

# Meanings of Weighing Female Patients and their Clinical Implications<sup>1</sup>

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## Abstract

Severe weight loss is the chief characteristic of anorexia nervosa. Weight is also one of the important indicators for evaluating a client's recovery. I weighed all clients at their pre-treatment interview, the beginning of every family session, and at the termination session, and kept records based on follow-up telephone calls after family treatment ended. I found the process of weighing to be noteworthy not only as an instrumental task, but also as a reciprocal learning experience between the clients and myself. Also, my role as the "weigher" of the clients had unexpected effects on my peers, my family and myself. Implications for clinical practice were suggested: an apparently simple task like weighing should be understood in a larger context, including the client's individual circumstances and psychological responses, and the possible reciprocal effects on the professional and their families.

*Keywords:* Weighing, anorexia nervosa, implications, & Hong Kong

## Introduction

Severe weight loss is the chief characteristic of anorexia nervosa. Weight is also one of the important indicators for evaluating a client's recovery. I weighed all our clients at their pre-treatment interview, the beginning of every family session, and at the termination session, and kept records based on follow-up telephone calls after family treatment ended. Over the past three years, I found the process of weighing to be noteworthy not only as an instrumental task, but also as a reciprocal learning experience between the clients and myself. A client should never be made to feel that her worthiness is related to her body weight. Weight restoration should be a means of evaluating a client's recovery only. Also, my role as the "weigher" of the clients had unexpected effects on my peers, my family and myself.

## A brief overview of anorexia nervosa

Anorexia nervosa has been defined as a mental disorder. Characteristics of anorexia

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<sup>1</sup> Remarks: This paper is not research-based. The content of this paper was the author's personal subjective experience and her observations on herself and her family members' behaviors. This paper serves to acknowledge the importance of female writer/health providers' personal view toward health care related issues.

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nervosa include weight loss that brings the weight to less than 85% of ideal, intense fear of weight gain, self-evaluation highly influenced by perceived weight and shape, and absence of at least three consecutive menstrual cycles (American Psychiatric Association, 1994).

#### *Diagnostic-oriented approach*

The above criteria can assist in classifying the mental disorder of patients who are suffering from anorexia nervosa with these manifestations. Standardization of diagnostic criteria can help identify susceptible patients quickly, and categorizing this eating disorder helps inform subsequent treatment. This symptom-focused approach allows for a straightforward cure. However, this approach has some limitations, as outlined below. The above criteria provide no means for understanding the individual in her family and social context. Rather, they add up to a medical label that sees the cause of the illness as the patient's over-concern with body image, and as an extreme attempt to be thin for reasons of vanity. When weight is the central pivot around which assessment and treatment are oriented, the patient's mental state becomes secondary to her physical body, and her relationships with her family and her roles in society are not examined.

Despite the limitations of these diagnostic criteria, the biological effects of the disease should be noted. Kotler and Walsh (2000) pointed out that anorexia nervosa affects mainly adolescents and can result in serious medical and psychiatric issues. To take a closer look at the possible manifestations of this illness, three aspects will be discussed: physical, psychological and behavioral.

#### *Physical symptoms*

A variety of physical symptoms may develop, such as loss of hair, growth of fine body hair, amenorrhea, absence of ovulation, constipation, tooth damage due to over exposure to stomach acid from frequent vomiting, intolerance of cold temperatures, low pulse rate, easy bruising due to a lack of vitamin C, shrinkage of the internal organs, and various dysfunctions, including of the cardiac system, endocrine system and gastrointestinal tract (American Psychological Association, 2000; World Health Organization, 1992).

Considering the above physiological effects, it is clear that minimizing bodily discomfort and preventing further deterioration of the internal organs are crucial medical concerns; however, if physical symptoms alone are addressed, patients will be treated like objects, with each of their bodily organs viewed as a separate entity. The eventual result may be the neglect of the psychological and behavioral issues associated with the illness. To round out an otherwise strictly mechanical view of the patient, attention to the psychological aspects is suggested.

#### *Psychological symptoms*

The psychological symptoms of anorexia nervosa consist of depressed mood, sleep disturbance, distorted attitude towards eating, food, body shape and weight, irritability, low self-esteem, interpersonal mistrust, slowed reaction time, impaired concentration,

poor information retrieval and suicidal ideation (Crisp et al., 1980; Garner et al., 1986; Grant & Fodor, 1986; Halek, 1997; Hamsher et al., 1981; Killian, 1994). Keeping these potential psychological concerns in mind helps prevent seeing patients merely as machines, a common side-effect of the biomedical approach to treatment. However, patients experience the above psychological issues in personal ways. If the patients are ready to share these feelings with their doctors and therapists, then intervention can be provided accordingly; whereas if the patients do not express these, mental health practitioners may be slow to respond. Therefore, watching for associated behavioral issues is another means to monitor the illness and provide appropriate treatment. Close observation and history provided by the patient's friends and family can be of assistance.

### *Behavioral issues*

Behavioral issues of anorexia nervosa may include excessive exercising, crying, frequent weighing, fluid restriction, vomiting, laxative abuse, secrecy and deceit (Ferron, 1999; Furth et al., 1996; Halek, 1997; Turner et al., 2000). When we realize that these problems have been encountered by other clinicians and researchers, then we are less likely to blame the patients, or to think they are responsible for maintaining their illness. In light of the biomedical aspects mentioned earlier, these behavioral issues can be either the causes or the results of anorexia nervosa. From the clinical viewpoint, when these behaviors are the result of long-term starvation, we have to assess them by taking into account their duration, severity and frequency, so we can provide health education and psychological support accordingly.

### **Weighing the patients**

Each time I asked patients suffering from anorexia nervosa to step on the scale for the first time, I encountered one of multiple reactions. For example, Tina (pseudonymous) did not have any resistance when I invited her to step up on the portable electronic scale. She did so without any hesitation or concern. Liza's reaction was similar to Tina's. Liza (pseudonymous) said: "Do I just step on, and then get weighed automatically?" (This was her first time being weighed on a portable electronic scale; at the out-patient clinic, they used a large, mechanical scale.) Both girls understood and accepted the need to weigh in. Perhaps they were agreeable in part because they were adolescents, and were more accustomed to being obedient than were the adult patients. It is also possible that they were not very weight-conscious at this stage, when they had just been referred to our family treatment program. Weighing the clients could be a straightforward procedure as with Tina and Liza, but it was not always so.

Lala (pseudonymous) was the most difficult person to convince of the need to be weighed. Although the purposes were simply to observe changes in her weight over the course of treatment and to monitor her health, Lala disagreed and did not want to be weighed. She said, "I am afraid to know how much I weigh; I don't like to know if I gain any weight." Also, "I will be unhappy if I gain weight; I will be able to feel my muscles expanding and I will become chubby." Lala had fat phobia. Fat phobia is one of the diagnostic criteria of the DSM-IV for anorexia nervosa. I explained that she must be

weighed for her own health benefits and to fulfill our treatment procedures. Later, Lala was more willing to be weighed, but occasionally she would close her eyes while on the scale. Lala intended not to know her weight, and did not want her family to know either. I discussed this with the therapist, and we decided to respect Lala's decision: as long as she showed progress and did not experience a significant weight loss (i.e., two to three kg between sessions), we would not mention her weight in the family sessions. I told her parents about our decision, and they understood and accepted that Lala wished to keep her weight a private matter.

In Sandy's (pseudonymous) case, the first time I learned how much she weighed was during the pre-treatment interview conducted in her home. She had her own electronic scale. I remember it vividly; I said to Sandy: "It would be very helpful if you could tell me how much you weigh periodically, so I can keep a systematic record." Sandy's father suddenly interrupted; in a firm voice, he said: "Sandy, take off your jacket and step on the scale." That sentence struck me deeply. It was a powerful illustration of the way her father spoke to her – so eagerly and even with degree of coercion. Sandy was an adult already; why did her father need to take charge of such a simple task? I had an unsettling interpretation. Although it was certainly premature, and although I still do not know why I had such an idea, somehow it occurred to me that Sandy had an untold secret. I knew I should not have any judgment on Sandy's relationship with her father just by one sentence, but I could not ignore this thought, which seemed to spring up out of nowhere, unbidden and completely naturally. The meanings of weighing in Sandy's case went beyond the number of kilograms on the scale, and assessing her physical condition instead triggered me to observe the nature of the father-daughter relationship.

### **Weighing myself, my peers and my family**

I regarded weighing as an instrument for the patients themselves, and thus it was detached from my daily life. I perceived weighing my client as my job. However, several months passed, and weighing my patients began to affect my life as well.

I had developed a need to weigh myself, and the meanings of this weighing escalated progressively. I had to weigh the clients in kilograms, but I would set the scale to weigh in pounds when I was going to weigh myself, as I was more accustomed to this method of measure. Later on, I became more obsessive about weighing myself. I set the scale to pounds all the time, and only changed it to kilograms when the clients came.

I weighed myself at least once -- and sometimes more than three times -- a day in my office. I always weighed myself when arriving at my office around 8 a.m. Almost every day after lunch, I would weigh myself again. I became sensitive to the minute changes in my weight, such as 111 pounds, 112 pounds, 114 pounds, 111.6 pounds, 112.8 pounds, 113 pounds, 109.4 pounds, and so on. These figures preoccupied my mind, except when I was fully engaged in other important matters, and then they would automatically be forgotten.

For my peers, there were two other female doctorate students working in my office. One of them came from Mainland China; the other grew up in Hong Kong. The former had begun her first year of Ph.D. study. When I weighed myself, this student was always

studying in the office, and she gradually developed the habit of weighing herself too. At first, she paid no attention to me, and would continue reading her journals, but after one or two months of being exposed to my behavior, she began to ask my permission to weigh herself. Her first weight was 136 pounds; subsequent readings were 135 pounds, 137 pounds, 132.5 pounds, 136.2 pounds, and so forth. I remembered those figures exactly: that is how sensitive I had become to such measurements. After some time, she no longer asked for my permission but just weighed herself whenever she wanted to do so. She, too, had developed the habit of weighing herself. However, I must emphasize that she did not weigh herself as frequently as I did. Yet she was very concerned with my weight, and often asked how heavy I was. Sometimes, she commented that I was losing or gaining weight. I did the same to her. We were both developing an obsession with our weight, as well as a common topic of discussion: body shape.

The other student in the office was in her fourth year of her doctorate studies. She was about 5 feet 10 inches tall, and when compared to the first student, she was not much influenced by our weight consciousness. Indeed, for the first six months that we spent studying together in the same office, she probably weighed herself only two times that I observed. Moreover, the first time she weighed herself on my recommendation because she looked very thin. That first time, her weight fell between 112 and 118 pounds. One day, she asked me if she could weigh herself because she needed to know how heavy she was. Her concern with weight was not a fear of getting fat, but rather a fear of getting too thin.

For my family members, my husband, mother and my six year old son began to take part in this weighing exercise. I liked to weigh myself after dinner. Then I would weight myself in the morning again, before going back to the office, and compare my weight at nighttime and morning time. My son observed this ritual for a while, then he began copying me: stepping onto the scale, putting his hands behind his body, standing upright properly and reading the figure aloud to the other family members. Sometimes he weighed himself on his own initiative, and sometimes I asked him to do so. He also became very sensitive to his weight. He also liked to compare his weight from one day to the next.

My mother weighed herself occasionally, i.e., one or two times a week. She hated to lose weight. She was 58 years old, 5 feet tall and weighed 102 pounds. She believed that women her age should be heavier, such as 110 to 115 pounds. She thought that being too thin would give the impression that she lived in a poor economic and social environment, and that wrinkles would appear on her face more easily, making her look older than she was. In part due to my influence, she tried to gain weight, but her poor appetite prevented her from doing so. However, she always maintained her weight in the range of 100 to 103 pounds.

My husband, 5 feet 9 inches tall, had experienced a problem of being overweight and his weight was in the range of 178 to 182 pounds. He weighed himself against the upper limit not exceeding 185 pounds. However, he found it very difficult to lose a few pounds. He did not actually follow a diet or exercise plan, but rather, just began a regime of weighing himself in the morning and at night every day. He developed a habit of

deceiving himself by weighing himself when he woke up, thus getting his lowest weight of the day. He would tell me how many pounds he had lost as compared to the previous night's reading. In reality, every person weighs less in the morning than at night, due to loss of water through urination and respiration.

### **Implications for clinical practice**

As the people being weighed were multiple and varied (the patients, myself, my peers or my family), the meanings attached to this process were also varied. Weighing was not simply a procedure for measuring body weight; rather, it came to embrace the patients' psychological responses -- like Lala's resistance to weighing and my perceptions about Sandy's relationship with her father. Several implications can be drawn from observing the effects of three years of weighing patients, myself, my peers and my family members.

Health care providers should clarify to their clients that their worthiness is not based on how much they weigh. Weight is a significant indicator of recovery and shows to what extent the body is rebuilding its mass. However, this is a measure of the client's physiological aspect only, not of the whole entity of themselves. Because they over-emphasize the importance of their weight, some clients might feel under extreme pressure, especially when their families and their care givers are closely watching the client's weight to evaluate the effectiveness of treatment and the patient's commitment to helping herself. If all attention focuses on the physical body, it might lead to ignoring the other facets of the client, such as the improvement of her social functioning and psychological status. Moreover, sometimes clients try their very best to eat more, but do not make progress because their bodies require a certain amount of time to adapt to the increased food intake. Some may develop other illnesses during the re-feeding phase, such as diarrhea or gastric pain that hinders the progress of weight gain.

Health care providers who have to weigh these clients should be alert to how this role may affect them or those around them. In my own case, my self-weighing behavior did not have a seriously negative influence on my classmates and family members, but it did affect them subtly and certainly created some potential for problems. For example, watching me, my husband and my mother weigh ourselves so frequently might easily have given my son a false impression of the importance adults place on weight. My son might become too weight-conscious from living in such an environment, which might eventually affect his perception of body image in his adolescence. To conclude, even an apparently simple task like weighing should be understood in a larger context, including the patient's individual circumstances and psychological responses, and the possible reciprocal effects on the professional and their families.

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