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## Weighing the options : professionals' weighing procedures in the treatment of eating disorder patients

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Sarah M. English  
Weighing the Options:  
Professionals' Weighing Procedures  
In The Treatment of Eating  
Disorder Patients

## **ABSTRACT**

This descriptive, mixed methods study examined the weighing practices of professionals presently treating individuals with an eating disorder. Following a comprehensive review of literature on the topic, only one prior study was found that examined the clinical practices of weighing patients with an eating disorder. Data were collected through an online survey questionnaire created by the authors, Kelsie T. Forbush, Jonathon Richardson, and Brittany Bohrer (2014), of the prior study mentioned above. Data collected allowed the researcher to identify the rates at which professionals incorporate blind- vs. open-weighing in their practice, whether their weighing policy has changed over time, and which therapeutic modalities guide their practice. Additionally, the researcher of the present study added three additional questions to the existing survey to better understand participants' perceived effectiveness of the different weighing methods. The size of the sample and the lack of geographic diversity served as major limitations of the study. The researcher's hope is that the study will highlight the need for further research on the topic as well as greater research within the field of eating disorder treatment.

**WEIGHING THE OPTIONS: PROFESSIONALS' WEIGHING PROCEDURES  
IN THE TREATMENT OF EATING DISORDER PATIENTS**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2016

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## **CHAPTER ONE**

### **INTRODUCTION**

Eating disorders are a complex and dangerous illness that have various impacts on one's physical, emotional, and mental functioning. Statistics suggest that roughly 20 million women and 10 million men experience an eating disorder in their lifetime (National Eating Disorder Association [NEDA], n.d.). Additionally, several individuals struggling with the symptoms of an eating disorder go undiagnosed or untreated, as it can be difficult to accept the idea that their behaviors are problematic. Initially, recovery from an eating disorder was focused on normalizing eating habits and stabilizing weight; however, the recovery process must also address the negative thoughts about body image and self-esteem as well as identify adaptive coping strategies (Noordenbos, 2013). Recovery from an eating disorder varies for each individual and the process often involves slips, lapses, and relapses. Such experiences often lead individuals to feel hopeless, unmotivated, and discouraged.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) major disturbances in eating behavior can be classified into four categories: Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorder (OSFED) (American Psychiatric Association [APA], 2013). Anorexia Nervosa is described as distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat (APA, 2013). Bulimia Nervosa is characterized by frequent episodes of binge eating, which is followed by inappropriate behaviors such as self-induced vomiting, excessive exercising, or misuse of enemas to avoid weight gain (APA, 2013). Binge-Eating Disorder was recently introduced into the DSM-V as its own category, and can be defined as recurring episodes of eating significantly more food in a short period of time than most people would eat

under similar circumstances, with episodes marked by feelings of lack of control (APA, 2013). OSFED is attributed to symptoms characteristic of eating disorders that have led to impairments in functioning, but do not meet the full criteria of an eating disorder in the diagnostic class (APA, 2013).

Research suggests that eating disorders are caused by a complex interaction of biological, genetic, psychological, and social factors (National Institute of Mental Health, 2016.). This information has led to various studies examining best practices, biological markers, risk factors, behavior, genetics, and medications for the treatment of eating disorders (National Institute of Mental Health [NIMH], 2016.). Eating disorders exist among all age groups, races, ethnicities, social classes, and genders. Eating disorders have the highest mortality rate of all psychiatric illnesses (NEDA, n.d.) and are associated with serious medical and psychiatric complications (Herzog et al., 2000).

Research on eating disorders is relatively underfunded, despite the numerous people affected by the disorder. Following research done by the National Institutes of Health (2011), eating disorder research received roughly \$28 million dollars, which was broken down into \$0.93 per affected individual. These numbers were compared to the \$450 million dollars spent on research towards Alzheimer's disease, which affects nearly 5.1 million individuals (NEDA, n.d.). To better understand effective and appropriate treatment for this complex illness, additional funding towards research is necessary. It appears that there has been one research study done regarding the weighing practices of professionals' treating individuals experiencing an eating disorder by Forbush, Richardson, and Bohrer (2014). The field of eating disorders would greatly benefit from additional research on this topic, as weighing is generally involved most treatment settings with this population.



It is the intent of this study to explore professionals' weighing procedures in the treatment of their eating disorder patients. Specifically, it will serve to understand the rate at which professionals incorporate weighing practices into their treatment, methods used, and self-report of effectiveness on treatment. This topic may inform practice among professionals working with patients with eating disorders and further research in the field.

## CHAPTER TWO

### LITERATURE REVIEW

This literature review functions as a brief introduction to eating disorders in regards to diagnosis; treatment protocols; the connection of theory in relation to the development of an eating disorder; behaviors associated with preoccupation with weight, and societal impacts on body weight. It will explore the current research regarding weighing practices among clinicians and notable variables associated with eating disorder treatment. Additionally, this literature review will briefly touch upon limitations in this area of research.

#### **Eating Disorders**

Prior to the *Diagnostic and Statistical Manual of Mental Disorders—5<sup>th</sup> Edition* (DSM-V), more than half of all eating disorder diagnoses fell under the category of Eating Disorder Not Otherwise Specified (Fairweather-Schmidt & Wade, 2014). The altered diagnostic descriptions of Anorexia Nervosa and Bulimia Nervosa, in addition to the introduction of Binge Eating Disorder, suggest improvement in understanding symptomology as well as informing treatment protocols. Although the DSM-V aimed to reduce the number of diagnoses falling under the “other-specified” category, recent studies suggest that Other Specified Feeding or Eating Disorder (OSFED) still represents about 15-30% of cases (Allen, Byrne, Oddy, & Crosby, 2013). Eating disorders appear to develop out of a combination of psychological, biological, and social factors, that result in the purging and/or restriction of food (Bulik, Sullivan, Wade & Kendler, 2000).

Most research on mortality rates in relation to eating disorders focuses on Anorexia Nervosa due to the high percentages of deaths resulting from the condition. When considering these rates, it is important to note that research shows that suicide is often a common cause of

death related to Anorexia Nervosa (Pompili, Mancinelli, Ruberto & Tatarelli, 2004). Of the four eating disorder diagnoses, Anorexia Nervosa has the highest mortality rate among any psychiatric illness (Herzog et al., 2000)

Steinhausen (2006) showed that only 46% of patients fully recovered from Anorexia Nervosa, while roughly 33% improved with residual features, and 20% remained chronically ill. Additional research on the treatment modalities and effectiveness is critical to increasing the number of cases of recovery. Despite the prevalence of the disorder, the funds for eating disorder research are limited (National Institutes of Health, 2011).

There are differing opinions within the field of what recovery from an eating disorder is comprised of and there is limited research on the topic (Bardone-Cone et al., 2010). Within the field of eating disorders, the definition of recovery has shifted its focus away from solely physical improvements, such as weight, to the inclusion of behavioral and psychological improvements of the disorder. Definitions of recovery have, in earlier years, emitted improvements based on psychological functioning, specifically improvements regarding how individuals think about their body image, food, and eating. Keski-Rahkonen & Tozzi (2005) suggest that omission of the psychological aspect in recovery can produce a false recovery state in which individuals appear recovered, but are still internally struggling with body image and cognitions regarding food. Participants of an internet based survey by Keski-Rahkonen and Tozzi (2005) regarding the process of recovery from an eating disorder identified multiple factors that are vital to the recovery process, including gaining willpower and motivation, and ceasing to identify with an eating disorder. Weight restoration was rarely mentioned within this study, as participants identified the language as harmful to recovery. Given that there are multiple factors involved in recovery, treatment settings have shifted focus from exclusively weight restoration

and are increasingly focusing on other factors such as the ones mentioned above. To address these factors, modalities such as cognitive- and behavioral-based strategies have been used, in addition to motivational interviewing (Waller, Stringer, Meyer, 2012; Macdonald, Hibbs, Corfield, & Treasure, 2012).

Many patients with eating disorders experience ambivalence to change. Although aware of the negative health consequences associated with eating disorders, many patients struggle to change in fear of losing control over their food consumption, gaining weight, and the impact on their self-esteem. Additionally, the eating disorder symptoms serve as a way to cope when faced with emotional distress, and many individuals struggling with an eating disorder are afraid to let go of their eating disorder behaviors to gain adaptive, healthier behaviors. In order to increase patient motivation to change it is vital to bring awareness of what their future holds including, better physical health and self-esteem, more positive body-image, improved cognitive functioning, and better social relationships (Noordenbos, 2012)

For many patients, eating disorder symptoms first arise during adolescence (Steinhausen, 2006) and can lead the patient into a lengthy treatment process. Due to the severity and prevalence of the disorder, treatment can be long and ineffective. Treatment for eating disorders varies across different levels of care, such as inpatient, residential, partial hospitalization, intensive outpatient, and outpatient therapy (Guarda & Heinberg, 2004). Such treatment settings also regularly involve a multi-disciplinary team, which is different from other mental health treatment facilities.

### **Treatment Options and Protocols**

There are various treatment options based on therapeutic modalities used in treatment, such as Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Family-

Based-Treatment (FBT), Psychodynamic Therapy, and Exposure and Response Prevention Therapy (ERP) (Ekern, 2012; Waller & Mountford, 2015). Of the various modalities that exist, 13% of survey participants reported adhering to one particular modality with their patients (Tobin, Baker, Weisberg & Bowers, 2007). The treatment recommendations vary amongst each modality and have changed over time. Eating disorders are complex psychological illnesses, composed of behavioral and cognitive components. Many treatment centers are moving towards individualized treatment approaches to address the patient's needs, and therefore often require protocols from multiple modalities.

Kosmerly, Waller, and Robinson (2015) note that psychological therapies are essential to the effective treatment of eating disorders; however, few of these therapies have empirical support. Individual needs of the client are often considered in the treatment of eating disorders and often involve a combination of individual, group, and family therapy in addition to medical care, nutrition counseling from a registered dietitian, and prescribed medications. Due to the vast treatment options that exist for eating disorder treatment, researchers are now interested in clinician adherence to these evidence based treatment protocols (Forbush, Richardson, & Bohrer, 2014). Each modality has differing treatment protocols, some of which are highly debated in the field, including the practice of weighing patients (Forbush et al., 2014).

Weighing practices and protocols vary amongst the treatment modalities noted above, including times at which patients are weighed during treatment in addition to what type of weight-related information is shared with the patient. Preoccupation with weight is a diagnostic criterion for Anorexia Nervosa and Bulimia Nervosa and can lead to persistent self-weighing and body checking behaviors. It is important to note that one's preoccupation with weight is not necessarily focused on a number, but may also be a preoccupation with their perceived weight,

as their perception may be distorted. Some treatment modalities aim at reducing the amount of self-weighing behaviors that occur outside of treatment and are working towards only collecting weights at designated treatment facilities (McIntosh, Jordan, & Bulik, 2010). This practice may serve to address patients' anxiety to the exposure of weight-related information, by providing therapeutic support.

Waller and Mountford (2015) state four reasons as to why CBT therapists weigh their patients: (1) safety (2) understand eating patterns (3) reduce anxiety and (4) modify cognitions. In CBT, weighing throughout treatment is considered an integral part of treatment, as it monitors patients' health in regard to cardiac functioning, muscular strength, glucose level, and electrolyte levels. Weighing clients regularly can help prevent the dangerous consequences that may otherwise be missed. Additionally, some treatment protocols require patients to be on meal plans and complete diary cards during treatment and in order to see progress and adherence to these requirements, monitoring patients' weight offers critical information. Patient self-report may be falsified, and collecting weights regular from patients can alert the therapist to any changes in eating patterns or eating disordered behaviors such as vomiting, restricting, and/or laxative abuse (Waller & Mountford, 2015).

Although the CBT modality incorporates weighing practices throughout the treatment of eating disorders, Waller and Mountford (2015) note that several therapists do not adhere to the evidence-based principles and protocols and end up missing important components, including weighing patients. In a study by Waller, Stringer & Myer (2012), 40% of CBT clinicians reported regularly collecting their eating disordered patient's weight, while 17.1% of CBT therapists reported never weighing their patients. Empirically supported practices vary in their protocols of taking weights and sharing the results with clients during treatment (Waller &

Mountford, 2015). These options include, patient self-weighing, daily weights collected by therapist, weights collected twice a week, weekly weights collected by the therapist, weighed by dietitian, weight collected during a later stage of therapy, and no weights collected throughout treatment. Additionally, the ways in which weight related information is reported vastly differs, depending on the modality, diagnosis, and age of the patient (Waller & Mountford, 2015).

Although these weighing options exist and are carried out within some treatments, many treatment protocols fail to report how, when, and why patients should be weighed. Family based treatment therapies provide relative consistency across treatment protocols in regard to weighing patients, which involves regularly weighing patients and sharing the weight related information to the patient and family as a marker of progress in treatment (Waller & Mountford, 2015). A major issue that arises in the adherence to treatment protocols is the vastly changing information about which weighing protocol is deemed most effective for treatment. Forbush, Richardson, and Bohrer (2014), note that it is unclear whether or not there is an impact on clinical outcomes of patients in relation to nonconformities to clinical adherence of evidence-based protocols.

Exposure and Response Prevention (ERP) can be effective in helping patients cope with anxiety related to food, body-image, and weight (Ekern, 2012). This method has been effective in reducing urges to binge/purge in addition to decreasing feelings of lack of control, anxiety, and guilt. ERP works to help individuals adjust to various situations that influence mild to moderate anxiety. It is vital that a professional is present to support patients through these anxiety-provoking moments. Length of treatment is dependent on the patient's progress in treatment, based on the patient's report of their anxiety level (Ekern, 2012).

Individuals with Anorexia Nervosa often express difficulty relaxing and describe themselves as feeling nervous. In addition, they often experience the physical symptoms of

anxiety. Studies suggest a high rate of comorbidity between anxiety disorders and Anorexia Nervosa, varying between 38 and 60% (Raney et al., 2008; Bulik, Sullivan, Fear & Joyce, 1997)

Forbush et al., (2014) define “blind weighing” as weighing patients and withholding the results. It is said to reduce potential distress and anxiety of an increase in weight. Withholding information about weight from patients may reduce patients’ preoccupation with the number, and prevent any therapeutic ruptures between the patient and the therapist. Weighing the patient and sharing the results with the patient, also known as “viewed weighing” also reveals some potential benefits and limitations. This technique is considered as a form of exposure therapy that is said to decrease anxiety around weight gain and thoughts about body weight. Open weighing techniques may also serve as an opportunity for the therapist and patient to discuss any concerns or reactions about their weight. Although many manualized and evidence-based treatments recommend the use of open-weighing techniques, the limited research on the topic suggests that clinicians may be disinclined to use the method (Forbush et al., 2014). One of the reasons for this opposition is the anxiety of clinicians.

### **Behaviors Influenced by Preoccupation with Weight**

Preoccupation with weight and disturbance in the experience of body weight are diagnostic criteria for Anorexia Nervosa and Bulimia Nervosa, and often a part of the symptomology associated with OSFED (American Psychological Association, 2013). Due to the intense fear of gaining weight and distorted perceptions of actual body weight, individuals often engage in body checking behaviors including frequent self-weighing, persistent use of a mirror, and obsessive measuring of body parts (American Psychological Association, 2013). Individuals engage in these behaviors to address their assumptions and beliefs about their weight and body image and may serve as reassurance that they have not gained weight following a meal or snack.



The cognitive process of individuals struggling with an eating disorder is distorted by disproportionately fearful beliefs that the food they consume, or the amount of food they consume, will have an undesirable impact on their weight (Waller & Mountford, 2015).

Body checking can vary in length from a few seconds to multiple minutes and the rate at which individuals engage in this behavior vastly differs. Body measuring techniques may be guided by the fit of clothing or jewelry or may include the use of measuring tape or hand- or grip-size. Some individuals also engage in body checking through the use of mirrors and comparisons to others. Recent awareness of this behavior has led to improved research efforts and clinical knowledge (Mountford et al., 2006). Body checking is not only performed by individuals with eating disorders, as it is also a common behavior among women in general (Haase, Mountford, & Waller, 2011). This behavior coincides with the overvaluation of eating, shape, and weight, a cognitive construct associated with eating disorders (Fairburn, Cooper, & Sharfran, 2003). A study done by Sharfran, Fairburn, Robinson, and Lask (2004) examined body checking behavior among individuals with an eating disorder which concluded that over half of the participants stated that body checking affected their sense of control in relation to eating, weight, as well as their sense of self and shape.

Waller and Kennerley (2003) note the significance of focusing on both behaviors and cognitions in eating disorder treatment. For treatment to be effective in eliminating maladaptive behaviors, it is advised that the individual's cognitions be observed and challenged. A study by Mountford, Haase, and Waller (2006) revealed four main beliefs associated with body checking behavior: (1) object verification, body checking will help an individual form an accurate picture of their own body; (2) reassurance, body checking will reduce anxiety and improve thought; (3) safety beliefs, if body checking behavior does not occur, a feared outcome will follow; (4) body

control, the idea engaging in body checking behavior helps maintain weight and control over eating.

Body checking may serve to reduce anxiety in the moment; however, these behaviors typically elevate anxiety in the long term (Waller & Mountford, 2015). Kaye (n.d.) and his colleagues researched the neurobiological factors that increase anxiety around weighing. The study revealed that individuals with Anorexia Nervosa are more likely to experience high levels of anticipation in regard to future events, which suggests that any reference or exposure to stimuli regarding weight will trigger anxiety. The study also revealed that when individuals who recovered from Anorexia Nervosa taste sugar or experience pain, they experienced a reduced reaction to events, suggesting a “disconnection between anticipated and actual interoceptive state, which may alter learning from experience.” In relation to weighing practices, the individuals are more likely to experience anxiety as a result of anticipation, and it may make little difference whether they participate in blind or open weights (Kaye, n.d.)

Weighing patients during treatment provides an opportunity to work with patients around their beliefs and perceptions about their weight, increase awareness of reactions, and provide reality testing in regard to their weight. It can also offer the clinician information about the patient’s beliefs associated with their weight as well as any particular urges that arise as a result of knowing their weight. Prior to weighing the patient, it is beneficial for the clinician to request the patient to provide information about the prediction of their weight as well as their level of certainty (Waller & Mountford, 2015). There is a strong value of having the clinician prompt the patient for their imagined response to their weight. Exposure to weight-related information while in treatment and with a trained professional, can lead to adaptive coping skills, that may be otherwise inaccessible when self-weighing occurs.

## **Societal Implications**

As mentioned earlier, research shows that eating disorders are a result of biological, psychological, genetic, social, and environmental factors (NIMH, 2013). Body image is a social construct influenced by sociocultural pressures to be thin. Mass media platforms, such as television, magazines, radio, and the internet, serve as a major influence on societal expectations and norms (López-Guimerà, Levine, Sánchez-Carracedo, & Fauquet, 2010; Sepúlveda & Calado, 2011). These large industries create high standards of beauty; images which created in editing programs that are often impossible obtain without cosmetic surgery. Fear of gaining weight and distorted perception of body image are diagnostic criterion of anorexia nervosa which can become increasingly distressing, and in turn, exacerbate symptoms as a result of societal pressures on appearance.

Greenberg, Rosaen, Worrell, Salmon and Volkman (2009) state that the content of these platforms often contain “unhealthy messages about the beauty ideal, body size, food, weight control, and the gender roles of women and girls...” With advances in technology, images are routinely altered, yet appear untouched, which has led to increasingly unattainable and unrealistic expectations of beauty and ideal body image. Researchers contend that the media’s display of idealistic beauty and body standards has led to increased body dissatisfaction, eating disordered behavior, and concern regarding weight (Levine & Murnen, 2009).

Bearman, Presnell, and Martinez (2006) found that roughly 50% of girls and undergraduate women report being disappointed with their bodies. Research on the media’s effect on body image and body dissatisfaction has led to over 100 studies in which the findings offer evidence that dissatisfaction with body image plays in predicting eating pathology (Stice & Shaw, 2002). Research by Grabe, Ward and Hyde (2008) show associations throughout multiple

measures of women's eating behaviors, and beliefs, which "provide strong support for the notion that exposure to mass media depicting the thin-ideal body is related to women's vulnerability to disturbances related to body image" (p.470). These findings suggest the importance of media literacy for both adolescents and adults. Women and girls who already display greater internalization of the thin-ideal, compare themselves to ideal figures, and are negatively affected by these factors tend to seek out content from mass media for inspiration, guidance, and self-evaluation (López-Guimerà et al., 2010). This is an important factor in the treatment of eating disorders as resources available on the internet for individuals to access include pro-anorexia websites as well as diet websites, which can have negative cognitive effects on viewers (Bardone et al., 2010).

The Western standard of beauty is based on youth and thinness for women and thinness, muscularity, and fitness for men (Sepúlveda & Calado, 2011). Although the media plays a significant role in the influence of beauty standards and expectations, other factors also contribute to the perception of the beauty-ideal. Parents, peers, and family also contribute to "the transmission, reinforcement, and modeling of the thing beauty ideal and disordered eating behaviors and beliefs..." (López-Guimerà et al., 2010, p. 408) and are usually without awareness of these negative impacts. According to Shroff, (2006) adolescent girls value the opinions of their peers in regard to appearance, which is likely to have an impact on the rate of body satisfaction and probability of participating in disordered eating. For individuals receiving treatment related to enhancing self-esteem regarding body image or an eating disorder, it is equally important for the people surrounding the individual to be educated in media literacy. Family members and peers also may be social supports for individuals struggling with body dissatisfaction and disordered eating (Shroff, 2006).

## **Strengths and Limitations**

Due to the major health risks associated with eating disorders, more research is needed in the field and is crucial to the recovery of those affected by the disorder. These studies have offered treatment recommendations and general knowledge of eating disorders that was previously unknown. The research on the connection between media content and body dissatisfaction has provided a strong foundation to further examine the sociocultural factors contributing to an eating disorder (Grabe, Ward, & Hyde, 2008).

A major limitation surrounding this topic area is the lack of previous research conducted on weighing procedures in the field of eating disorders. Based on a review of past and current research, there appears to be only one prior study regarding clinicians' weighing practices with eating disorder patients (Forbush et al., 2014). The study by Forbush and her colleagues indicates that the study lacked information regarding whether not blind or open weighing is preferable for patient outcomes, and therefore it continues to be unknown which treatment protocol is more effective.

The researcher's intent is to add knowledge and information to field of eating disorders around weighing procedures used in treatment, as there is presently limited data that exists. Specifically, which therapeutic modalities and weighing methods are used by professionals, whether their weighing protocol has changed over time, and does their weighing method differ based on eating disorder diagnosis. Additionally, the researcher seeks to understand which weighing methods professionals perceive as more effective.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **Research Purpose and Questions**

The purpose of this research was to examine the weighing practices of professionals, such as social workers, psychologists, counselors, dieticians, and medical personnel, in the treatment of patients with eating disorders. Following a comprehensive review of literature on this topic, it appeared that there was only one existing study examining the clinical practices of weighing eating disordered patients (Forbush et al., 2014). By examining the weighing practices of clinicians from various disciplines, future treatment of eating disordered patients may be better informed by the research and lead to a better understanding of current weighing practices, more effective outcomes, and adherence to empirically supported protocols regarding weighing practices. In order to identify these factors, the study sought out to answer the following questions:

1. How many clinicians participate in blind weighing, open weighing, or a combination of the two?
2. Do weighing practices change over the course of treatment stages?
3. Does age of the patient affect clinicians' choice of weighing practices?
4. Does diagnosis of the patient affect clinicians' choice of weighing practices?
5. Is the practice of weighing eating disordered patients a regular component of treatment?
6. Based on clinical experience, is one weighing practice more effective, regarding consistent weight gain, than others in the treatment of eating disorders?

## **Research Method and Design**

The study utilized a descriptive, mixed-method survey design. It gathered information from practicing clinicians and professionals working with patients who are diagnosed with an eating disorder. Data were collected through an online survey created by Dr. Kelsie Forbush, Jonathon Richardson, and Brittany Bohrer, in 2014 and used in their study, “Clinicians’ practices using blind versus open weighing among patients with eating disorders.” Permission to use this survey was granted by the authors via email (Appendix J). Three additional questions, created by the researcher, were added to measure perceived effectiveness of weighing practices. This survey was uploaded to an online survey distribution website, Qualtrics. It was comprised of questions regarding demographics, weighing procedures, factors that identify clinicians’ reasoning behind their chosen weighing procedure, and any potential differences in weighing procedures based on the client’s diagnosis and age. The survey included 38 multiple choice and fill-in questions, as well as two open response questions for participants to write any additional comments or information regarding their weighing practices with patients. This survey design served to collect data on a large scale regarding clinicians’ weighing practices for patients with eating disorders.

Engel and Schutt (2013) note that surveys have the potential to reach a vast group of individuals and are a relatively inexpensive way of collecting data from a large number of people in various geographic locations. This is an effective tool, as many clinicians’, counselors’, and dieticians’ work generally requires access to a computer and internet. This factor may also increase response rates, leading to a more representative sample of the larger population. One limitation of surveys is their inability to provide in-depth data (Engel & Schutt, 2013); however, this method of data collection is most suitable for the current study, since the primary goal was to

collect data from professionals among various disciplines and geographic locations, to diversify the sample and increase generalizability.

## **Sample**

This study welcomed participation from eating disorder professionals from any discipline who hold a Bachelor's-level degree or higher, with the hopes of gaining a largely representative sample. A total of 37 respondents from a variety of educational backgrounds completed the survey. Participants were required to currently be treating one or more individuals with an eating disorder, including anorexia nervosa, bulimia nervosa, binge-eating disorder, purging disorder, or eating disorder not-otherwise-specified, at the time they took the survey.

The survey was open to clinicians in various countries around the world; it welcomed participants of any gender, race, sexual orientation, or ethnicity. Due to the researcher being monolingual, all participants were required to be able to read and write in English. Exclusion criteria were clinicians who were not currently treating eating disordered patients, clinicians who did not have a Bachelor's degree or a higher educational level, and non-English-speaking participants.

## **Recruitment**

Participants were primarily recruited by a nonprobability, purposive, convenience-sampling methods. The recruitment process utilized four sources: (1) E-mail advertisement sent to personal networking contacts of the researcher (2) social networking tool (Facebook), (3) a link to the survey distributed on the National Eating Disorder Association's website, under "Support Groups & Research Studies" (4) a link to the survey distributed on the Eating Disorder Collaboration of Massachusetts for distribution. Participation in this study was voluntary. The E-mail advertisement (Appendix F), Facebook advertisement (Appendix G), the National Eating



Disorder Association's listing (Appendix H), and the Eating Disorder Collaborative of Massachusetts (Appendix I) contained a brief synopsis of the study and a link to the survey on the Qualtrics website. These advertisements asked recipients to consider forwarding the email to their colleagues.

Steinberg (2009) suggests nonprobability sampling offers a convenient way to collect data which allows the researcher to make specific eligibility criteria for inclusion and exclusion. This method is generally considered to be efficient and to require less money and time than a random selection process. This research was completed over a restricted time frame with limited monetary funds. Purposive sampling selects participants who meet particular inclusion criteria, such as professionals experienced in working with a particular population. This study required respondents to have experience treating a patient with an eating disorder. This method ensures representation in expertise and increases the ability to collect information about a specific topic area. However, a weakness of this recruitment technique is that it limits generalization.

### **Data Collection Methods**

A screening questionnaire was provided prior to taking the survey. This portion of the questionnaire ensured that the participants met the inclusion criteria for the study. If participants did not meet the criteria, they were directed to a disqualification page and thanked for their time and interest in the study. If participants met the criteria, they were provided access to the informed consent form. This document contained information regarding the purpose of the study, eligibility criteria, and the researcher's contact information. Participants were then required to read and electronically sign the informed consent form, by selecting "yes," prior to beginning the survey.

The online survey was accessible to participants from January 28, 2016 until April 10, 2016. Demographic information from the participants was collected to examine the diversity of the sample. The study also included questions regarding weighing procedures, factors that identified their reasoning behind their chosen weighing procedure, and any potential differences in weighing procedures based on the client's diagnosis and age. The survey contained a total of 39 questions: three eligibility questions, 34 multiple choice and fill-in questions, and two open response questions, in which respondents were able to share any information regarding the survey or their practice regarding weighing patients with eating disorders and their perceived effectiveness of their method used.

### **Ethical Concerns**

The questionnaire was administered through the website Qualtrics.com. This website does not collect any names, e-mail address, IP addresses, or any identifying information of participants. This feature ensured anonymity for those who participated. Participants were advised to withhold any identifying information in the open-ended question at the end of the survey. Upon review, the researcher removed any names or place names that could potentially reveal the participant's identity. The survey responses were only accessible to the researcher, the researcher adviser, and the data analyst. The data was secured electronically, password-protected and encrypted. All data will be kept secure for three years as required by Federal regulations. After three years, the data will be destroyed or will continue to be kept secured as long as the researcher needs them for research purposes. The data will be destroyed when it is no longer needed.

## **Limitations**

Using an electronic survey method represented a limitation, as it prevented the researcher from being able to ask follow up questions to participants' responses. It was difficult to predict how successful the survey distribution would be in regard to the recruitment methods. Following a review of online resources for professionals working within the eating disorder field, my ability to share my survey was limited, which in turn made it difficult to collect numerous responses.

Another possible limitation of this study is the lack of diversity in the sample. The vast majority of participants were white women. Previous research does not report demographic information of professionals treating patients with eating disorders and therefore this researcher was unable to determine whether or not the sample is representative of the larger population of professionals treating patients with eating disorders. Similarly, to the present study, however, some studies whose participants were eating disorder professionals reported a high rate of white female respondents (Forbush et al., 2014). Additionally, nearly all of the participants were from the United States. In order to address this limitation and access a more diverse sample, the researcher would have benefitted from using a random sampling method. Unfortunately, due to time and monetary restraints, the researcher utilized nonprobability, purposive, convenience-sampling methods.

Additionally, the small time frame in which this survey was active also served as a limitation to the research. The number of responses collected was less than anticipated and therefore the results may not be generalizable to the larger population of professionals treating patients with eating disorders. If the survey had remained open for a longer period of time, it is likely that more respondents would have participated.

## **Data Analysis**

Due to the quantitative nature of the study, the data were analyzed using quantitative methods. With the assistance of Smith College's data analyst, Marjorie Postal, the data were examined using descriptive statistics (multiple choice questions). For the open-ended questions, the qualitative method of thematic analysis was used. The researcher read through each response to uncover possible themes and categories (Engel & Schutt, 2013). Following this process, the researcher analyzed the narrative responses and considered how these responses may or may not answer the research questions and whether they related to prior information discussed in the literature review. The thesis adviser assisted in this process to check on the validity of the assessments.

## CHAPTER FOUR

### FINDINGS

The purpose of this research was to assess the weighing practices of professionals treating patients with eating disorders. Prior to this study, it appeared that there was only one existing study examining the clinical practices of weighing eating disordered patients (Forbush et al., 2014). In an effort to gain insight into professionals' perception of effective weighing practices, participants were asked to complete a survey regarding their weighing practices with patients being treated for an eating disorder. The survey asked several questions regarding demographics, weighing procedures, factors that identify clinician's reasoning behind their chosen weighing procedure, and any potential differences in weighing procedures based on the client's diagnosis and age. The survey included 38 multiple choice and fill-in questions as well as two open response question for participants to write additional comments or information regarding their weighing practices with patients.

This chapter will report the major findings of this study. The first section will review the demographics of the sample, which includes the following sub-sections: race, location, age, and educational/degree demographics. The second section will review the quantitative results of the survey regarding professionals' weighing practices with specific populations, and policies regarding patient characteristics, and policy changes over time. Lastly, the qualitative results of the survey will be reviewed (i.e., the results of the open-ended questions).

#### **Demographics of the Participants**

The survey was available online from January 28, 2016 until April 10, 2016 for participants to complete. Over the course of that time, 37 individuals participated in the survey.

The participants included 31 females, one male, one gender-nonconforming individual, and four individuals who did not disclose their gender.

### **Racial Demographics**

The vast majority of respondents, 86.5% (n=32), described their racial background as Caucasian; 2.7% (n=1) identified as multi-racial, and 10.8% (n=4) chose not to disclose their racial identity.

### **Location Demographics**

Of the 37 respondents, 83.8% (n=31) reported their country of origin was the United States; 2.7% (n=1) were from Canada, 2.7% (n=1) were from Australia/New Zealand, and 10.8% (n=4) did not disclose their country of origin. Similarly, when asked to report the country in which they currently reside, 81.1% (n=30) currently reside in the United States, 2.7 % (n=1) reside in Canada, 2.7% (n=1) currently reside in Australia/New Zealand, and 13.5 (n=5) did not disclose the country in which they currently reside.

Additionally, participants were asked to identify the area in which they practiced. Participants were able to select from the following options: rural area, suburban area, and urban area. The majority of participants, 45.9% (n=17), reported practicing care in a suburban area. Table 1 below displays these data.

**Table 1.** Practicing Location Demographics

Area	Frequency	Percent
Rural	2	5.4
Suburban	17	45.9
Urban	12	32.5
Did Not Disclose	6	16.2
Total	37	100.0

## Age Demographics

Participants' ages ranged from 23-57 years old. As can be seen in Table 2 below, the vast majority of participants (75.7%) were between the ages of 23 and 34. Four participants did not disclose their age. Only one participant (2.7%) identified being between the ages of 47 and 58.

**Table 2.** Age Demographics

Age Range	Frequency	Percent
23-28	13	35.2
29-34	15	40.5
35-40	1	2.7
41-46	3	8.1
47-52	0	0
53-58	1	2.7
Did Not Disclose	4	10.8
Total	37	100.0

## Educational Background

In regard to educational background, participants were able to select multiple options to describe their educational experience. The results indicated that of the 37 respondents, 12 identified having a Social Work background, 8 were PhDs, 6 were Counseling Psychologists, four were Bachelor's Degree Counselors, three were Registered Dietitians, two were Nutritionists, two were Clinical Psychologists, one was a PsyD and one an MD. Table 2 displays these data.

**Table 3.** Educational Background

Educational Degree	Frequency	Percent
MD	1	2.6
PhD	8	20.5
PsyD	1	2.6
Social Worker	12	30.8
Counseling Psychologist	6	15.4
Clinical Psychologist	2	5.1
Bachelor's Degree Counselor	4	10.2
Registered Dietitian/Nutritionist	5	12.8
*Total Educational Background	39	100.0

\*Number does not equal 37 because some participants held more than one degree and/or identified with more than one educational background.

### **Quantitative Findings Related to Clinical Practice**

Participants were asked to report the number of years they had worked with patients struggling with an eating disorder. This number ranged from 1-35 years, however, four participants did not report the number of years they were working with the population. Within this range, the majority of participants, 18.9% (n=7), worked with the population for one year. Overall, the mean was 5.24 years. Those who identified as having greater than 10 years of experience included one participant who reported 18 years of experience and one individual who identified working with the population for 35 years.



## Years of Experience in the Field

**Table 4.** Years of Experience

Years of Experience	Frequency	Percent
1-3	15	40.6
4-6	11	29.7
7-9	4	10.8
10-12	1	2.7
18-34	1	2.7
35+	1	2.7
Did Not Disclose	4	10.8
Total	37	100.0

Participants were also asked to identify which therapeutic modalities they utilize in their practice with this population. Several participants identified multiple modalities. The options included: Cognitive Behavioral Therapy, Interpersonal, Eclectic, Family Systems, Family-Based/Maudsley Model, Psychodynamic, Psychoanalytic, Behavioral, Motivational Enhancement, Acceptance Based, and Other. The table below displays these data.

**Table 5.** Therapeutic Modalities Followed

Therapeutic Modality	Frequency	Percent
Cognitive Behavioral Therapy	26	19.2
Interpersonal	9	6.6
Eclectic	3	2.2
Family Systems	10	7.3
Family-Based/Maudsley Model	21	15.4

Psychodynamic	8	5.9
Psychoanalytic	2	1.5
Behavioral	25	13.2
Motivational Enhancement	15	11.1
Acceptance Based	14	10.3
Other	6	7.3
*Total	136	100.0

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\*Number does not total 37 because some participants reported following more than one therapeutic modality.

Ten respondents identified “other” modalities utilized in their treatment of patients with an eating disorder. These participants were able to record the other modalities used, which were not offered in list of options offered by the researcher. Participants identified Narrative Therapy, Psychoeducation, Internal Family Systems, Solution Focused, Feminist Theory, and Post Modern Approaches. Seven participants also identified Dialectical Behavioral Therapy as a modality used in their treatment. Those seven responses were included in the modality referred to as “Behavioral” for the purpose of data analysis.

Participants were asked to report the treatment setting(s) in which they work. Patients were able to choose from the following options: inpatient, outpatient, private practice, academic medical center, non-academic medical center, and college/university counseling center. Table 6 displays these data.

**Table 6.** Treatment Settings

Setting	Frequency	Percent
Inpatient	11	24.4
Outpatient	19	42.2
Private Practice	9	20.0
Academic Medical Center	3	6.7
Non-Academic Medical Center	2	4.5
College/University Counseling Center	1	2.2
*Total	45	100.0

\*The total number does not equal 37, as participants were able to select multiple settings in which they work.

Participants were also asked to report the age of the patients with whom they worked. The options listed on the survey included: adults, teenagers, and children. Due to the likelihood that professionals worked with more than one specific age group, respondents were able to select more than one option. The 37 respondents who completed the survey reported 73 responses based on the population they treated. Of the responses recorded, 21.9% (n=16) worked with children, 39.7% (n=29) worked with teenagers, and 38.4% (n=28) treated adult patients.

Of the 37 participants who completed the survey, 33 answered the question about weighing procedures used. The data collected indicate that slightly more than half (54.5%, n=18) of the participants generally use blind weighing in their treatment of patients with an eating disorder, whereas just under half of the participants (45.5% n=15) do not generally use blind weighing procedures. The 18 respondents who generally use blind weighing were asked whether

they use this weighing procedure throughout the entire treatment of the patient or for a portion of the treatment. Table 7 below displays these results.

**Table 7.** Blind Weighing Length of Treatment

Length of Treatment	Frequency	Percent
Entire Treatment	11	29.7
Portion of Treatment	7	18.9
Total	18	100.0

The participants who indicated that they did not generally use blind weighing procedures in their treatment of patients with an eating disorder were asked to identify their reason or multiple reasons for not using blind weighing. Table 8 below lists the options that participants were able to select. Of the 15 participants who reported using blind weighing practices with their patients, 50 responses were recorded. All 15 participants identified that they wanted to help their clients manage their reactions to weight increases. In addition, 10 participants identified “other” reasons for not using Blind Weighing and were able to write-in their responses. Some responses included, “Transparency with adolescents. To interrupt fears/significance of numbers,” “I do blind vs. seen weights on a case by basis,” “Company model requires viewed weights and open discussion about weight with adolescent clients and family members. I do not always find this helpful/therapeutic so we try to make case-to-case exceptions,” and “There is no evidence that blind weighing leads to better outcomes, and I believe that weight should not be something that feels taboo or hidden to patients.”

**Table 8.** Reasons for not using Blind Weighing

Reasons for not using blind weighing procedure	Frequency	Percent
I think that sharing weights with my client is therapeutic	7	14.0
I think exposure to weight leads to better outcomes	11	22.0
I want to be able to help my client manage their reactions to weight increase	15	30.0
I think clients weigh themselves at home, so I decided weighing them in treatment is appropriate	7	14.0
Other	10	20.0
*Total	50	100.0

\*The total number does not equal 37, as participants were able to select multiple answers

Participants were also asked to identify whether a patient's status in treatment changed their weighing policy. Five participants did not disclose this information. Of the 32 responses collected, 56.3% (n=18) reported "Yes" a patient's status in treatment does dictate their weighing policy, while 43.8% (n=18) reported "No."

Additionally, participants were asked to identify if they belonged to a larger treatment program that dictated their policy with regard to sharing patients' weight related information. Four participants did not indicate whether or not they belonged to a larger treatment program, while 33 responded either "Yes" or "No" to the question. The majority of respondents, 59.5%

(n=22) reported that they do belong to a larger treatment program. Table 9 below presents these results.

**Table 9.** Status of Belonging to a Larger Treatment Program

Status	Frequency	Percent
Yes	22	59.5
No	11	29.7
Did not Disclose	4	10.8
Total	37	100.0

The vast majority of participants (90.9% n=30 out of 33 responding to this question) reported that they discourage patients from weighing themselves at home. Two participants indicated they do not discourage this behavior and one stated it does not apply, as they only work with inpatient clients. Four participants did not answer this question.

Participants were asked to indicate whether or not their policy with regard to blind weighing changed of the course of their time working with the patient. Respondents were able to select one of the following three options: “no change,” “I used to share more information about weight than I do presently,” “I used to share less information about weight than I do presently.” Four participants did not answer this question, while 33 respondents did. Table 10 below displays these data.

**Table 10.** Weighing Policy Changes Over Time

Policy Over Time	Frequency	Percent
No Change	22	66.7
I used to share more information about weight than I do presently	2	6.1

I used to share less information about weight than I do presently	9	27.3
Total	33	100.0

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To better understand weighing practices based on diagnosis, participants were asked to select one option that described their typical practice with a patient diagnosed with a specific eating disorder. Thirty-three respondents participated in answering this question. The findings are shown in Tables 11-14.

**Table 11.** Weighing Practices for Anorexia Nervosa

Weighing Practice -Anorexia	Frequency	Percent
Share exact weight with patient	8	24.2
Share magnitude of weight change with patient but not an exact weight	3	9.1
Share with patient the direction of weight change only	6	18.2
Share with patient whether he/she is in or out of a specific range	3	9.1
Share with patient he/she is “on track” with regard to weight gain.	6	18.2
Display the patient’s past and current weights on a graph	1	3.0
Don’t share any information about his or her weight.	4	12.1
Not applicable	2	6.1
Total	33	100.0

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**Table 12.** Weighing Practices for Bulimia Nervosa

Weighing Practice - Bulimia	Frequency	Percent
Share exact weight with patient	9	27.3
Share magnitude of weight change with patient but not an exact weight	2	6.1
Share with patient the direction of weight change only	8	24.2
Share with patient he/she is “on track” with regard to weight gain.	3	9.1
Display the patient’s past and current weights on a graph	1	3.0
Don’t share any information about his or her weight.	3	9.1
It depends on the client’s weight	4	12.1
Not applicable	3	9.1
Total	33	100.0

**Table 13.** Weighing Practices for Binge Eating Disorder

Weighing Practice- Binge Eating Disorder	Frequency	Percent
Share exact weight with patient	4	12.1
Share magnitude of weight change with patient but not an exact weight	4	12.1



Share with patient the direction of weight change only	7	21.2
Share with patient he/she is “on track” with regard to weight gain.	2	6.1
Display the patient’s past and current weights on a graph	2	6.1
Don’t share any information about his or her weight.	4	12.1
It depends on the client’s weight	3	9.1
Not applicable	7	21.2
Total	33	100.0

**Table 14.** Weighing Practices for Purging Disorder

Weighing Practice – Purging Disorder	Frequency	Percent
Share exact weight with patient	7	21.2
Share magnitude of weight change with patient but not an exact weight	2	6.1
Share with patient the direction of weight change only	5	15.2
Share with patient whether he/she is in or out of a specific range	2	6.1

Share with patient he/she is “on track” with regard to weight gain.	4	12.1
Display the patient’s past and current weights on a graph	1	3.0
Don’t share any information about his or her weight.	3	9.1
Not applicable	9	27.3
Total	33	100.0

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Additionally, participants were asked to describe their weighing practice protocol based on the characteristics of the patient in conjunction with their eating disorder diagnosis. Participants were able to select multiple options to answer this question. Tables 15 through 18 display these results.

**Table 15.** Weighing Practice for Anorexia Nervosa based on Patient Characteristics

Weighing Practice – Anorexia, Patient Characteristics	Frequency	Percent
If a patient is more motivated to change, I am willing to share his/her weight	9	11.4
If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight	16	20.3
If a patient does not want to know his/her weight, I will not share it with him/her	11	13.9

If a patient has relapsed in the past in response to knowing his/her weight, I am less likely to share his/her weight	11	13.9
If a patient's cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight	18	22.8
If a patient is under 18, I am willing to share or withhold weight information based on parent's wishes	6	7.6
Not Applicable	8	10.1
*Total	79	100.0

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\*Total does not equal 37, as participants were able to select multiple answers to this question.

**Table 16.** Weighing Practice for Bulimia Nervosa based on Patient Characteristics

Weighing Practice – Bulimia, Patient Characteristics	Frequency	Percent
If a patient is more motivated to change, I am willing to share his/her weight	10	12.7
If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight	18	22.8
If a patient does not want to know his/her weight, I will not share it with him/her	12	15.2
If a patient has relapsed in the past in response to knowing his/her weight, I am less likely to share his/her weight	11	13.9

If a patient's cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight	14	17.7
If a patient is under 18, I am willing to share or withhold weight information based on parent's wishes	4	5.0
Not Applicable	10	12.7
*Total	79	100.0

\*Total does not equal 37, as participants were able to select multiple answers to this question.

**Table 17.** Weighing Practice for Binge Eating Disorder based on Patient Characteristics

Weighing Practice – Binge Eating Disorder, Patient Characteristics	Frequency	Percent
If a patient is more motivated to change, I am willing to share his/her weight	6	10.2
If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight	10	16.9
If a patient does not want to know his/her weight, I will not share it with him/her	15	25.4
If a patient has relapsed in the past in response to knowing his/her weight, I am less likely to share his/her weight	6	10.2
If a patient's cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight	6	10.2

If a patient is under 18, I am willing to share or withhold weight information based on parent's wishes	3	5.1
Not Applicable	13	22.0
*Total	59	100.0

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\*Total does not equal 37, as participants were able to select multiple answers to this question.

**Table 18.** Weighing Practice for Purging Disorder based on Patient Characteristics

Weighing Practice – Purging Disorder, Patient Characteristics	Frequency	Percent
If a patient is more motivated to change, I am willing to share his/her weight	2	3.4
If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight	9	15.3
If a patient does not want to know his/her weight, I will not share it with him/her	8	13.6
If a patient has relapsed in the past in response to knowing his/her weight, I am less likely to share his/her weight	11	18.6
If a patient's cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight	11	18.6
If a patient is under 18, I am willing to share or withhold weight information based on parent's wishes	2	3.4

Not Applicable	16	27.1
*Total	59	100.0

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\*Total does not equal 37, as participants were able to select multiple answers to this question.

Respondents were asked to clarify differences between sharing weight related information to a client who is significantly overweight, as opposed to a client who is of normal weight. These data are displayed in Table 19.

**Table 19.** Weighing Practice for Clients who are Overweight

Weighing Practice for Clients who are Overweight	Frequency	Percent
I am less likely to share and emphasize information about his/her weight	10	27.0
I am more likely to share and emphasize information about his/her weight	2	5.4
There is no significant difference in my practice of sharing and emphasizing information about his/her weight	21	56.8
Total	33	100.0

Participants were asked report if they have used each method (blind- and open-weighing) for at least six months of their career. Of the 33 participants who responded to the question, 54.5% (n=18) reported, “Yes” to using both methods for at least six months of their career. Of these 18 respondents, 77.8% (n=14) reported they found open-weighing to be generally more effective, while 22.2% (n=4) found blind-weighing to be generally more effective.

## **Qualitative Results**

The survey contained two open-ended questions, which were offered to give participants the opportunity to speak about their weighing practice freely. These questions were optional, thus not all of the participants responded. Of the responses that were collected, the researcher observed certain themes emerging and grouped such answers together into particular categories.

The first question, **“Please feel free to write any additional comments that relate to your decision to blind weigh or not blind weigh patients with eating disorders,”** yielded eleven open-responses from participants. Following a thorough review of the responses, the researcher identified themes that emerged. Four themes were identified: patient characteristics, awareness of research, preoccupation with weight, and processing weight related information.

### **Patient Characteristics**

Five participants identified patient characteristics being an important factor in their weighing practice with patients who are being treated for an eating disorder. One participant expressed, “answers are more dependent on age/phase of treatment. Diagnosis is important, but less so.” Another participant expressed a similar belief, stating, “It depends on many factors—where is the patient in process recovery? Are they weighing themselves anyway? Does it make sense to do expose work at this time? How old is the patient and have viewed/blind weights been used in the past?” The other participants who offered similar responses expressed, “there should be an individualized approach” and the “decision to share weight is based upon multiple factors.”

### **Awareness of Research**

Four of the participants expressed their awareness of research around weighing practices as a factor in their decision to use or not use one a particular method. One respondent indicated, “Honestly, I haven’t really heard a good argument for blind weighing...” while another

expressed suggested asking questions about past weighing practices used and "...which were effective, as there is little research to guide me..." The other two participants stated, "I am more open to the concept of sharing weight with clients and have seen it have a positive therapeutic impact on the client" and "Research suggests that [open] weighing serves as important exposure practice."

### **Preoccupation with Weight**

Two open-responses expressed concern about blind weighing practices leading to a preoccupation with weight. In addressing this concern, one participant expressed, "If it causes the client distress or they are likely to relapse or are unmotivated without weight (or any other reason given in this questionnaire) addressing these issues is a treatment target. I feel blind weighing would be just avoiding these and lead clients to be further preoccupied with their weight." The second response indicated, "I do not believe it is helpful for a patient to be focused on a specific number because weight naturally fluctuates within a range. We sometimes share weight range with patient when in PHP if clinically appropriate to discharge."

### **Processing Weight Information with Clients**

Two participants expressed their strategies for processing weight related information when treating a client for an eating disorder. One respondent declared, "I typically utilize CBT-based thought diaries and process/provide skills coaching approximately after doing a viewed weight." A second respondent shared information about their dialogue with the client, "If a patient asks about their weight, in therapy, I will ask them to weigh the pros/cons of knowing their weight vs. not knowing and as "how will knowing your weight help you or not help you?"

The second open-response question was similar to the first; however, it differed in that it asked participants to answer the question based on their perceived effectiveness of the weighing



method. The question, **“Please feel free to write any additional comments that relate to your decision to use blind weighing or open weighing, in relation to perceived effectiveness,”** yielded five open responses. Some of these responses were similar to answers provided in the first open response question.

Two main themes unfolded from this question. The first theme expressed the belief that open-weighing serves as exposure therapy. The majority of participants, 77.8%, who reported using both methods in their career, identified open-weighing as generally more effective. A second theme uncovered in the responses was in relation to the weighing method being determined on an individual basis.

### **Exposure Therapy**

One participant expressed, “seeing weights allows for additional cognitive work and practice challenging cognitions and behaviors that come up in response to the weight.” Another respondent stated, “While open-weighing generally provokes a higher level of distress, it is my preferred long-term method as it functions as exposure therapy, thereby reducing the fear of the stimulus (numerical weight) as well as increasing body acceptance/satisfaction.” A third response in this category reported, “Weighing a [patient] in session is a form of exposure and I have found better outcomes when [patients] are able to see and tolerate the number without engaging in [eating disorder] behaviors in reaction to the number.

### **Decision Based on Individual**

The second theme that appeared amongst the responses expressed that the decision to use a specific weighing practice should be determined upon the individual client. One respondent simply expressed that it “depends on the individual,” while another suggested, “I’m not sure which is more effective. It depends on the clients.”

## CHAPTER FIVE

### DISCUSSION

This study was designed to examine the weighing practices of professionals treating a patient with an eating disorder; specifically, the use of blind- vs. open-weighing and the perceived effectiveness of each method. The study included 37 professionals currently treating a client diagnosed with an eating disorder. In an effort to better understand professionals' weighing practices, the researcher sought to understand the rate at which professionals participated in a particular method, whether a professional's practice changed over time based on the client's stage in treatment, and which weighing method was perceived as more effective in treatment.

Research on this particular topic is limited and therefore requires additional research to better understand which weighing practices are considered effective in eating disorder treatment. Of the research that does exist, many treatment protocols recommend open-weighing; however, these recommendations are impacted by clinician adherence to protocols, as some professionals may be reluctant to engage in open-weighing (Forbush et al., 2014).

This chapter will compare and contrast the major findings of the study with the results found in previous literature, while discussing the possible reasons and implications of the results. First, the researcher will state the hypotheses formed prior to the study; next, the quantitative results—the weighing procedure used and the reasons behind using a particular method—will be reviewed. Next, the qualitative results detailing professionals' perceived effectiveness of particular weighing methods will be discussed. Lastly, the researcher will state the study's areas of strength and limitations, and identify areas for future research.

Based on a prior study (Forbush et al., 2014), the researcher hypothesized that the number of professionals engaging in blind weighing would be nearly 50%. Additionally, it was

hypothesized that the majority of participants' policy towards weighing practices has changed over time. The researcher anticipated that the majority of participants utilized behavioral and cognitive modalities in treating this population. Lastly, the researcher hypothesized that of the two weighing practices mentioned, open-weighing would be perceived as more effective.

## **Key Findings**

**Sample Similarities and Differences.** Although the sample size of the study was relatively small, it is important to examine the demographic information of participants and how it relates to prior research within this field. In examining demographics based on gender, 93.9% reported being female. Following a review of samples in prior research studies in the field of eating disorders, the majority of participants identified as female (Forbush et al., 2014; Kosmerly et al., 2015). Although there was a limited sample size in the present study, the results appear to be representative of the population treating eating disorders.

Additionally, in examining the racial demographics of participants who disclosed their racial identity, nearly all of the participants, 97.0 %, identified as Caucasian. Based on previous research by Forbush et al., (2014), who collected responses from a sample where 95.5% of participants identified as Caucasian, the sample of the present study suggests a similar racial makeup of the population treating eating disorders. Upon examining several prior studies whose sample consisted of eating disorder treatment providers, the participants often reflected a primarily Caucasian sample (Forbush et al., 2014; Waller, D'Souza Walsh, & Wright, 2016). Therefore, it appears that the racial demographics of the sample in the present study are similar to those of previous studies in this area.

The mean age of participants in the present study was 31.5 years of age, with a minimum of 23 years of age and a maximum of 57 years. The sample of the present study is relatively

young compared to prior research studies with similar sample inclusion criteria. The study by Forbush et al. (2015) reported a mean age of 44.2 while the study by Waller et al. (2016) reported a sample with a mean age of 39.0. The vast majority of participants, 75.7% of the present study ranged from ages 23-34, while only 13.5% identified as being age 35 or older (10.8% of participants did not disclose their age).

**Treatment Approaches.** There is no specific definition of what recovery from an eating disorder is comprised of; however, the concept of recovery has shifted focus away from only physical improvements, such as weight gain, and has become more inclusive of behavioral and psychological improvements (Bardone-Cone et al., 2010). Prior research identifies CBT as a common modality used in the treatment of eating disorders (Forbush et al., 2014; Waller & Mountford, 2015; Waller et al., 2012). Participants of the present study were able to select more than one option when identifying which therapeutic modalities they followed in the treatment of eating disorders. The majority of participants (n=26) identified using CBT, which is consistent with prior research. Waller and Mountford (2015) identified safety, understanding eating patterns, reducing anxiety, and modifying cognitions, as critical factors used in CBT approaches to treat eating disorders. Thus, utilizing a CBT approach allows professionals to incorporate psychological work in addition to working towards physical improvements.

The second highest frequency of responses, fell under “Behavioral” approaches, with 25 respondents reporting use of this modality. Additionally, Family-Based treatment approaches, also referred to as the Maudsley Model, was identified as a modality followed by most of the respondents (n=21). Research on weighing practices by Forbush et al. (2014) reported 83% of their sample utilizing CBT and 55.4% of their sample utilizing the Maudsley Model. The sample of the present study thus offers similar results in regard to modalities used in the treatment of

eating disorders with special attention provided to weighing practices. The researcher's hypothesis that the majority of participants utilized CBT and Behavioral approaches in the field was confirmed.

**Blind-Weighing vs. Open-Weighing.** Preoccupation with weight and the disturbance of body weight are diagnostic criteria for Anorexia Nervosa and Bulimia Nervosa. Such experiences often lead individuals to engage in maladaptive behaviors, such as body checking or excessive self-weighing. By incorporating the weighing practices into treatment, clients are able to address their distress, anxiety, and other emotions with a professional begin cognitive work (Waller & Kennerley, 2003). Prior to this research, one study has been conducted on the weighing practices of professionals in the treatment of eating disorders, leading to limited information on the topic.

Based on the researcher's clinical fieldwork experience in an eating disorder treatment facility, the topic remains widely debated among professionals. Some professionals are able to make their weighing decision based on personal preference, treatment protocols, or available research; however, other professionals are required to practice particular methods based on the policies of the larger treatment facility in which they practice. Slightly more than half, 59.5% of professionals surveyed in this study reported belonging to a larger treatment program that dictated their weighing practices. Past research on the topic identified 46.5% of the sample of eating disorder professionals "generally using" opening-weighing and 53.5% "generally using" blind-weighing (Forbush et al., 2014). The data collected in this survey was nearly identical to results from the prior study. 45.5% of professionals indicated generally using open-weighing, while 54.5% identified using blind-weighing practices with patients. The researcher's hypothesis

was confirmed that the results of the weighing practices used are dependent on additional factors based upon the individual client.

**Weighing Policy Changing Over Time.** Although research on weighing procedures is limited, research on clinician adherence to protocols has increased over time (Fairburn et al., 2003; Kosmerly et al., 2015). The researcher hypothesized that the majority of respondents' policy toward weighing practices changed over time. However, 33.4% of participants identified their weighing policy changing throughout their career. Specifically, 6.1% reported sharing more weight-related information in the past and 27.3% indicated sharing less weight-related information in the past than their present approach. Prior literature shows similar trends to the results collected in the present study; however, a greater percentage of professionals, 42.5%, reported sharing less weight-related information in the past (Forbush et al., 2014). Within the present study, 66.7% (n=22) of participants reported "no change" in their weighing policy over time, while prior research reported 48.7% experiencing "no change" in their practice of sharing weight-related information (Forbush et al., 2014). Unfortunately, due to the relatively small sample size, it is difficult to compare the results to prior research. However, the data collected can be interpreted with acknowledgement of the limited sample.

### **Qualitative Findings**

**Perceived Effectiveness of Weighing Practices.** There appears to be no past research that identifies professionals' perceived effectiveness of weighing methods, specifically blind- and open-weighing. The researcher hypothesized that open-weighing would be perceived as more effective by professionals who have utilized both blind-weighing and open-weighing for at least six months of their career. Of the 18 participants who met this criteria, 77.8% (n=14) identified open-weighing as generally more effective. Participants were provided the opportunity

to report any additional comments related to perceived effectiveness of the weighing procedures mentioned. As previous literature suggests, open-weighing serves as a form of exposure therapy and can be effective in the treatment of eating disorders (Ekern, 2012; Forbush et al., 2014).

Of the participants who responded to the optional open-response question, half expressed the use of open-weighing practices as a form of exposure therapy with their clients. Specifically, one respondent expressed, “While open-weighing generally provokes a higher level of distress, it is my preferred long-term method as it functions as exposure therapy, thereby reducing the fear of the stimulus (numerical weight) as well as increasing body acceptance/satisfaction.” Exposure therapy, or ERP, works to desensitize fears and distress (Ekern, 2012). In the treatment of eating disorders, allowing a client to know their weight provides the client the opportunity to lessen the power of the number and begin to practice distress tolerance, with the prospect of reduced anxiety around hearing weight-related information.

Additionally, participant responses suggested the importance of making decisions of weighing practiced is dependent on the individual client. The survey inquired about patient factors that played a role in sharing weight-related information. These factors were separated based on diagnosis (i.e. Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Purging Disorder). However, some participants expressed diagnosis as a less important factor in the process. Participants were able to select more than one answer when identifying patient characteristics that informed their weighing practice. In looking at patient characteristics as a whole and disregarding diagnosis, 23.1% reported, “If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight.” Also, 21.4% of participants reported, “If a patient’s cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight.” The results suggest that

these factors play an important role in deciding whether or not to share weight-related information with a patient. These results are consistent with prior research, which also identify cognitive and emotional functioning that is impaired by malnourishment as a critical factor in deciding whether or not to disclose weight related information with a client (Forbush et al., 2014).

### **Inferential Statistics**

The researcher and research analyst attempted to examine relationships between variables with inferential statistics; however, due to the ability for participants to “check all that apply” on several questions, participants were unable to be grouped into particular categories. A t-test was used to determine if there was a difference in years of practice and whether blind weighing was used throughout treatment vs. a portion of treatment; however, no significant difference was found. A t-test was also used to determine if there was a difference in years of practice in the field and if participants generally used the blind weighing method. There was no significant difference found.

### **Strengths and Limitations**

At the time that this research study was conducted, there was one prior study examining clinicians’ weighing practices with patients with an eating disorder. A major strength of the present study is that it provides further information on clinicians’ current practices regarding the weighing of patients with an eating disorder as well as offering insight towards future treatment approaches. Additionally, the study was able to provide a narrative from professionals regarding their experience with weighing clients. This opportunity offered professionals a space to detail their decisions and concerns about particular weighing practices. These data may also serve to



benefit future research regarding weighing practices with patients being treated for an eating disorder.

Several factors arose which served as major limitations to the study, including small sample size, lack of diversity among geographic location, and a limited time frame in which the survey was available. Despite the researcher's attempts to collect responses from a large and geographically diverse sample, only 37 responses were collected. The researcher recruited participants through nonprobability, purposive, convenience-sampling methods, which included emailing personal contacts, social media postings, and posting the research description and survey link on the National Eating Disorder Association website and in the Eating Disorder Collaborative of Massachusetts. The researcher made an attempt to access participants in Australia/New Zealand, but was challenged by organizational posting requirements and limited time to meet such requirements. Additionally, the time constraint on this study limited its scope and external validity based on the number of responses received. The survey was only accessible for 10.5 weeks. If the survey was accessible for a longer period of time, it may have collected a greater number of responses.

In examining the survey, the option for participants to select multiple responses for several questions limited the ability to conduct inferential statistics following the data collection process. In future research, it may be beneficial to limit participants to selecting the most appropriate answer, rather than all that apply. Additionally, the information collected by this survey was based on self-report of professionals and is unlikely to be entirely supported for future treatment protocol. This study is based on the perspective of professionals treating individuals with an eating disorder and did not obtain information from the perspective of the patient who is receiving the treatment.

## **Implications of the Study**

This topic continues to be widely debated in the field and this research may offer further insight into the treatment of eating disorders. At the time of this research, there is presently one past study examining clinicians' weighing practices with patients with an eating disorder.

Ideally, this study is that it will provide information on clinicians' current practices regarding the weighing of patients with an eating disorder as well as offer insight towards future treatment approaches. These data may also serve to benefit future research regarding weighing practices with patients being treated for an eating disorder and identify the need for additional research. Additionally, this study may serve to simply bring awareness to the need to increase funding to eating disorder research.

## **Areas for Further Research**

Given the limitations of the present study, future investigation should emphasize the need for a larger, more geographically diverse sample. Based on the responses of professionals noting their practice differs depending on the age of the client, researches may want to examine weighing practices specifically to adolescents and a separate study for the adult population. As mentioned by Forbush et al., (2015) conducting randomized controlled trials would be valuable in determining if a particular weighing protocol is beneficial to patient outcomes.

## **Conclusion**

The results of the present study offer a glimpse into the weighing practices in the treatment of eating disorders. As shown in prior study, professionals tend to focus on the individual patient in determining the weighing practice used in treatment. However, some

professionals noted their weighing practices were directed by the larger agency in which they were employed or by the age of the patient. Further research is needed to determine the effectiveness of each weighing practice noted in this study.

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Appendix A: Smith College Human Subjects Review Board: Approval Letter

SMITH COLLEGE

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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-  
7994

January 26, 2016

Sarah English

Dear Sarah,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Jesse Metzger, Research Advisor

**Appendix B: Informed Consent**

**2015-2016**

**Consent to Participate in a Research Study**

**Smith College School for Social Work • Northampton, MA**

.....  
**Title of Study:** Weighing the Options: Clinicians’ Weighing Procedures in the Treatment of Eating Disorder Patients

**Investigator(s):** Sarah English, MSW Candidate, Smith College School for Social Work, Researcher

Jesse Metzger, PhD, Research Adviser  
.....

**Introduction**

- You are being asked to be in a research study exploring clinicians’ weighing procedures in the treatment of eating disorder patients.
- You were selected as a possible participant because you reported being age 18 or older, having a Bachelor’s Degree or higher educational level, can read and write in English, and are currently treating one or multiple patients with a diagnosed eating disorder.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

**Purpose of Study**

- The purpose of the study is to examine the rate at which clinicians incorporate weighing practices into their treatment, the methods used, and clinicians’ self-report of effectiveness on treatment in the hopes of informing practice among clinicians working with patients with an eating disorder as well as further research in the field of eating disorder treatment.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

**Description of the Study Procedures**

- If you agree to be in this study, you will be asked to do the following things: participate in an online survey which will collect demographic information including: race/ethnicity, gender, geographic location in which you are practicing, years of clinical practice with the population, highest degree obtained, and age. They survey will also include questions about the treatment setting in which you practice. The study will also be composed of questions regarding weighing procedures, factors that identify the reasoning behind the chosen weighing procedures, and any potential differences in weighing procedures based on client’s diagnosis and age. You will also be asked to respond to one open-response question, which will allow you to share any information regarding the survey or your practice in weighing patients with a diagnosed eating disorder.

**Risks/Discomforts of Being in this Study**

- There are no reasonable foreseeable (or expected) risks.

### **Benefits of Being in the Study**

- The benefits of participation include the opportunity share your experiences and clinical procedures regarding your work with patients with an eating disorder. Participants may feel validated knowing that their experience is valuable to research and may gain satisfaction knowing that their experience may contribute to future research services to support individuals suffering from an eating disorder.
- The benefits to social work/society are: enhance knowledge regarding weighing practices in eating disorder treatment, increase the dialogue around treatment approaches to weighing procedures, and potentially serve to benefit future research regarding weighing practices with patients being treated for an eating disorder.

### **Confidentiality**

- This study is anonymous. We will not be collecting or retaining any information about your identity.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

### **Payments/gift**

- You will not receive any financial payment for your participation.

### **Right to Refuse or Withdraw**

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You may choose to withdraw by stopping your participation in the survey. Partially completed surveys (less than 50% completed) will not be used in the findings. You may skip any question in the survey; However, once a survey is submitted, the responses cannot be edited or withdrawn from the study as a result of the websites function to make all responses anonymous.

### **Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Sarah English at XXXXXXXXXXXX or by telephone at XXX-XXX-XXXX. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

## Consent

- By clicking “Yes” below, you indicate that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. Please print a copy of the Informed Consent form for your personal records prior to beginning the survey.

- .....
- YES
  - NO

## Appendix C: Screening Questionnaire

### Eligibility Questions

Q1 Are you able to read and write in English?

Yes

No

If No Is Selected, Then Skip To

Disqualification page....

Q2 Do you have a Bachelor's degree or higher educational degree?

Yes

No

If No Is Selected, Then Skip To

Disqualification page....

Q3 Are you currently treating one or multiple patients with a diagnosed eating disorder in your professional career?

Yes

No

If No Is Selected, Then Skip To  
Skip To What is your age?

Disqualification page. ...If Yes Is Selected, Then

## Appendix D: Survey

### Survey Questionnaire

Q5 What is your age?

Q6 What is your gender?

Male

Female

Other: \_\_\_\_\_

Q7 What is your racial background?

African-American

Asian

Caucasian

Native-American/Alaskan Native

Multi-Racial

Other: \_\_\_\_\_

Q8 What is your ethnicity?

Hispanic

Non-Hispanic

Q9 What is your country/continent of origin?

United States

Canada

Mexico

Western Europe

Eastern Europe

Southeast Asia

Middle East

East Asia

Central America

South America

Australia/New Zealand

Africa

Q10 Where do you currently reside?

United States

Canada

Mexico

Western Europe

Eastern Europe

Southeast Asia

Middle East

East Asia

Central America

South America

Australia/New Zealand

Africa

Q11 What is your educational background?

(check all that apply)

MD

PhD

PsyD

Social Worker

Counseling Psychologist

Clinical Psychologist

Bachelor's Degree Counselor

Nutritionist

Registered Dietitian

Q12 Where do you currently practice?

Rural Area

Suburban Area

Urban Area

Q13 How long have you been treating clients with eating disorders (in years)?

\_\_\_\_\_



Q14 What therapeutic model do you follow?  
(check all that apply)

Cognitive Behavioral Therapy

Interpersonal

Eclectic

Family Systems

Family-Based/Maudsley Model

Psychodynamic

Psychoanalytic

Behavioral

Motivational Enhancement

Acceptance Based

Other: \_\_\_\_\_

Q15 Which patients do you work with?  
(check all that apply)

Children

Teenagers

Adults

Q16 In what treatment(s) setting do you currently work?  
(Check all that apply)

Inpatient

Outpatient

Private Practice

Academic Medical Center

Non-Academic Medical Center

College/University Counseling Center

Weighing Procedures:

This research survey will ask you very specific questions about your practices regarding weighing clients. However, we understand that some questions may not apply to you or represent the way you practice. Please note that at the end of the survey, you will have an opportunity to provide your comments, thoughts, and additional information about your specific weighing practices that were not assessed by the survey.

Q17 Do you generally use blind weighing procedures (e.g., a weighing procedure in which information about the patient's weight is not shared with him/her) during eating disorder treatment?

Yes

No

If No Is Selected, Then Skip To What are your reasons for not blind w...

Q18 Do you generally use blind weighing during:

Entire treatment

Portion of treatment

If Portion of treatment Is Selected, Then Skip To During which phases of treatment do y...

Q19 What are your reasons for not blind weighing? Check all that apply.

I think sharing weights with my client is therapeutic

I think exposure to weight leads to better outcomes

I want to be able to help my client manage their reactions to weight increase

I think clients weigh themselves at home, so I decided weighing them in treatment is appropriate

Other: \_\_\_\_\_

Q20 During which phases of treatment do you use blind weighing? Check all that apply.

Early Phase

Middle Phase

Late Phase

Q21 Does a patient's status in treatment change your weighing policy?

Yes

No

Q22 Do you belong to a larger treatment program that dictates your policy with regard to sharing patients' weights?

Yes

No

Q23 Do you practice as part of a team in which you generally do not share information about a patient's weight because another team member is in charge of doing so?

Yes

No

If Yes Is Selected, Then Skip To When you practice as part of a team, ...If No Is Selected, Then Skip To Do you discourage weighing at home?

Q24 When you practice as part of a team, which team member shares the patient's weight or related information (weight trends, weight range, etc.) with them?

Therapist

Dietitian

Medical Doctor or Nurse

Other: \_\_\_\_\_

Q25 Do you discourage weighing at home?

Yes

No

This does not apply; I only work with inpatient clients

Q26 Has your policy with regard to blind weighing changed over the course of your time working with clients who have eating disorders?

No change

I used to share more information about weight than I do presently

I used to share less information about weight than I do presently

Q27 What is your typical practice when treating a patient with **Anorexia Nervosa**? Select one.

Share exact weight with patient

Share magnitude of weight change with patient (e.g. telling them that they gained a little bit or lost about two pounds) but not an exact weight.

Share with patient the direction of weight change only (e.g., telling the patient his/her weight has increased, decreased or stayed the same).

Share with patient whether he/she is in or out of a specified range.

Share with patient only whether he/she is "on track" with regard to weight gain.

Display the patient's past and current weights on a graph.

Don't share any information about his or her weight.

Not applicable.

Q28 Please select those that apply, in regard to treating a patient with **Anorexia Nervosa**...

If a patient is more motivated for change, I am willing to share his/her weight.

If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight.

If a patient does not want to know his/her weight, I will not share it with him/her.

If a patient has relapsed in the past in response to knowing his/her weight, I am less likely to share his/her weight.

If a patient's cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight.

If a patient is under 18, I am willing to share or withhold weight information based on parents' wishes.

Not applicable.

Q29 What is your typical practice when treating a patient with **Bulimia Nervosa**? Select one.

Share exact weight with patient

Share magnitude of weight change with patient (e.g. telling them that they gained a little bit or lost about two pounds) but not an exact weight.

Share with patient the direction of weight change only (e.g., telling the patient his/her weight has increased, decreased or stayed the same).

Share with patient whether he/she is in or out of a specified range.

Share with patient only whether he/she is "on track" with regard to weight gain.

Display the patient's past and current weights on a graph.

Don't share any information about his or her weight.

It depends on the client's weight.

Not applicable.

Q30 Please select those that apply, in regard to treating a patient with **Bulimia Nervosa**...

If a patient is more motivated for change, I am willing to share his/her weight.

If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight.

If a patient does not want to know his/her weight, I will not share it with him/her.

If a patient has relapsed in the past in response to knowing his/her weight, I am less likely to share his/her weight.

If a patient's cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight.

If a patient is under 18, I am willing to share or withhold weight information based on parents' wishes.

Not applicable.

Q31 What is your typical practice when treating a patient with **Binge Eating Disorder**? Select one.

Share exact weight with patient

Share magnitude of weight change with patient (e.g. telling them that they gained a little bit or lost about two pounds) but not an exact weight.

Share with patient the direction of weight change only (e.g., telling the patient his/her weight has increased, decreased or stayed the same).

Share with patient whether he/she is in or out of a specified range.

Share with patient only whether he/she is “on track” with regard to weight gain.

Display the patient's past and current weights on a graph.

Don't share any information about his or her weight.

It depends on the client's weight.

Not applicable.

Q32 Please select those that apply, in regard to treating a patient with **Binge Eating Disorder**...

If a patient is more motivated for change, I am willing to share his/her weight.

If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight.

If a patient does not want to know his/her weight, I will not share it with him/her.

If a patient has relapsed in the past in response to knowing his/her weight, I am less likely to share his/her weight.

If a patient's cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight.

If a patient is under 18, I am willing to share or withhold weight information based on parents' wishes.

Not applicable.

Q33 What is your typical practice when treating a patient with **Purging Disorder**? Select one.  
Share exact weight with patient

Share magnitude of weight change with patient (e.g. telling them that they gained a little bit or lost about two pounds) but not an exact weight.

Share with patient the direction of weight change only (e.g., telling the patient his/her weight has increased, decreased or stayed the same).

Share with patient whether he/she is in or out of a specified range.

Share with patient only whether he/she is “on track” with regard to weight gain.

Display the patient's past and current weights on a graph.

Don't share any information about his or her weight.

It depends on the client's weight.

Not applicable.

Q34 Please select those that apply, in regard to treating a patient with **Purging Disorder**...

If a patient is more motivated for change, I am willing to share his/her weight.

If a patient shows excessive worry or strong obsessive symptoms regarding his/her weight, I am less likely to share his/her weight.

If a patient does not want to know his/her weight, I will not share it with him/her.

If a patient has relapsed in the past in response to knowing his/her weight, I am less likely to share his/her weight.

If a patient's cognitive and emotional functioning seem impaired by malnourishment, I am less likely to share his/her weight.

If a patient is under 18, I am willing to share or withhold weight information based on parents' wishes.

Not applicable.

Q35 When treating a client who is significantly overweight, as opposed to a normal weight client...

I am less likely to share and emphasize information about his/her weight.

I am more likely to share and emphasize information about his/her weight.

There is no difference in my practice of sharing and emphasizing information about his/her weight.

Please do NOT include any personal, identifiable information (e.g. names, locations)

Q36 Please feel free to write any additional comments that relate to your decision to blind weigh or not blind weigh patients with eating disorders

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The following questions are separate from the survey designed by Forbush, Richardson, and Bohrer:

Q37 Have you used each method, blind- and open-weighing, for at least six months during your career?

Yes

No

If No Is Selected, Then Skip To End of Survey

Q38 Of these two options, which method have you found to be generally more effective in your practice?

Blind-Weighing

Open-Weighing

Q39 Please feel free to write any additional comments that relate to your decision to use blind weighing or open weighing, in relation to perceived effectiveness:

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## Appendix E: Disqualification Page

### **Thanks!**

Thank you for your time and interest in this study. Unfortunately, your answer to one or more of the previous questions indicate that you are not eligible to participate in this study.

Please share this survey with others by forwarding the survey link:

[https://smithcollege.qualtrics.com/SE/?SID=SV\\_cUPupG3Fef0FCAZ](https://smithcollege.qualtrics.com/SE/?SID=SV_cUPupG3Fef0FCAZ)

To exit, close the browser window.



## Appendix F: Email Recruitment Statement

Dear \_\_\_\_\_,

Will you please help me find participants to complete a survey for my Master's Thesis? I am examining the weighing practices of professionals treating patients with an eating disorder. I am looking for participants who are 18 or older, can read and write in English, hold a Bachelor's degree or higher, and are currently working with a patient diagnosed with an eating disorder, such as Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or Purging Disorder. The survey includes several multiple choice questions and two open-ended questions. The survey should take roughly 10-15 minutes to complete.

Would you please forward this email to anyone you know who might fit the eligibility requirements and may be interested in completing my survey?

Please click on the link to complete the survey:

[https://smithcollege.qualtrics.com/SE/?SID=SV\\_cUPupG3Fef0FCAZ](https://smithcollege.qualtrics.com/SE/?SID=SV_cUPupG3Fef0FCAZ)

Sarah English  
MSW Candidate '16  
Smith College School for Social Work

The data collected from this study will be used to complete my Master's in Social Work (MSW). The results of the study may also be used in publications and presentations. I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

## Appendix G: Facebook Recruitment Statement

Facebook Friends,

Will you please help me find participants to complete a survey for my Master's Thesis? I am examining the weighing practices of professionals treating patients with an eating disorder. I am looking for participants who are 18 or older, can read and write in English, hold a Bachelor's degree or higher, and are currently working with a patient diagnosed with an eating disorder, such as Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or Purging Disorder. The survey includes several multiple choice questions and two open-ended questions. The survey should take roughly 10-15 minutes to complete.

Would you please forward this email to anyone you know who might fit the eligibility requirements and may be interested in completing my survey?

Please click on the link to complete the survey:

[https://smithcollege.qualtrics.com/SE/?SID=SV\\_cUPupG3Fef0FCAZ](https://smithcollege.qualtrics.com/SE/?SID=SV_cUPupG3Fef0FCAZ)

The data collected from this study will be used to complete my Master's in Social Work (MSW). The results of the study may also be used in publications and presentations. I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

## Appendix H: National Eating Disorder Association Description of Research Study National Eating Disorder Association Description of Research Study

### Contact Information:

Research Study Name: Weighing the  
Options: Clinicians' Weighing Procedures in  
the Treatment of Eating Disorder Patients  
Contact Name: Sarah English  
Site Address: Online  
Contact Phone: (XXX) XXX-XXXX  
Email: XXXXXXXXXXXXXXXXXXXX  
Website:  
[https://smithcollege.qualtrics.com/SE/?SID=SV\\_cUPupG3Fef0FCAZ](https://smithcollege.qualtrics.com/SE/?SID=SV_cUPupG3Fef0FCAZ)

### Research Field Period:

Start Date: 01/28/2016  
End Date: 04/10/2016

### IRB Information:

IRB Approved: Yes  
IRB Expiration Date: TBD

### Research Setting:

Community Mental Health: No  
University/College Counseling Program: No  
Private Practice: No  
Residential Setting: No  
Hospital with Separate Setting: No  
Hospital without Separate Setting: No  
Online Survey: Yes

### Population Researched:

Anorexia Nervosa: Yes  
Binge Eating Disorder: Yes  
Bulimia Nervosa: Yes  
Population Researched - Other: Other  
specified feeding or eating disorder

### Participant Requirements:

Gender: All  
Age Requirement: 18+  
Travel Requirements: None

### Study Involves:

The study involves completing an online survey (10-15 minutes) regarding the professional's weighing procedure in the treatment of eating disorder patients.

### Compensation:

Due to the monetary restraints of the student researcher, no compensation will be offered.

### Additional Participant Requirements:

Participants must be able to read and write in English, hold a Bachelor's degree or higher, and be currently working with one or multiple patients diagnosed with an eating disorder, such as Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or other specified feeding or eating disorder.

### Describe Research Study:

This study will explore clinicians' weighing procedures in the treatment of eating disorder patients. Specifically, it will serve to understand the rate at which clinicians incorporate weighing practices into their treatment, methods used, and clinicians' self-report of effectiveness on treatment. This topic may inform practice among clinicians working with patients with eating disorders and further research in the field, as there is currently very limited data available on weighing procedures in treatment.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

## **Appendix I: Eating Disorders Collaborative of Massachusetts Posting**

My name is Sarah English, and I am a second year graduate student at the Smith College School for Social Work. I am conducting a research study regarding clinicians' weighing practices in the treatment of their patients with a diagnosed eating disorder. The data collected from this study will be used to complete my Master's in Social Work. I am emailing you to request that you post this information and the link to my survey in your newsletter, LinkedIn Group, and Facebook group. The research period for this study will conclude on April 10, 2016.

### **Study Involves:**

The study involves completing an online survey (10-15 minutes) regarding the professional's weighing procedure in the treatment of eating disorder patients. Survey Link: [https://smithcollege.qualtrics.com/SE/?SID=SV\\_cUPupG3Fef0FCAZ](https://smithcollege.qualtrics.com/SE/?SID=SV_cUPupG3Fef0FCAZ)

### **Compensation:**

Due to the monetary restraints of the student researcher, no compensation will be offered.

### **Additional Participant Requirements:**

Participants must be able to read and write in English, hold a Bachelor's degree or higher, and be currently working with one or multiple patients diagnosed with an eating disorder, such as Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or other specified feeding or eating disorder.

### **Describe Research Study:**

This study will explore clinicians' weighing procedures in the treatment of eating disorder patients. Specifically, it will serve to understand the rate at which clinicians incorporate weighing practices into their treatment, methods used, and clinicians' self-report of effectiveness on treatment. This topic may inform practice among clinicians working with patients with eating disorders and further research in the field, as there is currently very limited data available on weighing procedures in treatment.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

**Appendix J: Request and Approval for Permission to use Published Survey**

From: Kelsie Terese Forbush

To: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXX

Re: Request for Published Survey

Hi All,

Sounds good! Sarah, please go ahead and feel free to use the questionnaire (with the appropriate citation). Best of luck with your research!

Best wishes,

KF

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Kelsie T. Forbush, Ph.D.  
M. Erik Wright Scholar Assistant Professor  
Lab Director, Center for the Advancement of  
Research on Eating Behaviors (CARE)

XXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXX

E-mail: XXXXXXXXXXXXXXXXXXXX

From: Kelsie Terese Forbush  
To: Me Cc: Richardson, Jonathan H Bohrer, Brittany Kay  
Re: Request for Published Survey  
Hi Sarah,

I'm copying my co-authors on this paper, who helped to develop our survey of clinicians' weighing practices.

Jon and Brittany, would you mind back-channeling me to let me know if you're okay with Sarah using the online survey items we developed for her Master's Thesis? Once I hear from you both, I'll respond to Sarah (and copy you both) with the response. Thanks much!

Best wishes,

KF

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Kelsie T. Forbush, Ph.D. M. Erik Wright Scholar Assistant Professor  
Lab Director, Center for the Advancement of Research on Eating Behaviors (CARE)

XXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXX

E-mail: XXXXXXXXXXXXXXXX

From: Me  
To: Forbush, Kelsie Terese  
Re: Request for Published Survey  
Dr. Forbush,

Thank you for your response and access to the full questionnaire. I have found the survey and the published article to be very helpful during the process of reviewing existing literature on the topic. The survey offers clear, and detailed questions about the weighing practices in eating disorder treatment. With permission, I am interested in using the full questionnaire developed by you and your colleagues for my study. Proper acknowledgment and credit would be provided in the methodology section of my thesis if you are to approve this request. I believe that continued research on the weighing procedures in the treatment of eating disorders is vital to making advancements in the field and I hope that the data I collect can further clinical knowledge in the treatment of eating disorders.

Thank you,

Sarah English  
MSW Candidate '16  
Smith College School for Social Work  
XXXXXXXXXXXXXXXXXX