Motivational work for eating disorders: When, why and how?

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Outline

- What are motivational interventions?
- Received wisdom and myths of motivation
- Assessing the received wisdom: what does the literature actually say?
- Working towards change, despite the manifesto…

What are motivational interventions?

What are motivational interventions?

- Core elements
- Engage the patient as an active agent of change
  - necessary where there is some ego-syntonicity
  - present in some patients, but not all
- Reduce the sense of helplessness/hopelessness
  - present in a lot of patients, but not always noted
  - sometimes due to failure of efforts to change
  - sometimes due to failure of previous therapies
- Tend to focus on the former
  - hence the conclusion that ‘the patient is not ready’ when motivational work fails

What are motivational interventions?

- Two broad types
- 1. Discreet units of treatment
  - Adaptations of Motivational Interviewing (AMIs)
    - e.g., motivational enhancement therapy
- As practiced in the eating disorders, assume that motivational change is a one-time thing
  - not the original intent

What are motivational interventions?

- Two broad types
- 2. Underlying stance throughout therapy

- Based on different models
  - stages of change
  - decisional balance
  - conscious vs unconscious vs systemic
    - e.g., behavioural vs psychodynamic vs family therapy

- Aiming to bring us back to the behavioural
  - in case anyone is on the edge of their seat about it…

Received wisdom and myths of motivation

The problem with received wisdom

- Received wisdom is the stuff that we all <u>know</u> must be true
  - commonly in ignorance of the evidence
- Sometimes we are actively resistant to changing our beliefs
- Sometimes we believe the hype
  - and motivational interventions in the eating disorders sure do get a lot of hype…

Received wisdom: Truth or myths?

- Stuff that we often hear (but rarely question…)
- Clinicians are good at identifying motivation
  - particularly predicting engagement and outcome
- Motivational stages are meaningful and well understood
- Motivational interventions
  - increase motivation
  - reduce eating pathology
  - improve engagement in treatment
- Improving motivation enhances outcomes

Dismantling the received wisdom: What does the literature actually say?

1. Identifying motivation

- Are we any good at identifying motivation in a meaningful way?
- Geller (2002) - clinicians, patients and neutral observers judged motivation of anorexic patients
  - who was any good at judging motivation in a way that was linked to outcomes?
    - Clinicians – useless
    - Patients – poor
    - Neutral observers – pretty good
- Time to focus on more standardised measures?

What about more standardised measures?

- Moral so far – do not trust the judgement of those who are heavily involved in the process

- Given that our clinical judgement is ineffective in predicting clinical outcomes…

- What standardised measure should I use?
  - lots of them
  - but what is the last one that you used?
    - not just administered, but used
    - e.g., shared with your patient; used in formulation, revisited…

Do standardised measures tell us much?

- Patchy association with outcomes of treatment
  - remaining in therapy, symptom improvement
  - e.g., initial ANSOCQ scores linked to improvement in in-patient anorexics (Wade et al., 2009)
  - but decisional balance (Dean et al., 2007; Knowles, 2009) is unrelated to outcome

- Decisional balance and stages of change have weak/conflicting evidence of association

- So what is the point that we are missing about motivation?

What is motivation?

- Common assumption
- It is what the patient says they plan to do

- A grumpy old man's take on this question
- It is what the patient does
  - the best indicator of motivation is whether the patient is changing…

- Expressed motivation is not to be trusted unless it is backed up by behavioural change
  - For all the smokers in the room...

- So how to make sense of expressed motivation?

Motivation as a manifesto

- We commonly treat expressed motivation as a statement of intent
  - our error is in believing that
  - understandable, given our desire to be likeable, but an error…
- More rational to treat expressed motivation as a manifesto
  - what a political party says it will do, rather than what it actually does
- A political manifesto is about getting into power
  - not necessarily related to what that party or individual will do when in power

Motivation as a manifesto

- A patient's statement of motivation can be about achieving things other than change
  - getting care
  - getting others off their back/making others feel better
    - 'pseudomotivation' (Engel & Wilms, 1986)
    - convincing family or clinicians that they are OK
  - getting relief from other demands/being allowed to continue with other demands (e.g., work, study)

- The three states of therapy
  - 'In therapy'
  - 'Going to therapy'
  - 'Doing therapy'

2. Do we understand motivational ‘stages’?

- ‘Categories’ or ‘multiple dimensions’?
  - e.g., scoring some measures can give a stage of change that is unrelated to any individual symptom/behaviour
- ‘Stages’ or ‘states’?
  - consider the sequential nature of ‘stages’
    - nice in a diagram, but not in reality…
  - the construct is criticised in the wider literature
    - Littell & Girvin, 2002; West, 2005
- Are ‘stages’ a human attempt to impose an order that does not exist in reality?

Questioning deeply-held beliefs

- What are the motivational stages/states anyway?
- In the eating disorders, we usually cite the five mentioned by Prochaska & DiClemente (1982)
  - but what is going on in the outside world…
- Outside the eating disorders, several very relevant constructs have been added to the usual suspects
  - Freeman & Dolan (2001)
- Let's compare those states…

Prochaska & DiClemente	***Freeman & Dolan***	***F & D definitions***
	Noncontemplation	*Unaware of any problem or need to change*
	Anticontemplation	*Violent opposition to change/therapy*
Precontemplation	Precontemplation	*Metacognitive element of change (possibility)*
Contemplation	Contemplation	*Cognitive element of change (practicality)*
Preparation	Preparation	*Action planning (neutral)*
Action	Action	*Taking action (drive)*
	Prelapse	*Was all the change worthwhile/needed…?*
	Lapse	*Single event off track*
	Relapse	*Return to old behaviours*
Maintenance	Maintenance	*Assess and refine changes until habitual*

3. Do motivational interventions work in the eating disorders?

- Nearly all of the literature addresses adaptations of motivational interviewing (AMI)
  - e.g., motivational enhancement therapy
- About 10 randomised controlled trials
- This literature has been extensively reviewed
  - very consistent outcomes

High quality reviews of high quality studies

- We now have nearly as many reviews as RCTs...
  - Waller (2012)
  - Macdonald et al. (2012) - Treasure
  - Dray & Wade (2012)
  - Knowles et al. (2013) - Serpell
  - Clausen et al. (2013)

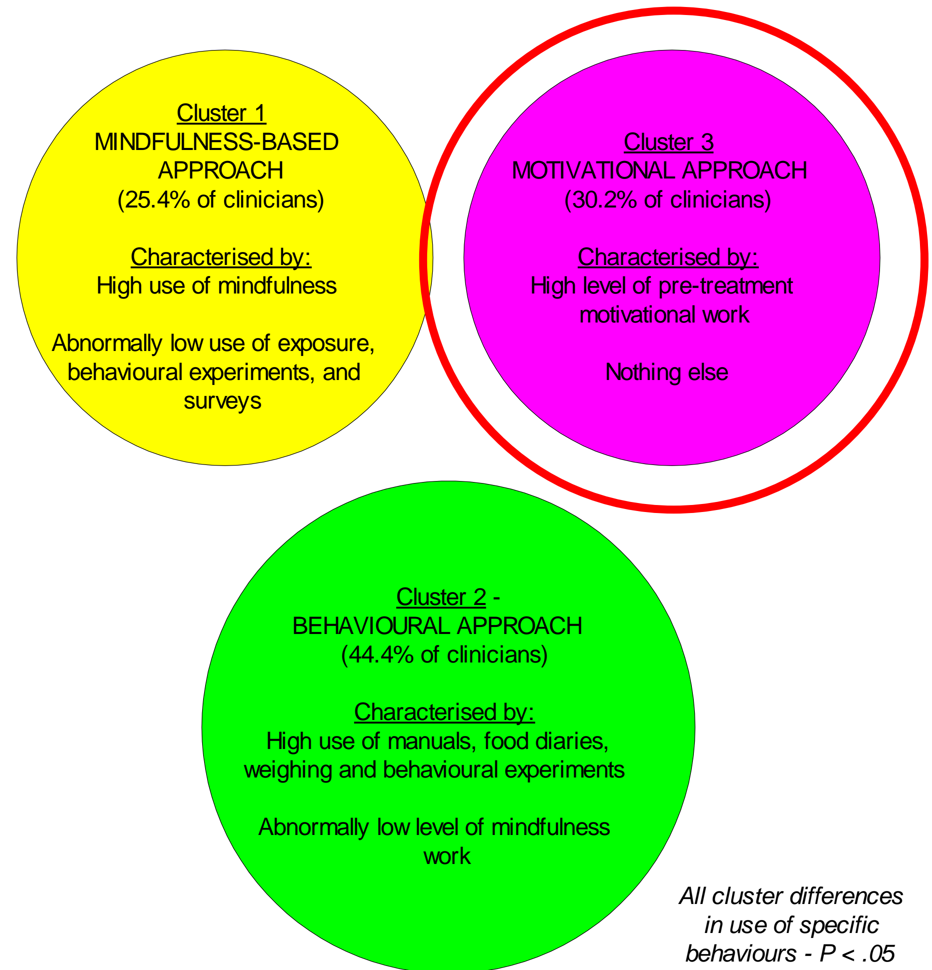
- Backed up by evidence since
  - e.g., Vella-Zarb et al. (2015) – Carter

So, do motivational interventions work?

- The reviews all say the same thing...
- Early motivation levels *sometimes* predict outcome
- AMIs/MET *sometimes* leads to an increase in stated motivation
- AMIs/MET does not improve outcome at all
- But the reviewers think that it *should* work...

So surely we do not do them?

- Unfortunately, we do
- About 50% of CBT clinicians start with these interventions
- Some do little else
  - presumably, waiting for them to work...
  - risk losing the early, high-impact change



What can clinicians do to develop and maintain motivation for change?

Stop being part of the problem

Clinician stance and technique

Change the rules

Stop being part of the problem…

- Accept that we play a role in maintaining poor motivation for change
  - we believe in manifestos, because we are (nearly) all lovely people

- We assume that expressed motivation to attend/be in treatment = motivation to change

- We assume that getting patients to attend will make them improve

- We ignore clear indices of demotivation

- We take responsibility for change

Clinician stance and technique

Stance and technique

- Both of these matter

- Gets us away from the idea that motivational enhancement is something that is done once at the start of treatment

- But also needs to be so integrated into therapy that the motivational material does not stop other elements of the intervention
  - need to be noting and responding to motivational states all the time

Received wisdom: Stance and technique

- Lots of suggestions in the literature as to the guiding principles for motivating our patients
  - e.g., Garner et al., 1982; Geller et al., 2001, 2003; Goldner, 1989; Sallas, 1985; Vitousek et al., 1998
- Eight themes emerge
  - 1. Collaboration
  - 2. Maximise autonomy
  - 3. Acceptance
  - 4. Empathic understanding
  - 5. Transparency
  - 6. Curiosity
  - 7. Remain focused
  - 8. Take a long-term approach

Personal suggestions to add to that lot and to clarify them in real life settings

- Empathy is not enough
  - need a blend of firmness and empathy (Wilson et al., 1997)
- Aim for an alliance with the patient (and family) against the eating disorder
- Consistency
  - aim to be boring
- Need to think about motivation as being something that is continuously addressed
  - not just a start point

Personal suggestions…

- Constructive scepticism re expressed motivation
  - parking lot syndrome (Fairburn, 2008)
  - share this with the patient
- Do not treat motivation as contagious
  - our motivation is unlikely to rub off on the patient
- Our motivation can be a problem
  - overinvestment leads to blindness
- The most effective index of motivation is early behavioural change
  - share this with the patient as early as possible
  - do not wait until they have blown their chance

Personal suggestions…

- The patient needs to take responsibility for change
  - our job is to spell out that the patient is the therapist
    - "Not sure why you are choosing to stay ill…"
- Honesty matters
  - outcome if there is no change
  - the likelihood of change if one does the therapy
  - deal with patients being angry and upset about change
- Safety behaviours prevent behavioural change
  - our own as well as those of the patient

And one final suggestion…

- Forget 'stand-alone' motivational work
- Motivational work seems to be most effective when meshed into therapy rather than being stand alone
  - as motivational interviewing was intended to be)
- What is the most powerful motivator in the psychology literature?
  - the one that barely gets a mention in therapy texts?
- Positive reinforcement
  - you can only do this if the patient is making change...

Change the rules

When motivation is a manifesto rather than a plan of action...

- When the actions do not match the words
- Remember the point of the manifesto
  - eating disordered patients are highly motivated
  - want something (implicitly or explicitly)
    - others off their back, feeling cared for, reduction in disliked symptoms, etc.
  - just not what we thought they wanted
    - recovery, ‘good health’, etc.
- Therefore, the key is to make the patient’s manifesto plans clearly impossible to achieve…

Making the manifesto irrelevant

- What can we do to make the manifesto impossible for the patient to sell to clinicians, carers or us?

- Thus leaving the patient with the consequences of their actions
  - and no words of motivation to hide behind

- In other words, if the patient’s actions indicate that they want X, then make it clear that they cannot get X through their eating disorder

Suggested techniques

- Clearer boundaries
  - therapy interfering behaviours
  - reduce thought action fusion…
  - inconsistent clinicians
- Working with cognitions and emotions
- Strategic ‘withdrawal’

Clarify the boundaries

- Address therapy interfering behaviours
  - not attending consistently
  - not doing the work
  - aggression
  - etc.

- Remember our own role in encouraging/allowing such failure to do the work
  - consider our own ‘prelapses’

- Focus the ourselves and the patient on the need to do the therapy (not just turn up for sessions)
  - inc. five minute sessions
  - thought-action fusion is not real…for us or the patient

Work with the cognitions and emotions

- Identify and work on permissive cognitions
  - what are the beliefs that underlie failure to make or maintain behavioural change?
  - e.g., “Not just yet”; “It doesn’t matter if I binge now, as I can start again tomorrow…”; “I want to be a bit anorexic…”
- Treat change as a choice that has to be an active one
- Turning ‘immobility’ into a choice to stay ill
  - the slippery slope analogy

Work with the cognitions and emotions

- Work with the emotional reactions to failure to progress and with pressure to change
  - e.g., patient anger at consistent presentation of consequences of behaviours/permissive cognitions
  - e.g., the case of Lauren and her frustration at being told "This is not working…"

- Focus on the role of emotions as motivators to action
  - only become a problem if the emotion is treated as an end in itself, rather than as a motivator

Strategic withdrawal (or not…)

- <u>Refuse treatment?</u>
  - e.g., Vandereycken & Meerman, 1985

- Seems harsh, but think about the negative consequences of doing something that cannot work…
  - others suffer (e.g., those on the waiting list)
  - general sense of hopelessness on the part of everybody

Strategic withdrawal (or not…)

- Disinvestment (Geller, 2005)
- Keeping treatment going can maintain the eating disorder
  - we need to be prepared to step away from treatment
- Admit defeat, ensure that the patient is safe, and await the patient's return
  - usually more ready for change
- Makes the unstated 'no change' manifesto more difficult to deliver on
  - the individual has to face the fact that life is no better when no-one is pushing…

Strategic withdrawal (or not…)

- Disability training (1)
  - pushing patients to accept the inevitability of deterioration
  - balancing stress and coping
    - "reduce stress if you are not going to enhance your coping…"
- "So how can we make life less stressful…?"
  - stop work/do a job that is less demanding
  - act towards a reduced social life
  - focus on being an aunt rather than a mother
  - plan for disability (live on the ground floor/no driving/no travel, etc.)

Strategic withdrawal (or not…)

- Disability training (2)
- Essential to be honest, genuine and empathic
  - keep stressing that you have no magic wand that will prevent the anorexia/bulimia from winning if the patient is on its side
  - therefore, you are doing the best that anyone can to support the patient in this reduced life…
- Amazing how often patients push back to avoid the real consequences of their manifesto
  - "But I don't want to be that sort of person – what if I ate more – would that help…?"

So what have we learned today...?

To summarise

- Our patients are very highly motivated
  - just not how we think they are
  - and we are not good at spotting their commitment
- We want existing motivational methods to work
  - they do not work
  - but we do them anyway
- We have ways of overcoming poor motivation, but they require us to focus on the ‘doing’ element of CBT, rather than the ‘talking’ bit

The big questions for Monday

- How will you change your own clinical behaviour when you meet a new patient
  - being more skeptical about what the patient wants?
  - five minute sessions?
  - positive reinforcement for positive changes?
  - being more willing to disengage?

- And how will you change for your existing patients?
  - will you have that uncomfortable conversation that says: ‘I got it wrong, and now it is time to change…’?