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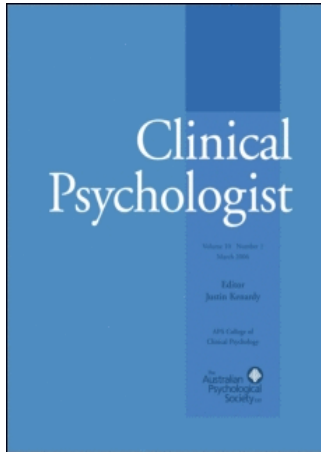
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Louise George<sup>a</sup>; Chris Thornton<sup>a</sup>; Stephen W. Touyz<sup>ab</sup>; Glenn Waller<sup>c</sup>; Pierre JV Beumont<sup>de</sup>

<sup>a</sup> Peter Beumont Centre for Eating Disorders, Wesley Private Hospital. Sydney, New South Wales. Australia

<sup>b</sup> School of Psychology, University of Sydney. New South Wales. Australia

<sup>c</sup> Department of Psychiatry, St. George's Hospital Medical School, University of London. United Kingdom

<sup>d</sup> Department of Psychological Medicine, University of Sydney. New South Wales. Australia

<sup>e</sup> Wesley Private Hospital. Sydney, New South Wales. Australia

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## Motivational enhancement and schema-focused cognitive behaviour therapy in the treatment of chronic eating disorders

LOUISE GEORGE<sup>1</sup>, CHRIS THORNTON<sup>1</sup>, STEPHEN W. TOUYZ<sup>1,2</sup>, GLENN WALLER<sup>3</sup>, & PIERRE J. V. BEUMONT<sup>4,5\*</sup>

<sup>1</sup>Peter Beumont Centre for Eating Disorders, Wesley Private Hospital, Sydney, New South Wales, Australia, <sup>2</sup>School of Psychology, University of Sydney, New South Wales, Australia, <sup>3</sup>Department of Psychiatry, St. George's Hospital Medical School, University of London, United Kingdom, <sup>4</sup>Department of Psychological Medicine, University of Sydney, New South Wales, Australia, and <sup>5</sup>Wesley Private Hospital, Sydney, New South Wales, Australia.

### Abstract

A day hospital program for the treatment of patients with long-term anorexia nervosa (AN) is described. This program forms part of a comprehensive system of day programs that reflect and incorporate patients' varying degrees of readiness for change and attempt to match patients' readiness for change to the interventions offered in treatment. Preliminary outcome data are presented, showing clinically valuable changes of motivation in this group.

Difficulties in treating patients with anorexia nervosa (AN) are well documented. In particular, they are known for their marked absence of motivation to engage in treatment and their ambivalence about changing their eating disorder behaviours (Bruch, 1973; Lasegue, 1873/1997; Vitousek, Watson, & Wilson, 1998). For patients with chronic AN, resistance to change is particularly evident and they often develop a history of negative treatment experiences and repeated treatment failures. Approximately 20% of patients with AN are known to remain chronically ill over the long term (Steinhausen, 1999). A sense of hopelessness prevails regarding the possibility of change on both the part of clinicians and patients. Their uptake in treatment is particularly problematic, with up to 50% of patients with a 10-year history of AN dropping out of treatment from specialist services (Lowe et al., 2001). Despite these negative outcomes, there has been little investigation into the specific treatment needs of this patient group.

There is a marked absence of research regarding the treatment of chronic AN but two broad approaches appear to be suggested or implied when reviewing the literature. The first actively recommends that treatment should focus on changing

anorexic symptoms (including weight restoration) for all patients with AN, including those with a long history of illness (Theander, 1992). The second suggests a more cautious approach, which stresses that patients with chronic AN are less motivated to change their behaviour because their symptoms have become integral to their day-to-day lives and functioning. Where this is the case, efforts to enforce change could exacerbate the problem or increase patients' risk of depression and suicide (Crisp, 1980; Geller, Williams, & Srikaneswaran, 2001).

In the light of these difficulties, motivation or readiness to change has become a focus of theoretical and empirical investigation in the field of eating disorders (Treasure & Ward, 1997; Vitousek et al., 1998). The stages of change model (Prochaska & DiClemente, 1982) has been increasingly applied to AN to support the notion that such individuals either manifest a total absence of desire to recover or at best experience a profound ambivalence about recovering from their illness (Orimoto & Vitousek, 1992). Readiness for change has been found to predict treatment outcome. Rieger et al. (2000) reported that readiness to change (as measured on the Anorexia Nervosa Stages Of Change Questionnaire; ANSOCQ) at the commencement of treatment was

significantly correlated with the amount of weight gained by patients in the subsequent 4 weeks of treatment. Further, it has been suggested that treatment refusal and drop-out may arise from treatment attempts to bring about symptom reduction in individuals who are not ready to change (Prochaska & DiClemente, 1992). Such findings have highlighted the need to provide interventions to enhance motivation for change in patients with AN as well as the need to match the treatment provided to the patients' stage of change if treatment is to be successful. The lack of such an approach can be hypothesised to be partly responsible for the failure of existing treatment strategies for patients with chronic AN. Due to the special needs of patients with chronic AN, specific programs need to be developed for this patient population (Noordenbos, Oldenhav, Muschter, & Terpstra, 2002).

#### *Day program treatment for chronic anorexia nervosa*

A program was specifically designed for the treatment of long-term sufferers of AN in the precontemplation/early contemplation stage of change (Touyz, Thornton, Rieger, George, & Beumont, 2003). Due to the ambivalence about change inherent in patients with long-term eating disorders, the program utilised the techniques (Miller & Rollnick, 1991; Treasure & Ward, 1997; Vitousek et al., 1998) and tone (Geller et al., 2001) of motivational therapy.

The goal of motivational enhancement therapy (MET) is to increase motivation for change. The task of the therapist is seen to vary depending on the patient's stage of change; however, a number of underlying therapeutic guidelines exist across all the stages of change. MET highlights the fact that responsibility for change lies with the patient rather than with the therapist or treatment program and thus allows the therapist to avoid arguing with the patient that they must change, but rather to roll with patients' resistance to change as it arises. In this way patients are able to shift their focus from resisting treatment and defending their eating disorder to exploring other issues relevant to their recovery. The tone of MET is conveyed through displaying empathy and respect for the patient as well as curiosity and interest in the dilemmas of living with, in this case, a chronic illness. The importance of reflective listening, particularly to the ambivalence and contradictions inherent in chronic AN, is highlighted. In this way an attempt is made to develop discrepancy between present behaviours and the patients' wider goals. Supporting self-efficacy and hope as well as building self-esteem are encouraged.

Because the patients with chronic AN were either precontemplative or in the early contemplative stage

of the change, the central aim of the program was to work with the patients to provide a cognitive and affective re-evaluation of their disorder (Treasure & Ward, 1997). Furthermore, an attempt was made to assist them in understanding the barriers to giving up their eating disorder and to explore the barriers to change that existed for them. Given the patients' stage of change, the task of the therapists was to raise awareness and doubt about living with chronic AN, as well as to assist the patients in examining the pros and cons of the status quo versus change.

Although motivational therapy was predicted to be helpful in increasing motivation for change, in our experience a barrier for change in patients with chronic eating disorders may be the presence of early maladaptive schema. It has been suggested that powerful maladaptive schema might play a role in preventing change (Miller, 1999). Therefore the program drew on schema-focused cognitive behaviour therapy (CBT) to understand the role that early maladaptive schema may play in maintaining eating disorders and preventing change. Schema-focused CBT techniques (Waller & Kennerley, 2003; Waller, submitted for publication; Young, 1994) were adapted for a group setting in an attempt to identify and modify early maladaptive schemas. Schema-focused CBT is an extension of CBT and attempts to address more complex, chronic and characterological problems. While CBT focuses primarily on cognitive phenomena at the level of automatic thoughts, cognitive distortions and underlying assumptions, schema-focused CBT attempts to focus on the deepest level of cognition, schemata (Young, 1994).

#### **Method**

The goal of this study was to explore the usefulness of this innovative day program, involving the use of MET and schema-focused CBT, in the treatment of patients with long-term AN.

#### *Participants*

The initial sample approached consisted of 10 patients. Following a brief assessment period two patients decided not to enter the program. Therefore, the final sample consisted of eight female patients. There were no drop-outs from treatment in the 6-month period for these remaining eight patients. The core behavioural pathology for all eight patients was restrictive. Seven met *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., DSM-IV; American Psychiatric Association, 1994) criteria for AN at admission, while the remaining patient met full diagnostic criteria for an eating disorder not otherwise specified (American Psychiatric Associa-

tion, 1994) with a past diagnosis of AN. Their average length of illness was 18 years (range = 7–42 years). Their mean body mass index (BMI = weight[kg]/height<sup>2</sup>[m]) at admission was 16.53 (range = 13.8–19.2). Their average age was 36 years (range = 23–56 years). One of the patients was married, but no other patients were in a relationship. Five were living alone and three with living with their families. Two patients were in full-time employment, while the remainder were unemployed. All eight patients had a history of repeated unsuccessful inpatient and outpatient treatment experiences.

#### *Treatment program*

Patients attended the day hospital 2 days a week for 5 hr each day. Each day comprised two 1-hr groups and one 90-min group co-led by two highly experienced clinical psychologists (LG and CT). Patients contracted to join the group for 6 months with the contract being renewable at the end of each 6-month period. In line with the motivational therapy tone, most aspects of the program were negotiated within the group. Due to the high level of morbidity in chronic eating disorders (Herzog et al., 2000; Ratnasuriya, Eisler, Szumukler, & Russell, 1991), the only non-negotiable aspect of the program was patient safety. All patients were under the care of, and were regularly reviewed by, a psychiatrist and/or a medical practitioner who were responsible for medical safety, including decisions regarding hospitalisation. Medical concerns and impending hospital admissions were discussed in the group as an understandable consequence of maintaining a chronic illness. No other aspect of treatment or attendance was compulsory. This included meals where, although food was provided, responsibility for preparing and eating the food was left to the patients. Meals were regularly reviewed in group.

#### *Admission criteria*

Admission criteria to the program included the patient having a primary diagnosis of an eating disorder for a minimum of 7 years and that the illness had not remitted despite multiple previous treatment interventions. The patients were refusing to engage in more “action”-stage treatment programs but willing to attend the group to explore barriers to change.

#### *Measures*

On admission, the patients completed the following measures: the ANSOCQ (Rieger, Touyz, & Beumont, 2002) is a 23-item self-report questionnaire based on Prochaska and DiClemente’s stages of

change model, which assesses readiness to recover from AN. The Extended Satisfaction with Life Scale (Alfonso, Allison, & Dunn, 1991) is a five-item, multidimensional life satisfaction scale that taps nine domains of life, measuring them on a global level. The Eating Attitudes Test (Garner & Garfinkel, 1979) is a 40-item questionnaire used to evaluate a range of attitudes and behaviours associated with AN. The General Health Questionnaire–28 (Goldberg, 1972) is a self-administered screening test aimed at detecting psychiatric disorders among the general population. The Young Schema Questionnaire (YSQ), first edition (Young, 1994) is a 205-item self-report inventory that consists of self-statements related to a range of schema used for identifying early maladaptive schema.

Information regarding weight/BMI, bingeing, vomiting, laxative abuse and exercise levels was also obtained (either via self-report and/or with clarification from the responsible medical officer).

All data (both questionnaires and self-report) were collected again following completion of a 6-month treatment period. Qualitative data were collected in the form of written feedback from the patients as to what they found helpful or unhelpful about the program.

#### *Data analysis*

Statistical comparison between time-points was performed using the Wilcoxon matched-pairs signed-ranks tests.

### **Results**

At the end of the 6-month period, these chronic patients displayed an increase in their motivation for change as reflected by scores on the ANSOCQ ( $Z = -2.37$ , two-tailed  $p = .02$ ; Table I). However, no changes were recorded on the subscales of the YSQ. With regards to identifying early maladaptive schema, the five highest scoring YSQ scales were: unrelenting standards ( $M$  score = 4.98), defectiveness/shame ( $M$  score = 4.45), emotional deprivation ( $M$  score = 4.35), emotional inhibition ( $M$  score = 4.03) and social isolation ( $M$  score = 4.38). Upon closer scrutiny the Extended Satisfaction with Life Scale was found to have low face validity with this population and was thus excluded from further analysis. No significant changes were identified on the other questionnaires administered (Table I).

The clinical data regarding laxative abuse and exercise levels are recorded in Table I. Again there were no significant behavioural changes on these indices. Information regarding bingeing and vomiting was excluded from statistical analysis due to the small sample size for these behaviours.

Table I. Clinical characteristics of the eight patients at admission and at completion of the day program

Measure/symptom	<i>n</i>	State of treatment				Wilcoxon test	
		Admission		Completion			
		<i>M</i>	( <i>SD</i> )	<i>M</i>	( <i>SD</i> )	<i>Z</i>	<i>p</i>
BMI	8	16.53	1.60	17.04	2.34	-1.40	.16
Laxatives (per week)	4	259	232.66	98	186.70	-1.60	.11
Exercise(hr/week)	6	11	11.23	5.25	5.27	-.73	.47
ANSOCQ	8	2.06	.57	2.81	.82	-2.37	.02
GHQ	8	2.97	1.62	2.38	1.55	-1.20	.23
EAT	8	49.88	21.60	49.13	20.07	-.42	.67

Note. BMI=body mass index; ANSOCQ=Anorexia Nervosa Stages of Change Questionnaire; GHQ=General Health Questionnaire; EAT=Eating Attitudes Test.

## Discussion

Given the extended length of illness of this patient group, and the fact that symptom reduction is not the goal of motivational therapy, expectations regarding symptom reduction and the effectiveness of a 6-month treatment program were understandably cautious. However, there were some promising outcomes.

In light of the high treatment drop-out rates among patients with chronic AN (Lowe et al., 2001) a promising outcome of this MET/schema-focused CBT program was the low drop-out rate. This suggests that this form of treatment is useful in its ability to engage and hold a group of patients with chronic AN in therapy.

The program also appears to have been useful in increasing patients' motivation for change. The scores on the ANSOCQ (Reiger et al., 2002) indicated that patients moved from an "early contemplation" admission score, suggesting a "late contemplation" stage of change at completion of the 6-month treatment period. This change was also reflected in the qualitative feedback received from the patients themselves. For the first time, many patients were willing to consider making changes to their eating disorder behaviours. Although not willing to gain and maintain a normal weight, patients made changes such as introducing protein into their diet, reducing their laxative intake, taking medication and making limited increases to their weight. These changes resulted in improvements that were significant to the participants (such as an improvement in mood in the case of one patient with depression who agreed to take medication, and for another being able to prepare and eat a meal with her family for the first time in 30 years). It was also hoped that there might be some long-term physical benefits to such changes in behaviour.

Patients reported finding the match between therapy and their stage of change helpful in that,

unlike more action-orientated treatments, there was no expectation for behavioural change from the therapists. This, according to the patients, decreased their sense of being in battle against the team, allowing them to participate more freely in treatment. Despite the absence of expectation of behavioural change, two patients underwent voluntary, planned inpatient treatment during the 6-month program, and a further two patients underwent voluntary, inpatient treatment upon completing the 6-month day program. In each case, although they were not seeking full recovery, the patients had made decisions to make changes to some aspect of their eating disorder behaviour. Our colleagues working on the inpatient unit reported that these patients were able to use the treatment available to them far more effectively since their attendance at the day program and reported greater levels of compliance with treatment.

The motivational therapy tone was found to be useful with regard to the schema-focused CBT component of treatment. Although patients were often able to identify early maladaptive schema, those schema were resistant to change (Young, 1994). Schema are known to be rigid and difficult to modify (Young, 1994). As in the case of a chronic eating disorder, schemas are deeply embedded, serving an adaptive function in the patient's life over many years. Further, schemas, like eating disorders, are experienced as egosyntonic in that they feel right to the patient (Millon, 1981). Adopting a motivational stance to schema work in exploring the advantages and disadvantages of changing the schema was beneficial.

With regards to the Extended Satisfaction with Life Scale (Alfonso et al., 1991), patients frequently reported feeling reasonably satisfied with their lives in some of the areas assessed by the scale, but on enquiry these scores reflected a satisfaction with the absence of these factors from their lives rather than a satisfaction with the quality of these factors. For

example, one patient who was socially isolated scored as feeling highly satisfied on this dimension of the questionnaire, and upon enquiry reported that it kept her safe from the risk of being hurt by others. This suggests a need to develop more effective measures of satisfaction with life for this patient group. Although such measures exist for other psychiatric disorders, the development of a measure exclusively to eating disorders would be extremely useful in both clinical practice and research.

## Conclusions

The results presented above should be considered as a first impression of the usefulness of a new treatment program. It is acknowledged that the small number of patients in this group limits the possibility of performing meaningful statistical analyses. However, given that many patients with AN are known to take a chronic course, that they do not engage in treatment, and that mortality rates increase with chronicity, there remains a strong need to develop effective treatment programs for patients with chronic AN. This day program offers some preliminary ideas that have been helpful in treating this patient group.

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