Pierre Leichner, MD, FRCPC

A new treatment approach to eating disorders in youth

Active listening and other strategies have replaced the more coercive and confrontational methods used in the past to treat anorexia nervosa and related disorders.

ABSTRACT: A new approach to treating eating disorders minimizes the need for coercive interventions and offers a different perspective on what is sometimes labeled "treatment resistance." The Stages of Change model developed by Prochaska and DiClemente allows health care professionals and patients to appreciate that the course of recovery is not straightforward and that relapses provide new opportunities for understanding and further change. Strategies based on the Stages of Change model include active listening, providing information and feedback, exploring the costs and benefits of the disorder, clarifying goals for change, identifying helpers, finding appropriate rewards for action, and cheerleading. By recognizing that change is a choice and that it is ultimately the responsibility of patients and their family members, caregivers can focus their energy on being supportive, being patient, and finding solutions collaboratively.

Over the past two decades, the treatment approaches to eating disorders have evolved dramatically. Although some approaches still rely on strict behavior management protocols, including nasogastric tube refeeding and bed rest, many treatment centres are moving away from these techniques while maintaining good results and improving client satisfaction.[1]

The new approach—often referred to as Motivational Enhancement Interviewing—is in essence a repackaging of several different therapeutic approaches based on the Stages of Change model developed by Prochaska and DiClemente.[2,3] Most clinicians recognize in this approach components of cognitive behavioral therapy, psychoeducation, client-centred therapy, and narrative therapy. Although it is relatively new to the field of eating disorders, it has been used for smoking cessation,[4] nutrition counseling,[5] contraceptive use,[6] medication adherence in chronic disease,[7] and for teens with HIV.[8]

The clinical principles are relatively straightforward. However, they need to be applied consistently by the team or therapist and understood by the parents and the youth. They also require clinicians to have an understanding of their own feelings and reactions to the youth and the disorder, as discussed elsewhere in this issue (see "'No I can't be your…': Boundary issues for health care professionals").

Stages of Change from the patient perspective

Most often youth are brought to the physician's office by their parents at a time when the youth do not believe they have a problem or may just be starting to become aware of it. These youth are at the *Precontemplation* or the *Contemplation* stage (**Figure 1**). In our research with youth, we have learned that many feel the symptoms of an eating disorder provide protection, a sense of control, and increased confidence.[9]

If the symptoms persist, patients may in time come to realize that the eating disorder is a problem. They may then become more aware of feeling tricked by the disorder, of being taken over by it, and of having psychological symptoms such as anxiety, depression, and irritability. They may also become aware of the negative

Dr Leichner is psychiatric director of the Eating Disorders Program at BC's Children's Hospital and clinical professor in the Department of Psychiatry at UBC.

cost on relationships with friends and family[9] and may start considering their options for change. This is called the *Preparation* stage.

Following this, they may choose certain interventions, which they apply during the *Action* stage. If these actions are successful, the behavior is modified or decreased. They then enter the *Maintenance* stage, during which they continue to apply the strategies they have learned.

While relapses are common, patients rarely return to the *Precontemplation* stage. The *Relapse* stage should be seen as an occasion for review of issues, options, and renewed preparation for further action.

Stages of Change from the caregiver perspective

One of the most important Motivational Enhancement Interviewing principles involves the issue professionals call "treatment resistance" or "noncompliance." This is often the product of a mismatch between the Stage of Change the patient is at and the caregiver's expectations (**Figure 2**). Most health care professionals are trained to prescribe Action stage activities and make the assumption that patients come when they are at either the Preparation or the Action stage.

In fact, our ongoing research with youth with eating disorders shows that this is rarely the case, as most patients are at the Contemplation stage and are not ready for action at the time of referral. However, this does not mean that the caregiver has no specific work to do with the patient, only that the strategies used must reflect the stage the patient is at.

A general clinical stance in the treatment of eating disorders has been described by Geller and colleagues. This includes not making assumptions, being curious, being active, maximizing client responsibility for change, and fostering client self-acceptance.[10]

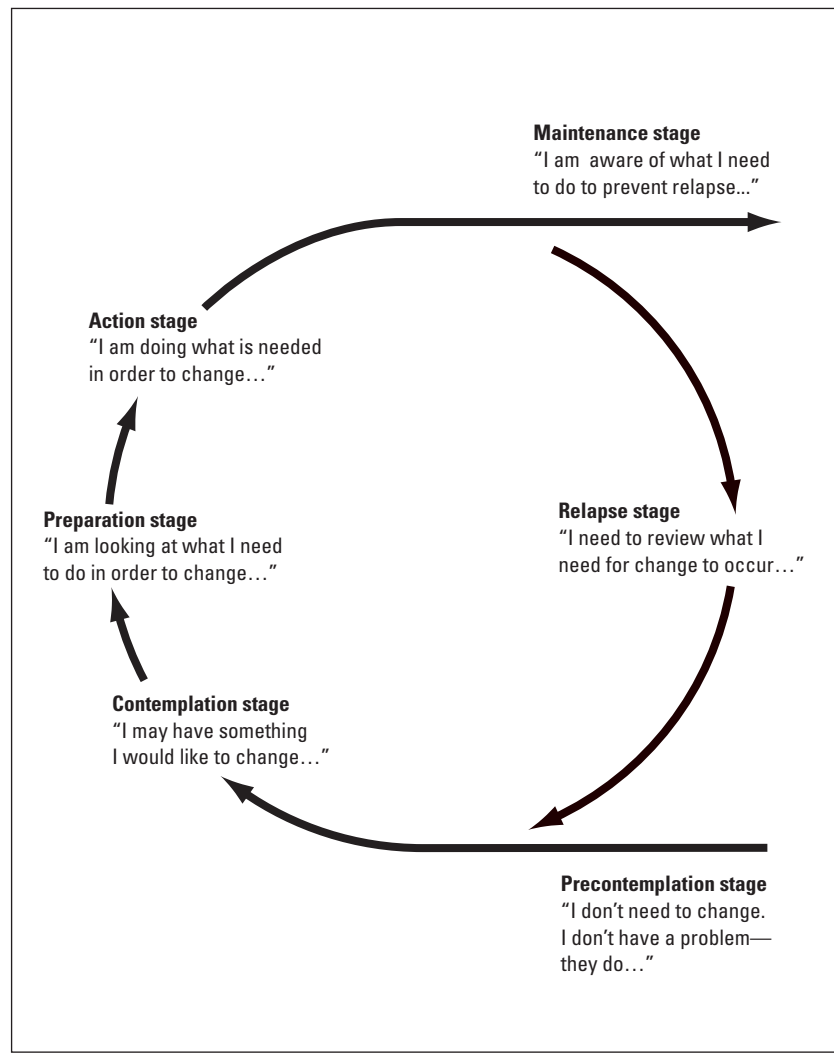

Figure 1. Stages of Change model from the patient's perspective.

Precontemplation stage

When a patient is at the Precontemplation stage, active listening is essential. In fact, this technique is used during all stages and is one of the most important and most difficult strategies to master. We tend to minimize it or not give it enough time. The goal of active listening is to understand—accurately—the perceptions of the patient. When the patient is at this stage, our personal feelings often lead us to jump to conclusions and make assumptions.

There is no shortcut to active listening, a technique crucial to establishing a therapeutic alliance. The clinician must be patient and focused. Whenever a point is made that might warrant clarification, a simple reflection or rephrasing by the clinician of what they have heard is often a good starting point.

Prefacing an enquiry with statements such as "Help me understand..."

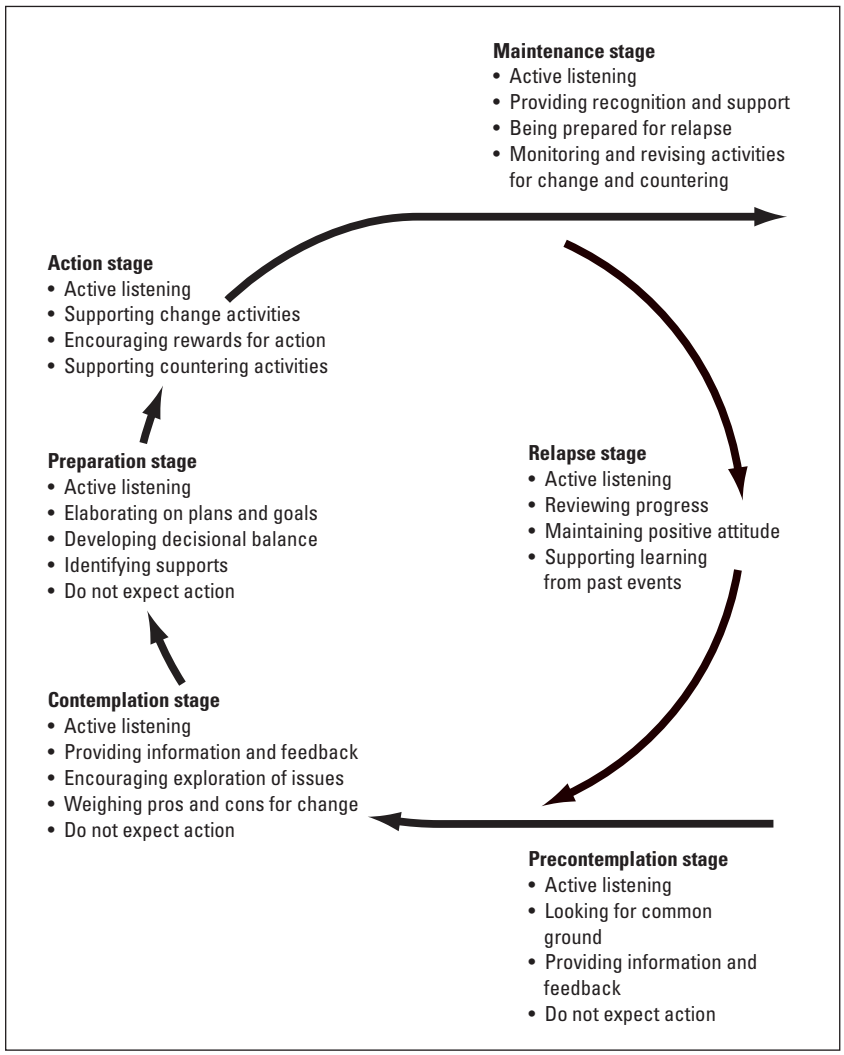

Figure 2. Stages of Change model from the health care professional's perspective.

or "I'm curious about..." allows patients to amplify their perceptions without feeling interrogated.

The active listening process allows the caregiver and patient to look for common ground—an issue that both can work on even at this stage. Physical symptoms or ongoing conflicts with friends or family are examples of issues that patients may be willing to identify and work on even when they do not believe they have an eating disorder. Other concerns that might be raised are discussed elsewhere in this issue (see "Medical complications in children and adolescents affected by eating disorders"). Even if common ground cannot be found, discussions during the Precontemplation stage allow the clinician to provide information and feedback. The feedback may be in the form of results from laboratory investigations and physical examinations; educational pamphlets regarding the effects of malnutrition, the dangers of dieting, and the symptoms of eating disorders; or referral to reputable web sites and self-help organizations (see "Information about eating disorders available on the web").[11]

The goal at this time is to begin establishing the therapeutic alliance so that the patient will return for the next appointment. The caregiver should not expect or prescribe any specific action regarding disordered eating. Providing written reports of assessments and follow-up appointments in the form of letters to the patient and the family is also helpful in building trust and avoiding misunderstandings.[12]

This does not mean that clinicians should not be transparent and authentic in their concern. Based on the facts available from a physical examination and laboratory investigations, the clinician should share clinical opinions honestly but not expect the patient to agree with them.

Contemplation stage

When patients move into the Contemplation stage, they become more conscious that some of their behaviors may be creating problems for themselves and for others in their lives. They are still not fully convinced nor are they ready to make a change. While patients are at this stage, the caregiver should continue to apply the same strategies used at the Precontemplation stage—providing information and feedback and active listening. However, at this time, patients might be open to exploring the costs and benefits of their behaviors.

The fact that an eating disorder might bring some benefits to patients is key to the clinician's understanding of why patients may be so reluctant to change their behavior. Qualitative research at our centre[13] and elsewhere[14] has recently found that youth with eating disorders say the disorder made them feel safe and looked after, gave them a sense of control, and improved

Information about eating disorders available on the web

- Adolescent Medicine Committee, Canadian Pediatric Society. Eating disorders in adolescents: Principles of diagnosis and treatment www.cps.ca/english/statements/AM/am96-04.htm
- American Psychiatric Association. Practice guideline for the treatment of patients with eating disorders www.psych.org/psych_pract/treatg/pg/eating_revisebook_index.cfm
- Eating Disorders Resource Centre of BC. www.disorderedeating.ca/default.html
- National Eating Disorder Information Centre (NEDIC) www.nedic.ca
- National Eating Disorders Association. www.nationaleatingdisorders.org
- National Institute for Clinical Excellence. Understanding NICE guidance: A guide for people with eating disorders, their advocates and carers, and the public. www.nice.org.uk/CG009NICEguideline

their confidence. The disorder also helped them avoid difficult emotions. However, they also identified the following costs of having an eating disorder: they felt cheated by the disorder, taken over by it, and angered and depressed by it.

The caregiver should not assume that issues are the same for all patients. The pros and cons need to be explored and understood before targeted interventions can be planned. Once more, the clinician will need to be patient and focused, and remain compassionate. This is sometimes challenging because the costs of the eating disorders to the youth appear more important or more obvious to the caregiver. It is useful to remember that in almost all cases, the youth will also come to recognize this.

As the patient gradually becomes more open to hearing about what treatment is available, the caregiver can provide complete information and review options with the patient prior to beginning the treatment.

Preparation stage

Adequate time should be given to the Preparation stage. For some patients developing and clarifiying goals may be useful. Having explored the pros and cons of having an eating disorder, the caregiver and patient can now explore the pros and cons of change. A crucial step is the identification of helpers. One of my favorite sayings at this stage is, "You alone can do it, but you cannot do it alone."

It is important that this be thought through carefully. It is also important that helpers be identified by the youth. These can include parents, other family members, or friends. Patients should be encouraged to think about the qualities they are looking for in a helper, and to be as specific as possible regarding the tasks they want help for. Meal support, which is discussed elsewhere in this issue (see "Strategies for supporting youth with eating disorders when intensive treatment is needed), might be such a task. A how-to video and manual for parents and friends who are providing meal support is available from the Eating Disorders Program at BC's Children's Hospital (BCCH).[15]

During the Preparation stage the pre-care interview can be useful. These interviews have become a routine part of all interventions at the BCCH Eating Disorders Program. Key staff will meet with patients and families to explain the therapeutic activities, review expectations and guidelines, and answer any questions. Issues such as the courage needed to work toward recovery, the need for open and direct communication with staff, the unpredictable up-and-down course of recovery, and the possibility of relapses are reviewed. The goal is to minimize any surprises for the patient and to avoid any battles around treatment while a patient is in treatment. These battles draw attention and energy away from addressing the issues related to the disordered eating and can temporarily threaten therapeutic alliances.

Action stage

When the patient eventually moves into the Action stage, implementing the strategies that have been identified can begin. This is a time for problem-solving around issues as they come up, "tweaking" stragegies, and cheerleading.

One of the aspects that tends to be neglected at this stage is encouraging rewards for action. The youth and their family members should be reminded to provide appropriate rewards for progress. These rewards need not be large, and can often be more symbolic. However, it is important that progress be acknowledged.

Maintenance stage

The work is not finished and must continue as the patient moves into the Maintenance stage. The countering strategies that the patient may have used in the Action stage may need to be modified. Continued cheerleading and support is important. The Maintenance stage varies in length, but can take months, during which monitoring can be spaced out at increasing intervals.

Relapse stage

Commonly, relapses of varying severity can occur.[16] During this time it is important to continue the process of active listening to understand better the factors associated with the relapse. An experimental stance is sometimes useful. The patient should be encouraged to *try*—to consider new strategies on a trial-and-error basis. It is important to maintain a positive atti-

tude and see relapses as necessary events that provide opportunities to learn more about issues and to move forward. Eating disorders are multifactorial and multilayered problems. It is to be expected that their solution will not come easily or on the first try.

Conclusions

It is important to remember that clinical intervention is most likely to be useful when it matches the patient's stage of change. Because resistance is often the outcome of a mismatch, noncompliance should not be viewed as willful opposition on the patient's part, but rather as an opportunity to better understand where the patient is on the Stages of Change model, and what the pros and cons of the disorder and of making change are for the patient.

Early on, a caregiver can help a patient move forward by providing information regarding the patient's physical status and giving relevant feedback on emotional problems and issues.

The importance of taking the time to establish a therapeutic alliance, as described elsewhere in this issue (see "What to say and how to say it: Connecting with the eating disordered adolescent at the initial consultation"), cannot be underestimated. More confrontational interventions that challenge the patient directly on the costs of the disorder should be used only after an alliance has been well established. It is important at those times to point out to the patient that getting better is often a long process that may include relapses, periods of doubt, and difficult feelings. *Getting* better does not mean *feeling* better right away.

In keeping with the Stages of Change model, the responsibility for change (except in life-threatening circumstances) belongs with the patient. It can indeed be distressing to see patients continue on a downward spiral—however, intervening against the patient's wish too early may be detrimental to forming the therapeutic alliance needed to help the patient with fuller recovery at a later stage.

In conclusion, most youth recover fully from eating disorders.[16] The process, however, is lengthy and rarely straightforward. Using Motivational Enhancement Interviewing principles allows health care professionals to develop therapeutic relationships with their patients while minimizing or eliminating the battles for control these disorders have previously been known for.

Competing interests

None declared.

References

1. Sandhu P, Leichner P. Effects of the implementation of motivational enhancement principles on patient satisfaction with a day treatment program for adolescents. Presented at the International Conference on Eating Disorders, Denver, CO, 29 May 2003.
2. Bell A, Rollnick S. In: Rotgers F, Keller D, Morgenstern, J (eds). Motivational Interviewing in Practice: A Structured Approach. New York: Guilford Press; 1999:266-265.
3. Prochaska J, DiClemente C, Norcross J. In search of how people change. Applications to addictive behavior. Am Psychol 1992;9:1102-1114.
4. Fava JL, Velicer WF, Prochaska JO. Applying the transtheoretical model to a representative sample of smokers. Addict Behav 1995;20:198-203.
5. Sandoval WM, Heller KE, Wiese WH, et al. Stages of change: A model for nutrition counselling. Top Clin Nutr 1994;9:64-69.
6. Calavotti C, Cabral RJ, Lansky A, et al. Validation of measures of condom and other contraceptive use among women at high risk for HIV infection and unintended pregnancy. Health Psychol 1995;14:570-578.
7. Willey C, Redding C, Stafford J, et al. Stages of change for adherence with medication regimens for chronic disease: Development and validation of a measure. Clin Ther 2000; 22:858-871.
8. Rogers AS, Miller S, Murphy DA, et al. The TREAT (Therapeutic Regimens Enhancing Adherence in Teens) program: Theory and preliminary results. J Adolesc Health 2001;29S:30-38.
9. Freedman G, Leichner P, Manley R, et al. Understanding anorexia nervosa through analysis of thematic content in letters in an adolescent sample. Presented at the Canadian Psychiatric Association 53rd annual conference, Halifax, NS, 1 November 2003.
10. Geller G, Williams KD, Srikameswaran S. Clinician stance in the treatment of chronic eating disorders. Eur Eat Disord Rev 2001;9:365-373.
11. National Eating Disorders Information Centre (NEDIC). www.nedic.ca (accessed 14 December 2004)
12. Davidson H, Birmingham CL. Letter writing as a therapeutic tool. Eat Weight Disord 2001;6:40-44.
13. Freedman G, Leichner P, Nang T, et al. A thematic analysis of letters written by youth to their eating disorders. Presented at the Canadian Psychiatric Association 53rd annual conference, Halifax, NS, 1 November 2003.
14. Serpell L, Treasure J, Teasdale J, et al. Anorexia nervosa: Friend or foe? Int J Eat Disord 1999;25:177-186.
15. Leichner P. Meal support—guidelines for parents of children with eating disorders [video]. Presented at the Canadian Psychiatric Association 53rd annual conference, Halifax, NS, 1 November 2003.
16. Strober M, Freeman R, Morrell W. The longterm course of anorexia nervosa in adolescents. Int J Eat Disord 1997;22:339-360.

BCMJ