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Weighing in: Clinician and Patient Perspectives on Discussions of Expected Body Weights in Eating Disorder Treatment

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ABSTRACT

Objective: Clinicians often determine an “expected body weight” (EBW) for patients who have lost weight due to an eating disorder (ED). However, there is inconsistent guidance and limited empirical research on when, how, and why to discuss EBWs with patients. This study explores clinician and patient perspectives on discussions of EBWs.

Method: Semi-structured interviews were conducted with 24 multidisciplinary ED clinicians and 16 individuals with outpatient ED treatment experience in the past 6 months. Clinicians shared their experiences with and rationales for sharing EBWs with patients and patients' family members. Patients shared their experiences of being informed about their EBWs, factors influencing their comfort level discussing EBWs with clinicians, and perceived impact of these discussions on their recovery. Interviews were analyzed using reflexive thematic analysis with a critical realist lens.

Results: Clinician and patient perspectives aligned regarding when, how, and why to hold these discussions. Both groups emphasized that these discussions should occur after patients have demonstrated engagement with recovery and underscored the importance of framing the EBW as one aspect of a holistic recovery. Additionally, clinicians and patients highlighted the potential therapeutic benefits of these discussions, while also acknowledging challenges relating to parental involvement and weight bias.

Discussion: Findings suggest that when discussions of EBWs are approached intentionally—accounting for timing, framing, and individual patient needs—clinicians and patients see potential therapeutic benefit. Future research can focus on developing evidence-based guidelines for sharing EBWs, addressing patient willingness to be informed of their EBW, weight bias, and parental involvement.

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Summary

- Expected body weights are often determined for patients in eating disorder treatment, but it is unclear when, how, and why they are shared with patients during treatment.
- This interview-based, qualitative study highlights that multidisciplinary clinicians and patients largely agree on how these conversations should be approached and identify potential therapeutic benefits when expected body weights are discussed thoughtfully and collaboratively.

1 | Introduction

Clinicians often determine an “expected body weight” (EBW) for patients who have lost weight due to an eating disorder (ED), with the expectation that reaching this weight will lead to improvements in a patient’s symptoms (Golden et al. 2012). This practice is common in the treatment of anorexia nervosa (AN) and atypical anorexia nervosa (AAN), where weight restoration is a core component of recovery (Waller and Mountford 2015; Johnson-Munguia et al. 2024; Bardone-Cone et al. 2010). EBWs may also be established in the treatment of other EDs, such as bulimia nervosa and purging disorder, when patients have lost weight over the course of their illness (Sangvai 2016; Bodell and Keel 2015; Tasca et al. 2012).

Although EBWs are commonly used in ED treatment, there is little consensus regarding how they should be determined. Approaches vary widely, ranging from population-based methods (e.g., Body Mass Index [BMI] > 18.5, median BMI percentile for age (Le Grange et al. 2012; Khalsa et al. 2017)) to individualized approaches that draw on growth charts, premorbid weights, pubertal stage, and biological markers (Schaumberg 2025; Norris et al. 2018; Steinberg et al. 2023; Nagata et al. 2018). Determination of EBWs is particularly complex for diagnoses such as AAN, in which patients experience significant weight loss but do not fall below conventional population-based thresholds (Nagata et al. 2018; Shachar-Lavie et al. 2022). The absence of standardized criteria for EBW determination may contribute to clinical uncertainty about discussions of EBWs with patients.

In line with this uncertainty, there is also inconsistent guidance on whether and when patients should be informed of EBWs during ED treatment. For example, gold-standard psychotherapy treatments for EDs—Family-Based Treatment (FBT) and Enhanced Cognitive Behavioral Therapy (CBT-E)—endorse diverging approaches to sharing EBWs with patients (Fairburn 2008; Lock and Le Grange 2012). Given conflicting guidance and lack of empirical investigation into this treatment component, research on when, how, and why to share EBWs can help optimize patient outcomes in the context of these discussions.

Notably, ED clinicians and researchers have mixed views about weight-related discussions with patients, exemplified in the debate around closed versus open weighing. Advocates of closed weighing (i.e., not disclosing current weight data) purport that

sharing this information can heighten patient anxiety and distress, detract from other treatment priorities, and harm the therapeutic alliance (Waller and Mountford 2015; Johnson-Munguia et al. 2024). Conversely, proponents of open weighing (i.e., disclosing current weight data) contend that avoiding weight-related discussions may inadvertently reinforce patients’ beliefs that weight data is dangerous or unbearable (Waller and Mountford 2015). Open weighing is also viewed as an opportunity for therapeutic exposure, enabling patients to confront their fears of weight gain and form new, less distressing associations with weight gain (Waller et al. 2007; Craske et al. 2014).

Patients have similarly expressed benefits and challenges to being exposed to weight-related information in treatment. In a qualitative study exploring ED recovery among youth with AN or AAN and a history of “overweight/obesity,” two-thirds of participants identified uncertainty about weight goals in treatment as a barrier to recovery (Jhe et al. 2024), suggesting potential benefits of EBWs being shared. Other research indicates that patients prefer weight data to be withheld. In a qualitative study of 41 women with a current or past diagnosis of anorexia nervosa or bulimia nervosa, participants reported that *not* knowing their *current* weight reduced anxiety and ED psychopathology, while increasing treatment engagement, particularly in early treatment stages (Froreich et al. 2020).

Thus, existing research highlights mixed views among clinicians and patients on whether patients should be informed of their weight data. However, perspectives on when, how, and why to discuss EBWs specifically remain underexamined. Understanding clinician and patient perspectives on discussions of EBWs is a critical first step toward clarifying when, how, and why to share EBWs in treatment, ensuring that these conversations are aligned with both therapeutic goals and patient needs. The present study uses reflexive thematic analysis of semi-structured interviews with 24 clinicians treating EDs and 16 patients in treatment for a restrictive ED to examine how clinicians and patients experience discussions of EBWs in ED treatment. By enhancing understanding of clinicians’ and patients’ perspectives on discussing EBWs, findings will provide actionable insights that can be integrated into current treatment practices to improve patient engagement and treatment outcomes.

2 | Materials and Methods

2.1 | Participants

Clinicians were recruited through social media and professional listservs. They were eligible if they had at least 1 year of experience treating patients with EDs, were currently treating patients with EDs, were currently residing in the US, and were English-speaking. To ensure a diversity of perspectives, clinicians of various professional backgrounds were purposively sampled.

Patients were recruited through social media, flyers in local health centers, and direct outreach based on participation in prior studies conducted by the study team. Eligible participants were English-speaking individuals between the ages of 14 and 26 years—the developmental period during which EDs most commonly emerge and are treated (Ward et al. 2019)—who

were currently residing in the US and engaged in outpatient ED treatment within the past 6 months. To focus on individuals with a medically stable ED receiving care in settings where psychotherapy is typically delivered, individuals were excluded if they had participated in higher levels of care (e.g., inpatient, residential, partial hospitalization, or intensive outpatient) within the past 6 months. Finally, participants were required to have restricted food intake in the past year due to weight or shape concern, with resulting weight loss, as discussions of EBWs may be particularly salient and potentially distressing for individuals with heightened weight or shape concern.

2.2 | Procedures

Study procedures were similar across groups. After providing consent online, participants completed an online survey. Participants then completed a video call-based semi-structured interview projected to take 60 min (range = 30–90 min). Upon completion of study activities, clinicians were compensated \$100 and patients were compensated \$50. All procedures were approved by the Institutional Review Board affiliated with the lead author's academic institution. Data were collected in Fall 2024.

2.3 | Measures

2.3.1 | Qualitative Data

Semi-structured interviews were used for qualitative data collection for their balance of structure and flexibility. The interview guide for clinicians covered their experiences and rationale for sharing (or not sharing) EBWs with patients and patients' parents. The interview guide for patients covered their experiences of being informed about their EBWs (or not), factors influencing their comfort level discussing EBWs, and perceived impact of discussions of EBWs on their treatment experience. See [Supporting Information](#) for interview guides.

2.3.2 | Descriptive Data: Clinicians

Clinicians self-identified their gender, age, race, ethnicity, and highest level of education completed. They provided information related to their clinical practice, including their professional role, community setting of practice, the ages of clients they see, and the treatment settings in which they work. Finally, they reported any personal experiences with disordered eating, a diagnosed ED, and disordered eating treatment.

2.3.3 | Descriptive Data: Patients

Patients self-identified their gender, age, sexual orientation, race, immigrant status, and number of years of education completed. Several self-report measures were used in a combined format (referred to here as the "ED100k+") to measure current and historical ED psychopathology. The ED100k+ integrates items from several established measures, including 90 items from the ED100K (Thornton et al. 2018), 10 items from the Eating Disorder Diagnostic Scale (Stice et al. 2000), 19 items from the

Eating Disorder Examination-Questionnaire (Fairburn 2008), and 10 items from the Dieting and Weight History Questionnaire (Witt et al. 2013). Additionally, 54 supplementary questions are included to ensure all criteria necessary for evaluating both current and historical ED diagnoses based on Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) (American Psychiatric Association 2013) for the following diagnoses: anorexia nervosa, atypical anorexia nervosa, bulimia nervosa, and purging disorder. Many were reworded versions of existing items tailored to retrospective reporting. Skip logic was implemented throughout the assessment such that individuals were not asked follow-up questions for a particular behavior or experience if they endorsed that it was not relevant to their ED.

2.3.4 | Analytic Approach: Qualitative Analysis

Team-based, reflexive thematic analysis was used to develop themes from the experiences of participants, with separate analyses conducted for clinicians and patients (Braun and Clarke 2022). See Table 1 for a description of the coding and analytic process.

3 | Results

3.1 | Descriptive Statistics

Forty participants were enrolled, including 24 multidisciplinary ED clinicians and 16 patients. Clinicians were predominantly woman-identifying ($n = 22$, 91.67%) and all were White, with a mean age of 41.71 years. Over half ($n = 14$, 58.33%) reported personal experience with disordered eating, including five (20.83%) who self-reported a prior ED diagnosis. See Tables 2 and 3 for full demographic and disordered eating history details. All mental health providers reported using CBT and Dialectical Behavioral Therapy. See Table 4 for more details on clinical practice characteristics.

Patients were predominantly woman-identifying ($n = 15$, 94%), White ($n = 15$, 94%), and heterosexual ($n = 11$, 69%), with a mean age of 19.5 years. Based on the ED100k+, 15 (94%) met criteria for a lifetime DSM-5 ED, with four (25%) meeting criteria for a current ED. Given eligibility was based on recent outpatient treatment, not all participants had active ED diagnoses, consistent with expected symptom remission over time. See Table 5 for full details on demographics and ED history of patients.

3.2 | Qualitative Results

Themes for both clinicians and patients are depicted in Figure 1 and grouped below under four subheadings: "When to Discuss EBWs," "How to Discuss EBWs," "Why to Discuss EBWs," and "Challenges." This structure was applied post hoc to aid with manuscript navigation and does not reflect a predefined coding frame or analytic hierarchy. Themes are also summarized in Table 6 with illustrative quotes. Pseudonyms are used throughout and are linked to participant demographic and descriptive information in the [Supporting Information](#) to contextualize quotes.

TABLE 1 | Description of reflexive thematic analysis.

Component	Description
Interview transcription	<p>Prior to analysis, interviews were orthographically transcribed based on audiorecordings. During transcription, “likes” and “ums” were replaced with “...” for ease of reading, identifying information (e.g., name of treatment center) was replaced with a non-identifying description (e.g., [Treatment Center Name]), and participants were assigned participant pseudonyms which are used when quoting individual interviews.</p>
Researcher bracketing and reflexivity	<p>Central to reflexive thematic analysis is the understanding that research is inherently subjective, necessitating reflexivity in both the research process and the writeup (Woodside et al. 2004). In the current analysis, reflexivity was an individual and collaborative endeavor. Before coding, coding team members reflected individually on their positionality and preconceived identities about discussions of expected body weights to better understand social identities and life experiences that would influence interpretation of the data (Savin-Baden and Major 2013). For example, the first author, who identifies as a White, heterosexual, smaller-bodied woman with personal experience of a restrictive ED and treatment in higher levels of care, felt deeply connected to the present research. During her own treatment, the lack of transparency around her expected body weight posed a significant barrier to her recovery. Hearing similar accounts from patient participants during data collection and analysis underscored, for her, the importance of researching effective approaches to these discussions, which influenced her interpretation of the data. The coding team acknowledged several assumptions about discussions of expected body weights, including: (a) Exposure to weight information is important, but only in the context of relapse prevention; (b) Expected body weights should be shared and justified using growth charts; and (c) There is not going to be a concrete answer of how to share expected body weights in ED treatment. These assumptions shaped the findings, but the team remained attentive to perspectives in the data that challenged or expanded their preconceived ideas.</p>
Coding guide development	<p>A. A. L., a doctoral student who had prior formal training in qualitative methods, trained the rest of the coding team and supervised all stages of the analysis. First, members of the coding team (A.A.L., A.H., M.F.S., S.V., S.K., C.R.) individually read all transcripts. At this stage, the size and adequacy of the dataset were assessed in relation to information power, focused on the information richness of the data, given the study’s aim and approach (Malterud et al. 2016). Review of the data indicated sufficient depth and breadth to complete analysis, so the team proceeded with analysis instead of collecting more data. Each member of the coding team inductively generated initial codes independently. Then, the coding team met to refine the codes and create an initial codebook, which was used for the test-coding of 12 transcripts (each member of the coding team test-coded two transcripts). After test-coding, the coding team met again to finalize the codebook, which primarily consisted of semantic codes (i.e., codes that capture surface-level meaning).</p>
Coding process	<p>Coding took place systematically, with each member of the coding team coding 12–16 transcripts total, across groups. Transcripts were distributed in a random manner to ensure roughly even distribution across coders, with attention to balancing transcripts from both participant groups. All coding was completed in <i>Dedoose</i>, version 9.2.22. Each transcript was coded twice by two different independent coders, who met to discuss differences in coding. Given that consensus is not a central aim of reflexive thematic analysis, these discussions were focused on exploring alternative interpretations and deepening understanding of the data. For example, one patient described viewing their EBW as a goal to meet to satisfy their treatment team, with the intention of returning to weight loss behaviors afterward. One coder applied the codes “hyperfixation” and “triggering,” capturing how the EBW appeared to activate disordered thoughts and promote strategic compliance. Another coder applied the code “tangible goal,” noting that although the participant’s framing was clearly shaped by their ED, the EBW still served as a goal that could be leveraged to promote recovery over time. This interpretive divergence prompted a discussion about how patients’ relationships with EBWs may shift throughout treatment, and how the timing and framing of these conversations must be approached with intentionality, while monitoring for the activation or reinforcement of disordered cognitions.</p>

(Continues)

TABLE 1 | (Continued)

Component	Description
Theme development	<p>For initial theme generation, the coding team used an online whiteboard to cluster codes. Clustering was informed by the coding team's familiarization with and understanding of the data. While clustering, the coding team considered the following research question: How do clinicians and patients experience discussions of expected body weights in ED treatment? Over the course of initial theme generation, code clusters were revised. Once initial themes were generated, the first author went back to the dataset to confirm the themes were relevant to the analysis and reflective of participant responses. During the writing process, the first author further revised the themes, which the team reviewed.</p> <p>In line with the principles of reflexive thematic analysis, we did not quantify theme prevalence across participants, as the aim was to develop rich, contextualized themes rather than measure frequency. Participant responses were shaped by the flow of semi-structured interviews, and the absence of a particular perspective should not be interpreted as its irrelevance to the individual.</p>

3.2.1 | When to Discuss EBWs

3.2.1.1 | Patients Must Demonstrate Engagement With Recovery (Clinician).

Clinicians described that they typically broach discussions of EBWs after patients are engaging with recovery, marked by more regular eating patterns, reduced preoccupation with weight, shape, food, or exercise, and the use of more adaptive coping strategies. For example, Brooke shared, "When we start to see the behaviors improve and the cognitions improve, ideally is when I've learned that [discussing EBWs-expected body weights] can be useful." Clinicians also emphasized the importance of having preparatory conversations with patients before sharing their EBWs to evaluate if patients' motivations to engage in these discussions are recovery-focused. Mark shared, "I need to understand their why...What purpose is [sharing their EBW] going to serve? Is it only going to validate their ED?" If patients expressed motivations that aligned with the intended purpose of these discussions, such as wanting to challenge their fear of weight gain, clinicians considered proceeding with the conversations to be justified. If patients instead expressed ED-driven motivations, such as using the EBW to justify continued restriction or to establish an upper weight limit, clinicians viewed sharing the EBW as potentially harmful and refrained from doing so.

3.2.1.2 | Patients Must Be Making Progress in Treatment (Patient).

Like clinicians, patients underscored the necessity of achieving some stability before discussing their EBWs in treatment, emphasizing that discussions of EBWs are best suited to occur "After some weight gain has already happened," (Charlotte), "In outpatient care" (Sophia), and "When you have a stronger relationship with food and your body" (Harper). They expressed a preference for prioritizing other aspects of treatment, such as regularizing eating patterns, establishing a relationship with a therapist, and developing new coping skills, before hearing potentially dysregulating EBW information.

3.2.2 | How to Discuss EBWs

3.2.2.1 | Emphasize That the EBW Is Not the Be all and End all (Clinician).

When discussing how they share EBWs with patients, clinicians described emphasizing that reaching the EBW

is not the sole goal of treatment but rather one aspect of recovery. For example, Margaret explained, "I tell my patients...your health is like a puzzle, there's many pieces that fit into it. Weight is one puzzle piece, but there's a million others. There's lab values, there is how much sleep you're getting throughout the night, how much movement you're doing to what feels comfortable with your body, there is managing stress, brushing your teeth, taking showers." Clinicians also emphasized that EBWs are not fixed and are a moving target depending on other health indicators, a fact they expressed communicating with patients.

3.2.2.2 | Frame the EBW as One Part of Recovery (Patient).

Patients similarly highlighted the importance of placing emphasis on other aspects of recovery in addition to EBWs, such as mental well-being, eating patterns, and overall health. Charlotte explained, "You're not just gonna reach that EBW and be fine...just talking about the whole process around it and what that actually can mean is important." Patients expressed that when clinicians treat reaching the EBW as the goal, it can feel dismissive of their recovery needs. For example, Lily noted that it is not helpful when a clinician is "Not interested in...helping the person and just thinking about the numbers."

3.2.2.3 | Involve Parents as Allies (Clinician).

Clinicians with experience treating youth underscored that sharing EBWs with parents from the start of treatment can help them understand the severity of their child's ED and motivate them to be more involved in treatment. For example, Allison described that sharing EBWs with parents allows them to "Grasp the severity of [her] concern, especially if...the EBW is...quite a bit [higher] than where the patient is at...Sharing that goal can also help them realize the severity of the problem." Clinicians also emphasized that discussing EBWs with parents helps develop the parent-treatment team relationship. Mark explained that one of the benefits of discussing EBWs with parents is "Just being aligned with the team, feeling like they're part of the treatment team, that caregivers are very much welcomed and respected in this space."

3.2.2.4 | Demonstrate Emotional Understanding (Patient).

Patients frequently emphasized that during discussions of EBWs, it is essential for clinicians to demonstrate emotional understanding of how challenging these conversations can be. Patients expressed that the most effective approach is for clinicians

TABLE 2 | Clinician demographics.

Demographic	
Gender— <i>N</i> (%)	
Cisgender man	2 (8.33%)
Cisgender woman	22 (91.67%)
Race— <i>N</i> (%)	
White	24 (100.00%)
Hispanic/Latino— <i>N</i> (%)	
Hispanic/Latino	0 (0.00%)
Educational attainment— <i>N</i> (%)	
Bachelor's degree	1 (4.17%)
Doctor of medicine (MD) or doctor of osteopathic medicine (DO)	7 (29.17%)
Doctorate degree (PhD, PsyD)	5 (20.83%)
Master's degree	11 (45.83%)
Age (in years)—mean (SD)	41.71 (14.17)

TABLE 3 | Clinician disordered eating experience.

Disordered eating experience <i>N</i> (%)	
Past disordered eating	15 (62.50%)
Current disordered eating	2 (8.33%)
Total received prior eating disorder diagnosis ^a	7 (29.17%)
Anorexia nervosa	6 (25.00%)
Atypical anorexia nervosa	1 (4.17%)
Bulimia nervosa	1 (4.17%)
Other	2 (8.33%)
Disordered eating treatment experience ^a	8 (33.33%)
Inpatient	2 (8.33%)
Residential	2 (8.33%)
Partial hospitalization	2 (8.33%)
Intensive outpatient	3 (12.50%)
Outpatient	7 (29.27%)

^aParticipants were allowed to self-report multiple responses.

to balance empathy with honesty, acknowledging the difficulty of the conversations while still being direct. For example, Evelyn shared that it's important that clinicians find "A balance of...being real with you, but also not so real that it's harsh, and they still have a sense of what might be...sensitive topics to discuss."

Patients expressed that a failure to find this balance was harmful, particularly when clinicians did not demonstrate emotional understanding. Victoria described a harrowing experience in the doctor's office, sharing: "The doctor told

TABLE 4 | Clinician clinical practice information.

Variable	
Specialty— <i>N</i> (%)	
Physician	7 (29.17%)
Mental health therapist	3 (12.50%)
Nurse	1 (4.17%)
Psychiatrist	1 (4.17%)
Psychologist	4 (16.67%)
Registered dietitian	8 (33.33%)
Years of experience treating ed patients—mean (SD)	11.25 (10.72)
% of Patients with EDs—mean (SD)	78.88 (27.35)
Practice location ^a — <i>N</i> (%)	
Urban	16 (66.67%)
Suburban	16 (66.67%)
Rural	6 (25.00%)
Patient population ^a — <i>N</i> (%)	
Children	13 (54.17%)
Teens	23 (95.83%)
Young adults	24 (100.00%)
Adults	20 (83.33%)
Older adults	4 (16.67%)
Treatment setting ^a — <i>N</i> (%)	
Inpatient	4 (16.67%)
Residential	0 (0.00%)
Partial hospitalization	5 (20.83%)
Intensive outpatient	8 (33.33%)
Outpatient	19 (79.17%)
Private practice	8 (33.33%)
Academic medical center	7 (29.17%)
University health services	4 (16.67%)
Therapeutic model ^a — <i>N</i> (%) ^b	
Acceptance and commitment therapy	6 (85.71%)
Cognitive behavioral therapy	7 (100.00%)
Dialectical behavioral therapy	7 (100.00%)
Eclectic	2 (28.57%)
Emotion-focused therapy	1 (14.29%)
Family-based treatment	4 (57.14%)
Internal family systems	1 (14.29%)
Motivational interviewing	3 (42.86%)
Psychodynamic	2 (28.57%)
Other	1 (14.29%)

^aParticipants were allowed to self-report multiple responses.

^bOnly mental health providers were asked about their therapeutic orientation; therefore, percentages are calculated based on a total of seven respondents rather than the full sample of 24.

TABLE 5 | Patient demographics and eating disorder diagnoses.

Demographic	
Gender— <i>N</i> (%)	
Man	1 (6.25%)
Woman	15 (93.75%)
Race— <i>N</i> (%)	
White	15 (93.75%)
East Asian	1 (6.25%)
Sexual orientation— <i>N</i> (%)	
Asexual	1 (6.25%)
Bisexual/Bi+/Pansexual	4 (25.00%)
Heterosexual	11 (68.75%)
Immigrant status— <i>N</i> (%)	
I am a second-generation immigrant	2 (12.50%)
My parents and I were born in the US	14 (87.50%)
Age—mean (SD)	
	19.5 (2.99)
Years of education—mean (SD)	
	13.06 (2.91)
Eating disorder history— <i>N</i> (%)	
Current anorexia nervosa	0 (0.00%)
Anorexia nervosa history ^a	8 (50.00%)
Current atypical anorexia nervosa	3 (18.75%)
Atypical anorexia nervosa history ^a	5 (31.25%)
Current bulimia nervosa	1 (6.25%)
Bulimia nervosa history ^a	2 (12.50%)
Current binge eating disorder	0 (0.00%)
Binge eating disorder history ^a	2 (12.50%)

Note: Current diagnoses reflect one eating disorder per participant, in line with the hierarchical structure of the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) (American Psychiatric Association 2013).

^aHistorical diagnoses could include multiple responses. One participant not meeting full DSM-5 ED criteria was retained based on reported restrictive behaviors and prior treatment history.

me, 'I have to tell you your EBW because you're going to be discharged in two weeks, and you're probably going to come across it at some point in your life,' I was like, 'What? Like, whoa. Slow down.'"

Patients also highlighted the necessity of clinicians expressing confidence in their ability to reach their EBW and recover. For example, Isabella shared that it made her feel better that her therapist would "Constantly send [her] home with a new 'Try this'... She was very optimistic like 'We're gonna get you back. We're gonna get you back.'" This confidence was seen as most helpful when paired with empathy for how difficult recovery can be. When empathy was lacking, patients described feeling that their efforts were dismissed. Amelia shared, "I personally hate going into therapy because all I know is they're just going to deliver me bad news and say 'Try harder,' when I'm really trying my best."

How do clinicians and patients experience discussions of expected body weights in ED treatment?

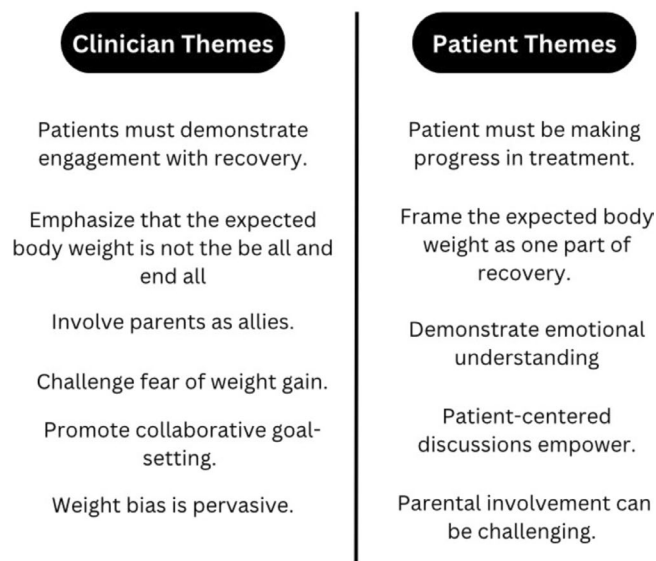


FIGURE 1 | Clinician and patient themes describing experiences with discussions of expected body weights in eating disorder (ED) treatment. Themes were generated through reflexive thematic analysis of interview data from multidisciplinary ED clinicians and patients with experiences of ED treatment.

3.2.3 | Why to Discuss EBWs

3.2.3.1 | Challenge Fear of Weight Gain (Clinician). Clinicians frequently acknowledged that discussions of EBWs can be distressing for patients. However, clinicians also emphasized that giving patients the opportunity to confront their fears of weight gain, including through discussions of EBWs, is crucial. Susan explained, "If we're not causing any distress, we're not really fighting back...ED treatment isn't easy, just like treatment for [obsessive-compulsive disorder] or anxiety isn't easy, because you have to be exposed to these things that are hard." Clinicians framed the conversations as a form of therapeutic exposure, helping patients challenge core ED symptoms. Beyond cognitive recovery, clinicians emphasized the practical necessity of addressing weight-related fears in treatment, as patients will inevitably encounter their weight in daily life.

3.2.3.2 | Promote Collaborative Goal-Setting (Clinician). Another reason clinicians expressed discussing EBWs with patients is to demystify treatment goals and promote collaboration. Rachel shared, "I think discussing EBWs is important as part of establishing treatment goals and helping patients understand what the treatment team is considering to evaluate progress. So, early on, if the client isn't likely to be triggered by it, we talk about it. If they are, we assess as we go." Withholding EBW information was often viewed as reinforcing an unjust power imbalance between clinicians and patients, potentially harming the therapeutic alliance. Natalie reflected on this imbalance, explaining, "The mystery surrounding EBW can feel unsettling. It's as if, 'I know the number, I know what your body should be

TABLE 6 | Themes identified from clinician and patient experiences of discussions of expected body weights, organized into four broad categories.

How do clinicians and patients experience discussions of expected body weights in ED treatment?	
Themes	Examples
When to discuss expected body weights	
Patients must show behavioral and cognitive improvement (clinician)	<p>“[Whether to discuss EBWs with a patient depends on] mentally where someone is—are they in a very malnourished state where they’re not thinking properly, or are they in a stable place, have they barely engaged in behaviors?” (Caroline)</p> <p>“Instead of setting a very specific time or level of care, I think it is so much more dependent on a person’s progress...I think somebody could be at 80% of their target and [these discussions could] be really helpful and positively impactful. I think somebody could be at 98% of their target of their expected body weight and it could still be very hindering for them...I don’t think it should be something that we’re doing until somebody is well-established in their meal plan...and not regularly engaging in behaviors.” (Samantha)</p> <p>“I think sometimes we use caution of when we do disclose that information...for example, if we’re having a patient who’s so afraid of gaining weight and...is incredibly malnourished, maybe that’s not the time yet to say the number that we’re going for...If I’m thinking from...the context of Family-Based Treatment, maybe I’m not [discussing expected body weights] in phase one, but I’m doing that in...phase two when they’re more nourished and...the goal is still to keep...eating and keep going.” (Julia)</p>
Patient must be making progress in treatment (patient)	<p>“I think once you feel that, or once people around you, or the provider...can tell that you’re in a better headspace...When you’re answering those questions they always ask you like, ‘How is your mood around restriction?’ or whatever and it’s...getting consistently better, I think it’s an okay time [to discuss your expected body weight]. And also when you’ve been consistently gaining weight. If you’ve been...all over the place, I just feel like it’s not the time.” (Scarlett)</p> <p>“I think timing is really key and could make...the biggest difference in whether or not the goal gets achieved or...whether or not the treatment is successful...If the timing was right, you would mitigate any of the downsides that I could see happening talking about expected body weights like...trigger relapse or...anything like that.” (Madeline)</p>
How to discuss expected body weights	
Emphasize that weight is not the be all and end all (clinician)	<p>“I probably sound like a broken record in my appointments because...even if I don’t share...[the expected body weight] from day one, we’re talking about how...weight is only one measure of health from day one.” (Allison)</p> <p>“I would like people to understand how their behaviors are affecting their health more than focusing on weight. Because I don’t think...there’s really... an ideal body weight based on your height...because everyone is different, but it’s more, how are the behaviors that you’re having affecting your health?” (Amanda)</p>
Frame the expected body weight as one part of recovery (patient)	<p>“I think that [clinicians] should...definitely use growth charts to explain because you need something tangible besides the provider just telling you what it is...You gotta back that up and explain to the patient...how, ‘Oh...your vitals at this weight will be good,’ and...that kind of stuff.” (Scarlett)</p> <p>“Instead of...making it...weight-centered since...we can’t really define an eating disorder by...someone’s weight, it’d be more helpful...of course taking it into consideration, but...taking so many other things into consideration as well” (Mia)</p> <p>“Be like, ‘Oh, how’s your diet been? How’s your appetite been?’ instead of focusing solely on weight.” (Lily)</p>
Involve parents as allies (clinician)	<p>“I want to make sure that we’re all on the same page so the kid does not end up getting mixed messages because eating disorders are really good at using mixed messages to manipulate.” (Susan)</p> <p>“I think [talking about expected body weights with parents] gives them a light at the end of the tunnel...and kind of...hope that...there’s something to work toward...I think it’s an opportunity to provide...education about...treatment for an eating disorder about what body weight means...the different...things that go into people’s health...that we’d be considering...and just transparency between the treatment team and client parent” (Rachel).</p> <p>“I would say with children that really need to gain weight, parents being able to see, ‘Oh gosh, my kid needs to gain 20 pounds,’ that really enlightens them of their child’s severity of their eating disorder. And also I feel sometimes pulls parents into that calling, ‘Oh, I need to show up more, support my child plating, portioning, redirection, because I’m seeing...the consequences of their prior historical actions.’” (Mark).</p>

(Continues)

TABLE 6 | (Continued)

How do clinicians and patients experience discussions of expected body weights in ED treatment?	
Themes	Examples
Demonstrate emotional understanding (patient)	<p>“Not being mean about it, but...not lying to me either...kind of finding the balance between...knowing that this information is hard, knowing that this information is really difficult, but also knowing that this information is necessary.” (Abigail)</p> <p>“[The impact of discussions of expected body weights] would really vary depending on the provider and how they handle that for sure because obviously, that’s a really delicate subject. And...if the rapport wasn’t there, if...they just didn’t have...a great bedside manner with their clients, then I could see...not being very receptive to anything they were saying. It needs to be handled correctly...with a lot of care.” (Madeline)</p>
Why to discuss expected body weights	
Challenge fear of weight gain (clinician)	<p>“We live in a very weight stigmatizing society and anytime you go to the doctor, you’re going to be weighed...Practicing those distress tolerance skills of being able to tolerate knowing your weight, I think that’s kind of the biggest reason [to share EBWs].” (Danielle)</p> <p>“I’ve seen [discussing expected body weights] work, I’ve seen it be really helpful....I think from an anxiety exposure perspective, this piece is really crucial to getting someone... on the path to recovery and fully recovered from an eating disorder.” (Christina)</p> <p>“[A benefit of discussing expected body weights is patients] knowing where we’re going and building acceptance around that...The more we can make the number just a number... talking about the number neutrally I think.” (Julia)</p> <p>“They end up finding out their numbers at some point...I’ve never treated anyone who doesn’t find out what they were at some point during treatment or right after. So I think it’s very hard if it’s been kept a secret and then that’s when they often will relapse. I also think to get their brain more cognitively flexible about it, they need to hear what a normal number for them would be and start to wrap their brain around it...I think that so much of this is exposure work...we have to do exposure work with food, we have to do exposure work with exercise, exposure work with clothing, and I think we have to do exposure work with the numbers too.” (Melissa)</p>
Promote collaborative goal-setting (clinician)	<p>“I think [discussing expected body weights] can...touch on that rapport and alliance piece of like, ‘Hey...let’s work toward this together.’ Like it’s not me setting this hard and fast rule and I’m keeping you out of the loop or keeping you in the dark in any way... So I do think it can help...facilitate trust and...that alliance with our working relationship.” (Danielle)</p> <p>“In general as a therapist, I try to be transparent about treatment goals and providing feedback so that I’m minimizing the power dynamic, right? And creating an equal relationship because people deserve to know...what we’re aiming for, what they’re aiming for and kind of what I’m considering as I’m assessing the situation...So transparency, establishing equality, making sure the person...feels like...I’m being honest, like I expect <i>them</i> to be honest is [a reason to discuss expected body weights].” (Melissa)</p> <p>“Withholding this information takes away their autonomy, especially for those holding marginalized identities—whether by age, gender, or socioeconomic background. The idea that we have important information about them but choose not to share it only perpetuates this power imbalance.” (Mary)</p>
Patient-centered discussions empower (Patient)	<p>“Not knowing... what I’m supposed to get to, it would make me not try as hard.” (Amelia)</p> <p>“[Knowing my expected body weight] and knowing how much I weigh has been extremely helpful.” (Evelyn)</p> <p>“I know the providers are talking about [expected body weights] in every level of care. So I think the patient should be part of that conversation if it’s a conversation that’s there.” (Charlotte)</p>
Challenges	
Weight bias is pervasive (clinician)	<p>“Sometimes [parents’] intrinsic weight bias is so significant that they choose not to engage with a treatment team that has those beliefs [about an EBW].” (Mary)</p> <p>“I have colleagues and other providers here where they will let the parents know what the expected body weight is, and the parents disagree with that. And they’re like, ‘Oh no, they don’t need to gain quite that much.’ Or like, ‘Oh, they’ve always been a super skinny child. They’ve always been really, really thin...I...don’t think she needs to gain quite that much...because she’s always been skinny.’” (Brooke)</p> <p>“The downside [of discussing expected body weights] is that we have had families leave because they feel that I’m pushing too hard.” (Christina)</p> <p>“I have had parents say, ‘Well...I know my child needs to gain weight, but I don’t think it’s that much weight.’” (Mark).</p> <p>“Sometimes there’s weight bias and weight stigma that comes from families. And they’re concerned about obesity and weight gain, when a kid really does need to be at a higher level...families resisting my recommendation, physicians’ recommendations around that.” (Christina)</p>

(Continues)

TABLE 6 | (Continued)

How do clinicians and patients experience discussions of expected body weights in ED treatment?	
Themes	Examples
Parental involvement can be challenging (patient)	<p>“[My mom] had some disordered patterns herself, and I really didn’t like her eating at the table with me... That was just so triggering for me because...I would have...my full...breakfast set up, and then she’d have... one yogurt, and I was just like, ‘In the nicest way possible, mom, you need to...leave.’” (Scarlett)</p> <p>“Occasionally I would have a deeper discussion with [my parents] but then right after, the day after, they’ll... make a comment about my weight again. Then I’m like, ‘Wow...did I just kind of waste my time trying to help you understand it, but then you kind of already brushed it aside the very next day?’” (Olivia)</p> <p>“I called [my mom]...told her that they diagnosed me with anorexia. And she’s like, ‘Well, I could have told you that.’ I’m like, ‘Well, why the fuck didn’t you?...You knew...I had an issue, you knew that things were wrong, but you didn’t do anything to help me?’” (Amelia)</p>

doing, and you don’t.’ There’s this tension between wanting to protect them by withholding the numbers but also recognizing that not sharing may be harmful.” Others emphasized that not disclosing EBWs could diminish patients’ sense of agency in their recovery. As Mary shared: “Withholding this information takes away their autonomy.” In not sharing EBW information, clinicians may limit patients’ ability to actively participate in and make informed decisions about their own treatment.

3.2.3.3 | Patient-Centered Discussions Empower (Patient). Patients consistently emphasized that discussing EBWs in treatment motivated them to recover, particularly when these discussions were tailored to their individual needs and preferences and supported their autonomy. When approached thoughtfully, patients described these discussions as empowering. As Charlotte expressed, “I would say...recognizing that it varies between a lot of patients and their experiences—I just think it’s really important to always include the patient in these conversations.”

Patients described feeling excluded and disempowered when these discussions were withheld. Isabella reflected on the impact of being left out of these conversations: “I think just from the start...you should have access to your own chart, your own knowledge of that...I think not having access to that...made me feel out of control of my own situation, my own treatment, because we’re here for me and...I was left out.”

Patients also highlighted various ways to personalize these discussions. For those who might struggle with hearing specific numbers, a gradual approach—such as starting with a numberless graph to visualize progress—was suggested as a way to ease into the conversation. Madeline shared, “I probably would not want to start out just hearing a number...probably just be...first like a visual aid, then maybe a range and then maybe...the number like after, you know, several sessions and going through some treatment.” For many patients, knowing their specific EBW clarified treatment goals and helped them stay focused, reinforcing a sense of ownership over their recovery process.

3.2.4 | Challenges

3.2.4.1 | Weight Bias Is Pervasive (Clinician). Clinicians frequently expressed encountering resistance, stemming from

weight bias, when discussing EBWs, particularly with parents. Samantha explained, “Sadly, I would say the biggest [challenge] is when...parents say in front of their children that they think [the EBW] is too high...and fears that, ‘Oh, that makes my child overweight’ or ‘I don’t agree with that, that puts my kid in the 90th percentile and that’s unhealthy.’” Clinicians noted that parental weight bias could significantly hinder treatment progress, especially when expressed in front of the patient. Additionally, in certain cases, clinicians shared that this bias is so entrenched that parents choose to disengage from treatment entirely.

3.2.4.2 | Parental Involvement Can Be Challenging (Patient). Independent of discussions of EBWs, patients frequently described negative experiences regarding their parents’ involvement in their ED and treatment. These concerns primarily centered on parents’ failure to understand the severity of their ED and parents’ own struggles with disordered eating or weight biases.

Many patients felt dismissed by their parents, particularly when they failed to acknowledge the seriousness of their ED. For example, Madeline shared, “I’m now a decade into...being symptomatic. And...it was definitely...a concern that I brought up [with my mom] many times but...I think it’s always kind of been a thing where she didn’t really see the severity.” Patients also reflected on how their parents’ own disordered eating behaviors negatively impacted their recovery. Isabella explained, “[My mom] didn’t really understand [my ED] and...looking back now it’s...very hypocritical because she was doing everything I was doing.” Parental fixation on weight was another significant source of distress for participants. Mia described how her mother’s focus on weight, regardless of context, was harmful: “If I’m at...a higher weight, then my mom will say that I need to lose the weight even though I’ve been in treatment. And then if I’m at a lower weight my mom will make it her whole goal...rather than just focusing on how I’m doing emotionally.”

4 | Discussion

This study explored clinician and patient experiences sharing EBWs in ED treatment, providing insights for approaching these discussions in a way that supports therapeutic goals and addresses patient needs. Ultimately, clinician and patient perspectives aligned regarding when, how, and why to share EBWs in ED treatment. Both groups emphasized that these

discussions are most appropriate after patients have demonstrated engagement with treatment and recovery. Participants also highlighted the importance of framing weight as one aspect of recovery, alongside broader health and behavioral goals, and emphasized the potential therapeutic benefits of these conversations. Additionally, clinicians and patients identified challenges related to parental involvement, underscoring the need for parental education to reduce weight bias and enhance parents' supportive role in treatment. Unique to the patient perspective was that clinicians must demonstrate emotional understanding when broaching these discussions, acknowledging how difficult it can be for patients to discuss gaining weight while also emphasizing its importance for recovery.

4.1 | When to Discuss EBWs

Regarding *when* to discuss EBWs, both groups emphasized that these discussions are most appropriate after patients have regularized eating and initiated weight gain. This recommendation aligns with empirical literature suggesting that cognitive processing can be impaired during acute malnutrition and that physical recovery is a prerequisite to cognitive recovery (Bardone-Cone et al. 2010). However, delaying these discussions too long risks reinforcing the fear of weight gain, a core cognitive aspect of EDs that is strongly associated with the persistence of disordered eating behaviors (Levinson et al. 2017). Thus, a tension exists around when to initiate discussions of EBWs: addressing fears of weight gain through these discussions relatively early may facilitate long-term recovery, while poorly timed discussions could risk disengagement or relapse (Woodside et al. 2004; Levinson et al. 2017).

Notably, in exposure-based protocols for conditions such as post-traumatic stress disorder, readiness for exposure to feared stimuli is often framed not as a prerequisite for initiating exposure but as something that can evolve during treatment (Foa et al. 2007). Applying this principle to ED treatment, introducing discussions of EBWs earlier, while supporting patients through the process, may help disrupt avoidance and reduce fears of weight gain. Future research should investigate when patients are willing to engage in these discussions, not necessarily when they are immune to potential distressing impacts, to optimize their therapeutic effect.

4.2 | How to Discuss EBWs

Beyond the question of timing, clinicians and patients also agreed on *how* these discussions should be framed. Both clinicians and patients emphasized the importance of framing weight within the context of holistic recovery, aligning with research that suggests weight-based recovery alone is insufficient, and that full recovery involves physical, behavioral, and psychological components (Bardone-Cone et al. 2010). Clinicians described providing psychoeducation about non-weight indicators of health and functioning during these discussions, which patients appreciated, particularly when their mental well-being and eating patterns were addressed. By integrating non-weight health indicators into the conversation, clinicians can foster a more comprehensive understanding of recovery.

In addition to framing discussions within a broader recovery context, patients emphasized the importance of clinicians demonstrating emotional understanding during discussions of EBWs. This finding aligns with prior research that highlights that patients with EDs value clinician empathy and collaborative communication (Webb et al. 2024). During discussions of EBWs, it is important that clinicians are direct, while also acknowledging the difficulty of discussing weight gain and conveying hope that recovery is possible.

4.3 | Why to Discuss EBWs

In terms of the *why* behind discussions of EBWs, clinicians and patients described these conversations as motivating and potentially therapeutic, particularly when patients are given autonomy over when and how the discussions occur, as well as what is shared. Such autonomy was noted as empowering patients to feel more in control of their recovery process. These findings align with self-determination theory, which posits that autonomy support enhances internal motivation and promotes sustained behavior change (Ng et al. 2012), as well as with motivational interviewing principles, which emphasize collaboration and evoking patients' own reasons for engaging in treatment (Lundahl et al. 2013). Moreover, informing patients of their EBW—an important treatment goal—can enhance the therapeutic alliance by fostering trust and collaboration between the patient and clinician, a meaningful endeavor as the strength of the therapeutic alliance is directly associated with better outcomes in ED care (Graves et al. 2017). Overall, clinicians and patients highlighted potential therapeutic benefits of EBW discussions through their capacity to support autonomy and promote the therapeutic alliance.

4.4 | Parental Involvement in ED Treatment

Clinicians and patients also frequently commented on the role of parents in ED treatment. With regard to parental involvement in discussions of EBWs, clinicians highlighted a key conundrum: while parents can be invaluable allies in their child's recovery—consistent with the FBT philosophy that parents are crucial agents of change in helping their child overcome an ED (Lock and Le Grange 2012) they may also exhibit weight bias, which can undermine the effectiveness of these conversations and hinder overall treatment progress. From the patient perspective, parental involvement was often seen as challenging. These findings suggest that while parents have the potential to be key contributors to their child's recovery, addressing biases and providing ED education may be critical to maximizing their supportive role in treatment.

5 | Strengths and Limitations

This study has several notable strengths. Most importantly, this study fills a gap in the empirical understanding of when, how, and why EBWs are discussed in real-world ED treatment settings. A depth and breadth of data was collected through semi-structured interviews with both clinicians and patients, allowing for reflexive thematic analysis (Braun and Clarke 2022) and providing a

nuanced understanding of clinician and patient perspectives on these discussions. However, there are several limitations to this study. First, there is the potential for self-selection bias, meaning that these findings may reflect the views of clinicians and patients who are more interested in discussions of EBWs. Offering financial compensation may have disproportionately appealed to individuals with greater financial need. Additionally, there was limited diversity in the final sample, particularly regarding race, ethnicity, and gender, which may be, in part, reflective of biases in access to ED care. Furthermore, the age range precluded an examination of important developmental differences in how EBWs might be discussed. This study did not capture how living situations, such as residing with parents and siblings versus living independently or with a partner, might shape these conversations. In addition, although participants commented on what was shared in discussions of EBWs (e.g., minimum, maximum, range), this study did not systematically characterize the specific content of EBW disclosures. Future research should explore what information is most often communicated and how it relates to treatment engagement and outcomes. Finally, the results of this study do not provide information regarding whether sharing expected body weights improves patient outcomes. Future randomized controlled trials are necessary to evaluate the effects of EBW disclosure, including when and how they are shared, on patient outcomes.

6 | Conclusions

Overall, this study provides insights into clinician and patient perspectives on discussions of EBWs in ED treatment. These findings offer a foundation for guiding future research into optimizing the timing and content of discussions of EBWs. A critical next step will be evaluating the effect of EBW disclosure on patient outcomes.

Author Contributions

Agatha A. Laboe: conceptualization, writing – original draft, investigation, funding acquisition, methodology, writing – review and editing, formal analysis, project administration, data curation. **Ava Heyrman:** data curation, formal analysis, writing – review and editing, investigation. **Siena Vendlinski:** investigation, writing – review and editing, formal analysis, data curation. **Molly F. Steinhoff:** data curation, formal analysis, writing – review and editing, investigation. **Sophia Kreckler:** investigation, writing – review and editing, formal analysis, data curation. **Caitlyn Ruud:** data curation, writing – review and editing, investigation, writing – original draft. **Kate Walsh:** conceptualization, investigation, writing – review and editing, methodology. **Daniel W. Grupe:** conceptualization, investigation, methodology, supervision, writing – review and editing. **James J. Li:** writing – review and editing, conceptualization, investigation, methodology, supervision. **Katherine Schaumberg:** conceptualization, project administration, investigation, methodology, supervision, software, writing – review and editing, writing – original draft.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.