara et al., 2013; Zhou et al., 2016)

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Case variations

1) Lucy's clinical psychologist does not have a set of calibrated scales available. Lucy also only sees her GP for a 15-min review every week. Her dietitian, who has experience in treating eating disorders, has a suitable set of scales and can offer regular 45-min appointments.
2) Lucy's GP is very busy and finds it difficult to keep up with communications between the multi-disciplinary team, however they need to record Lucy's weight in their brief weekly review to monitor her medical risk. Lucy is already being weighed weekly with the dietitian.
3) Lucy is an elite gymnast and having taken 9-month break from training and competition to engage in intensive treatment, she is now planning a return to sport. Her head coach usually has athlete's weights and skinfold measures monitored at the training centre and wants to know if he can continue to do so with Lucy.

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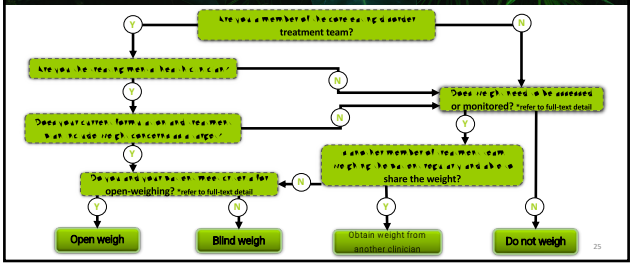
Decision-making Framework



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Limitations & Future Directions

- Methodology
- Absence of evidence for weighing as a specific factor in the outcomes of evidence-based treatment models.
- Absence of lived-experience perspectives on weighing practices in the literature.
- The framework may not capture *all* scenarios in clinical practice. We welcome the clinical experiences and feedback of colleagues in the field to inform further refinement of this framework. Please email any feedback to kate.lane@cfih.com.au .

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