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Weighing patients within cognitive-behavioural therapy for eating disorders: How, when and why

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ABSTRACT

While weight, beliefs about weight and weight changes are key issues in the pathology and treatment of eating disorders, there is substantial variation in whether and how psychological therapists weigh their patients. This review considers the reasons for that variability, highlighting the differences that exist in clinical protocols between therapies, as well as levels of reluctance on the part of some therapists and patients. It is noted that there have been substantial changes over time in the recommendations made within therapies, including cognitive-behavioural therapy (CBT). The review then makes the case for all CBT therapists needing to weigh their patients in session and for the patient to be aware of their weight, in order to give the best chance of cognitive, emotional and behavioural progress. Specific guidance is given as to how to weigh, stressing the importance of preparation of the patient and presentation, timing and execution of the task. Consideration is given to reasons that clinicians commonly report for not weighing patients routinely, and counter-arguments and solutions are presented. Finally, there is consideration of procedures to follow with some special groups of patients.

Cognitive-behavioural therapy is more likely to be effective when the clinician adheres to evidence-based principles and protocols. However, relatively few therapists espouse or use evidence-based therapies when working with eating disorders (e.g., von Ranson, Wallace, & Stevenson, 2013; Tobin, Banker, Weisberg, & Bowers, 2007). Even when they label what they do as an evidence-based therapy, many clinicians miss key components (e.g., Kosmerly, Waller, & Robinson, in press; Simmons, Milnes, & Anderson, 2008; Waller, Evans, & Stringer, 2012; Waller, Stringer, & Meyer, 2012).

A particularly prominent issue in the treatment of eating disorders is the weighing of patients. Waller, Stringer, et al. (2012) found that under 40% of CBT clinicians reported weighing their eating-disordered patients routinely. Indeed, the second most common pattern (17.1%) was for therapists not to weigh their patients at all during CBT for the eating disorders. Furthermore, even when patients are weighed by clinicians, Forbush, Richardson, and Bohrer (in press) have shown that there is substantial variation in the information that clinicians are willing to share with patients afterwards. Given that CBT has the best evidence in the psychological treatment of the eating disorders (e.g., Fairburn & Harrison, 2003), such routine failure to employ a key element of the therapy or to share information with the patient could be a matter of concern.

Of course, any such criticism is to assume that weighing is a central part of CBT, and many clinicians will (and do) argue that it is an optional extra or that it can and should be done by other people. This paper will consider the practical and therapeutic reasons that clinicians should weigh patients within CBT for the eating disorders. It will present a rationale for how and when this should be done. Finally, it will examine the logic (or otherwise) of reasons that clinicians commonly give for not doing so.

A key issue is that while some therapies for eating disorders are evidence-based, there have been few dismantling studies that would allow the individual elements of those therapies to be described as evidence-based. Indeed, weighing in therapy has not been consistently employed even in CBT for eating disorders, as will be detailed below. Therefore, given the broader evidence for exposure-based methods, it is assumed here that the exposure

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elements of weighing are likely to be those that are most effective, though this assumption will be returned to in considering future directions in the field.

1. What do clinical protocols recommend about weighing eating-disordered patients?

Before considering why we should routinely weigh eating-disordered patients, it is important to consider what is recommended in the literature. Psychotherapy treatment protocols differ substantially in their requirements about weighing eating-disordered patients. Table 1 provides a summary of what is recommended in a number of such protocols, selected here because they are widely used or have an evidence base in support of their use.

While weight is treated as important in many (though not all) protocols, how it is obtained and whether it is discussed with the patient differs (e.g., Forbush et al., in press) with therapy modality and stage of therapy. An issue is that many of the protocols do not directly address how, when and why patients should be weighed. For example, none of the available dialectical behaviour therapy protocols specified this element. Contact with those authors (see cited personal communications) clarified that patients were weighed in-session in some cases, self-weighed in others, and were weighed by other team members in the remainder. Indeed, the only group of therapies where there was relative consistency in the matter of weighing patients was in family-based therapy, though not all of those approaches clarified the issue of weighing in the manual itself. Some other recently-developed therapies also have recommendations about weighing patients that are similar to those underlying family-based approaches (e.g., specialist supportive clinical management; Maudsley model of anorexia nervosa treatment for adults), while others are less involving of the therapist (e.g., focal psychodynamic therapy) or do not require weighing at all (e.g., interpersonal psychotherapy).

Within CBT specifically, recommended practice has changed substantially over time. In the case of bulimic disorders, Fairburn's early recommendations (1985) were that the patient should weigh themselves, later transforming into a specific recommendation that the patient should not weigh themselves (Fairburn, Marcus, & Wilson, 1993). Similarly, the guidance for anorexic disorders has developed from an almost total absence of overt recommendations (Garner & Bemis, 1984) to a requirement that whoever weighed the patient should be 'reliable' (Garner, Vitousek, & Pike, 1997; Pike, Walsh, Vitousek, Wilson, & Bauer, 2003).

Only in later incarnations of CBT for different eating disorders (Fairburn, 2008; Gowers & Green, 2009; Touyz et al., 2013; Waller et al., 2007) has there evolved a consistent recommendation that the therapist should always weigh the patient within the session, whatever the nature of their disorder, and that this weight should be discussed with the patient overtly. Even then, this pattern is not replicated in more meta-cognitive approaches, where weighing is not specified as a task of therapy at all (e.g., Cooper, Todd, & Wells, 2009).

To summarise, not all evidence-based therapies address the issue of weighing patients explicitly, and the recommendations vary within therapies and across time. This variation is particularly the case for CBT, where any clinician whose main source of information was much over a decade old could reasonably argue that they had been directed not to weigh patients themselves. However, there is convergence in recent years, with most of the widely established therapies recommending that the patient should be weighed in the session by the therapist, and that the patient should be made aware of their weight. Unfortunately, even now, that guidance is not stated in all manuals.

2. Reasons for weighing eating-disordered patients within CBT

There are four strong reasons for weighing patients routinely within CBT for eating disorders. The first two apply across therapies, while the other two are more focused on cognitive behavioural processes.

2.1. Patient safety

The first reason is universal to all psychotherapies – the need to ensure that the eating-disordered patient is physically safe. Both low and high weight have potential for negative health consequences (e.g., cardiac function, muscular weakness, electrolyte imbalance, diabetes, etc.). Sudden or sustained loss of weight can be a particularly high risk. Of course, all of these patterns are easily missed if the patient is not weighed, making it possible to argue that failure to monitor weight effectively is dangerous practice on the part of clinicians. Some reasons that clinicians give for not weighing even high-risk patients will be considered below.

2.2. Indication of changes in eating patterns

Many clinicians working with eating-disordered patients also fail to monitor patients' eating patterns, despite recommendations in protocols (e.g., Fairburn, 2008; Fairburn et al., 1993; Waller et al., 2007). For example, Waller, Stringer, et al. (2012) reported that under 25% of CBT clinicians routinely had their patients complete food diaries. Thus, many clinicians are dependent on potentially unreliable *post hoc* self-reports from patients (if they ask about food at all). The clinician is dependent on knowing the patient's weight if they want to identify sudden changes in eating and related patterns (e.g., sudden increase in weight due to undisclosed binge-eating; sudden weight loss/fluctuations indicating resumed laxative abuse). In short, without regular weighing, it is possible that clinicians will miss sudden or long-term changes in weight that indicate important clinical targets or outcomes.

2.3. Anxiety reduction

A more CBT-oriented rationale for weighing patients in session is to address the anxiety that some (but not all) eating-disordered patients experience at the prospect of being weighed or as a result of self-weighing. This approach involves treating weight-avoidance as a problem behaviour, using two therapeutic tools – exposure and behavioural experimentation.

Exposure is valuable where the patient is fearful of being weighed and/or knowing their weight. Patients will often express their anxiety in forms such as "I will have to starve myself" or "Knowing my weight will just make me binge". Clearly, these are efforts to employ a safety behaviour, which would reduce that anxiety in the short term. The patient's safety behaviour has often been exacerbated by encounters with other clinicians, who have responded to it by backing off that demand – accommodating the patient's safety behaviour. Such accommodation exacerbates overvaluation of eating, weight and shape, resulting in problems in addressing the 'broken cognition' underpinning eating disorders (below). To reduce this anxiety requires the patient to be weighed and know their weight.

Behavioural experimentation is relevant when the patient engages in excessive body checking, where they weigh themselves many times a day. This body checking (Mountford, Haase, & Waller, 2006) serves the short-term function of anxiety reduction, but longer term results in elevated anxiety levels. Therefore, treatment requires experimentation with excessive weighing and no