Readiness for Change in the Treatment of Eating Disorders

EDRS 2011 CONFERENCE
Petaluma

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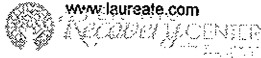


Outline

- The scope of the problem
- The willing <u>and</u> able
- Readiness as a treatment concept
- Practical suggestions

Outline

- The scope of the problem

Scope of the Problem

- Change is as inevitable as the passage of time
- Humans have a predisposition to resist change (adaptive for survival)
- In human pathology, treatment = change (short term and long term)
- Change requires ability <u>and</u> willingness

Scope of the Problem

- Different levels of readiness/expectations for different stake holders
  - Family
  - Schools / employers
  - Third party payors
  - Outpatient treatment providers
  - Inpatient treatment providers
  - Patient

Scope of the Problem

- Patient Readiness – willing and able
  - Adolescents – swift, decisive need to act
  - Adults – assess extent to which mental illness and nutritional state have hijacked their ability to think clearly and make sound decisions on their own behalf

Scope of the Problem

- In EDs, motivation to change is viewed as a key variable in predicting treatment outcome (Beato-Fernandez)
- Unlike many psychiatric conditions, EDs are unusual in that the associated thoughts and behaviors often perform a valued function in client's lives (Serpell)

Outline

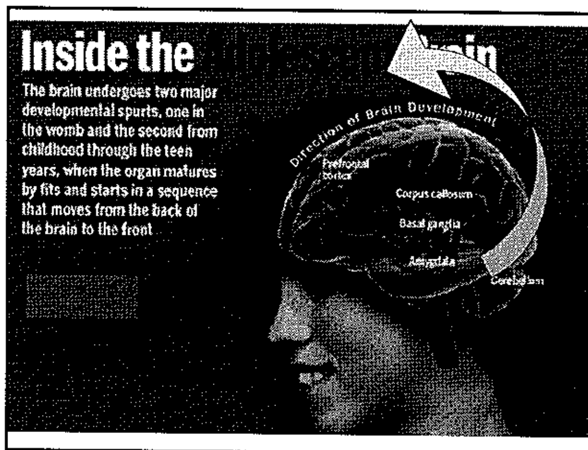
- The willing <u>and</u> able

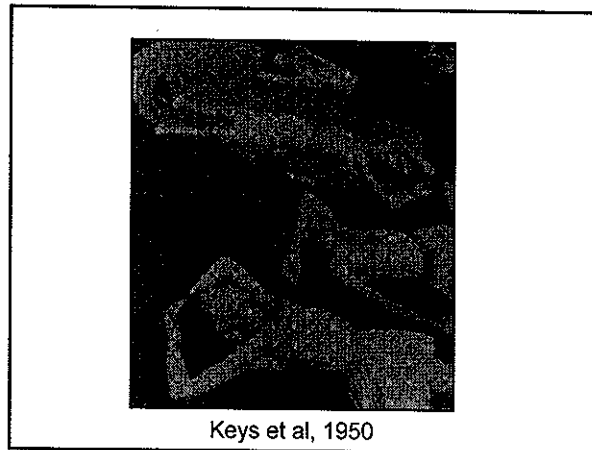
Ability to Change

- Unique challenge of readiness for change in eating disordered population due to the potential for severe nutritional, medical and psychiatric compromise
  - Cognitive impairment and general debilitation
  - Psychosis and paralyzing phobias

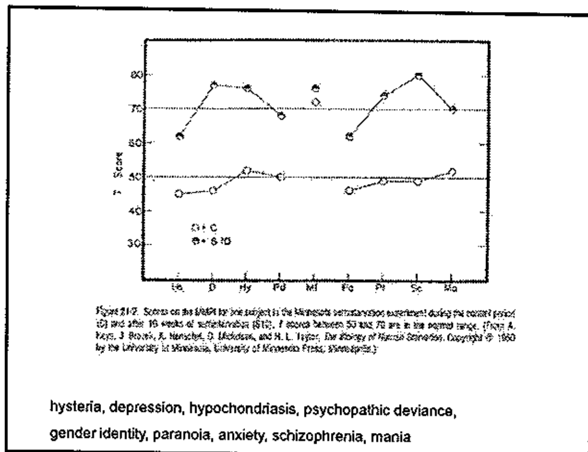
Ability to Change

- "I won't" = "I'm afraid" ("I am not ready")
- "I won't" = "I can't"
  - Brain maturation
  - Acquired cognitive deficits
    - Central cohesion
    - Set shifting
    - Alexithymia
  - Malnutrition and mood / emotional impairment
- In a population that is profoundly stressed (not relieved) throughout treatment





Keys et al, 1950



Ability to Change

- Patient must have enough brain function to be able to contemplate change
- This forces us to address the most difficult subgroup first
- Treatment before readiness for change
- Lack of "ability to choose" <u>may</u> justify compulsory treatment in selected patients

Outline

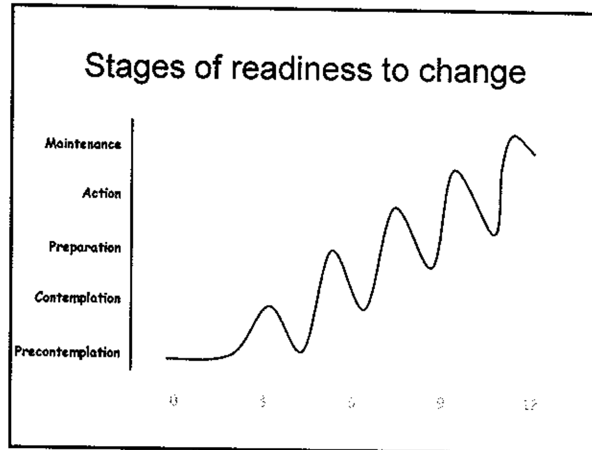
- Readiness as a treatment concept

Readiness as a treatment concept

- Non-ED specific models
  - From CD field
    - Stages of change (Prochaska & DiClemente 1983)
  - From general healthcare
    - Motivational Interviewing (Miller 1985)

The Transtheoretical Model Constructs (Prochaska & DiClemente)

- Stages of change
  - Pre-contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
- Decisional balance
  - Pros
  - Cons
- Self-efficacy
  - Confidence
  - Temptation
- Processes of change
  - Consciousness raising
  - Dramatic relief
  - Self-reevaluation
  - Environmental reevaluation
  - Self-liberation
  - Helping relationships
  - Counterconditioning
  - Stimulus control
  - Social liberation



Motivational Interviewing

- Patient centered clinical interview that attempts to assist the patient in exploring and resolve contradictions in their behaviors
- Increase level of consciousness about health risks and their ability to improve those risks
- The drive to implement change is derived from the discrepancy between what an individual is doing and what he/she wishes they would be doing
- By raising awareness in a patient about what their current situation and their wishes we facilitate change

Motivational Interviewing

- Based on 6 premises to effect change during brief interactions:
  - Objective feedback
  - Acceptance of personal responsibility for change
  - Direct advise
  - Offer a menu of therapeutic interventions
  - Empathy
  - Promote self-efficacy

Motivational Interviewing

- Express empathy, accepting and respecting the patient's point of view but without having to approve of it
- Bring forth the discrepancy so that the patient may recognize the gap between where they are at and where they would like to be
- Avoid arguments to minimize resistance
- Work through the points of resistance without imposing a commitment to change or negatively reinforcing resistance to change
- Support and promote self-efficacy and believe in the possibility of change

Readiness as a treatment concept

- Non-ED specific questionnaires
  - Stages of Change Questionnaire (SCQ)
    - McConnaughy et al, 1983
  - University of Rhode Island Change Assessment Scale (URICA)
    - McConnaughy, 1983
  - Concerns About Change Scale (CCS)
    - Vitousek et al, 1995
  - Processes of Change Questionnaire (PCQ)
    - Rossi et al, 1995 and Blake et al, 1997

Readiness as a treatment concept

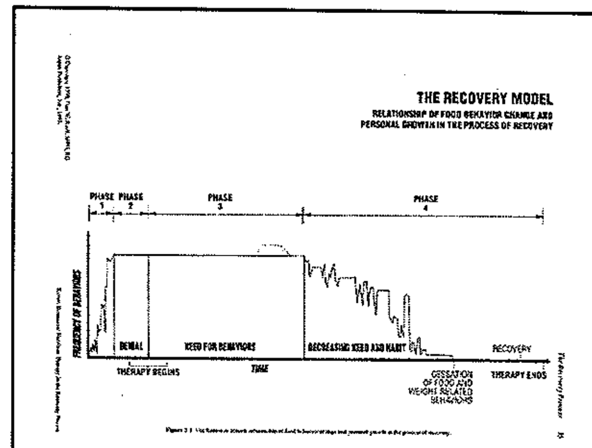
- Non-ED specific questionnaires
  - Decision Balance Inventory, adapted for EDs (DBI-ED)
    - Rossi et al, 1995 and Blake et al, 1997

Readiness as a treatment concept

- Eating disorders specific models
  - The Recovery Model, Nutrition Therapy in the Recovery Process, Reiff & Reiff

The Recovery Model (Reiff & Reiff)

- Relationship of food behavior change and personal growth in the process of recovery
- 5 phases
  - Symptom development
  - Denial
  - Need for behaviors
  - Decreasing need and habit
  - Recovery



The Socratic Method

- Provision of psycho-educational materials
- Examination of advantages and disadvantages of symptoms
- Explicit use of experimental strategies
- Exploration of personal values

Vitousek et al.

Enhancing Motivation for change in eating disorders. Clinical Psychology Review. Vol 18, Issue 4, 1998

Readiness as a treatment concept

- ED specific questionnaires
  - Motivation Scale towards the treatment of AN
    - Engels and Wilm, 1986
  - Concerns about Change Scale Revised (CCS-R)
    - Vitousek et al, 1996
  - Readiness and Motivation Interview (RMI)
    - Geller and Drab, 1999
  - Readiness to Change (RTC)
    - Jordan, 1999

Readiness as a treatment concept

- ED specific questionnaires
  - Decisonal Balance Scale (DBS)
    - Cockell, Geller, Linden, 2000
  - Anorexia Nervosa Readiness to Change Questionnaire (ANSOCQ)
    - Rieger et al, 2002
  - Bulimia Nervosa Stages of Change Questionnaire (BNSOCQ)
    - Serrano et al, 2004 and Martinez et al 2007

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ORIGINAL RESEARCH PAPER

Attitudes towards change and treatment outcome in eating disorders

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ABSTRACT. **Objective:** *To investigate the influence of the stage of change on treatment outcome among patients suffering from eating disorders.* **Method:** *Sixty-seven women receiving free outpatient treatment for eating disorders initially participated in this study. Their demographic, lifetime and clinical characteristics, eating disorder symptoms and general distress were assessed at baseline and after one year, together with the results of self-report questionnaire on Attitudes towards Change in Eating Disorders (ACTA).* **Results:** *High scores on the Maintenance subscale were protective for eating psychopathology as measured by the Eating Attitudes Test (EAT-40), Eating Disorders Inventory (EDI-2) and the frequency of purging. Action was predictive of weight changes. Precontemplation and Relapse respectively predicted little change in EAT and the Bulimic Inventory Test Edinburgh (BITE). High Preparation scores were predictive of the level of EDI-2 Interoceptive Awareness, Maturity Fears, and Asceticism.* **Discussion:** *Our results suggest considering the stage of change as a useful outcome predictor.*

Eating Weight Disord. 10: 59-65, 2005. ©2005, Editrice Kurtis

Readiness and Motivation Interview (RMI)

- the Readiness and Motivation Interview for Eating Disorders (RMI), a semi-structured assessment tool that elicits information on individuals' experience of, and attachment to their symptoms. The RMI allows for readiness and motivation for change status to be determined, and assesses the extent to which change, when occurring, is for internal versus external reasons. In contrast to more commonly used global measures of stage of change, the RMI provides detailed symptom-specific information about readiness and motivation in the eating disorders

ANSOCQ and BNSOQ

- 20 item questionnaire, each with 5 options with descending value (total score / 20 = average score)
- Overall stage classification
  - < 1.5 = precontemplation
  - 1.5 – 2.4 = contemplation
  - 2.5 – 3.4 = preparation
  - 3.5 – 4.4 = action
  - ≥ 4.5 = maintenance
- 3 subscales
  - Weight gain
  - Eating, shape and weight concerns
  - Ego-alien aspects

Attitudes Towards Change in EDs (ACTA)

- 59 item questionnaire, each with 4 Likert scale options about change activities with subscales for each stage of change
- Predominant stage of change is the one with highest score
- "Positive correlation between initial ACTA scores and changes in eating psychopathology at one year follow up, independent of
  - Diagnostic subtype
  - Duration of illness
  - Severity of illness
  - In adolescents and adults

Data on ED's and Stages for Change

- Patients who enter general psychotherapy in pre-contemplation are more likely to terminate early than if they enter in contemplation stage. The latter were more likely to actively participate (Derisley et al, 2000)
- Similar results in several non-eating disorders based populations

Data on ED's and Stages for Change

- Patients with eating disorders who enter treatment by self-referral had more motivation to change than those who were referred by someone else. Self referred patients continued treatment longer. (Hasler et al, 2004)
- Studies suggest that readiness for change can predict treatment outcome in the short term

Clinical Implications

- readiness for change can predict treatment outcome in the short term
- Only patients in the pre-contemplation stage are less likely to short term benefit from treatment, but
- Motivation may improve with nutritional rehabilitation and improved functioning ("everyone deserves a pass at treatment")

Clinical Implications

- In eating disorders, we may need to think "out of the box" about readiness to change
  - "tolerance of change"
  - "compartmentalized readiness"

Readiness for Change

need for different measures in eating disorder?

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance

- **Unwilling**
- **Concessionary**
- **Misdirected**
- **Cautious**
- **Committed**

Readiness for Change

need for different measures in eating disorder?

- 1. Unwilling: Unwilling to change any aspect of current eating disorder related behaviors (EDRB).
- 2. Concessionary: No personal investment in change, only willing to meet the minimal requirement imposed by the demand of others, e.g. family, treatment team, etc.
- 3. Misdirected: Recognizes dysfunction or diminished quality of life and desires improvement. Willing to consider change/treatment for concurrent problems but is unwilling to change EDRB.
- 4. Cautious: Recognizes the need for eliminating some EDRBs, but not others, and/or is generally skeptical about readiness and self-efficacy.
- 5. Committed: Recognizes the need for complete remission of all eating disorder related behaviors, feels confident in ability to accomplish this goal and has demonstrated steps toward this goal.

Outline

- Practical suggestions

Therapeutic alliance

- The agenda is NOT to try to enforce change
- The agenda is to form a therapeutic alliance and to seek understanding and promote change
- Therefore, we should be "agents" no "enforcers"

What clinicians can do

- **Assess for ability to change given medical and psychiatric condition**
  - Medical and/or psychiatric stabilization may be the first priority for some patients
- Assess for readiness to change given the stage or recovery the patient is coursing
  - focus your interventions towards treatment based on stage of readiness

What clinicians can do

- **Pre-contemplation:** no insight
  - Address denial
- **Contemplation:** insight, no wish to change
  - Motivational interviewing
- **Preparation**: wants to change but not yet
  - promote self-referral to treatment
- **Action:** wants to change now
  - Assist with finding adequate match of services to need
- **Maintenance**: wants to maintain the changes
  - Focus on relapse prevention

Motivation Enhancement

Four General Principles

- Express empathy
- Avoid argumentation
- Support self-efficacy
- Roll with resistance

Pitfalls to avoid

- Coercion
- Power struggles
- "lock-ins"

Motivation Enhancement

Role of the Therapist

- Provide structure (helps patient to slow down and focus)
- Encourage creative problem solving
- Interpret client's defenses
- Help client understand the meaning of behaviors
- Confront discrepancies, distortions and irrational thinking
- Establish an environment of trust and honesty

Motivation Enhancement

Effective Motivational Approaches

- Give advice
- Remove barriers to treatment
- Provide choice
- Clarify goals
- Provide feedback
- Practice empathy

The Spirit of Motivational Therapy

The sun and the wind were having a dispute as to who was more powerful. They saw a man walking along and they had a bet as to which of them could get him to remove his coat.

The wind started first and blew up a huge gale, the coat flapped but the man only fastened the buttons and tightened up his belt.

The sun tried next and shone brightly making the man sweat. The man took off his coat.

Valuable resource

- **Ready, willing and able to change: motivational aspects of the assessment and treatment of eating disorders.** Treasure J., Schmidt U. European Eating Disorders Review, 2001 9(1):4-18

The treatment of eating disorders is a complex interwoven ladder/helix where nutritional, medical, psychological, and psychiatric improvements are essential to overall treatment success and each builds on and supports the next through the process of change and into recovery...

Goals of the therapeutic alliance should include a spirit of cooperation and collaboration...