Motivational Interviewing for Eating Disorders

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One of the consistent aspects of anorexia nervosa is the denial that there is any problem in the face of an overt signal of disease, ie starvation. This clash of perceptions frequently leads to confrontation and coercion. It is possible that these factors contribute to the maintenance of his problem once it has begun (the average duration of illness is 6 years).

What do we know about the readiness to change in anorexia nervosa?

The transtheoretical model has been applied to patients with eating disorders (Ward et al 1996; Blake et al 1997; Stanton et al 1986). Less than 50 per cent of patients with anorexia nervosa referred to a specialist eating disorder clinic were in action; twenty percent were in precontemplation and thirty percent in contemplation (Blake et al 1997). The majority of patients with anorexia nervosa on an inpatient unit were in precontemplation or contemplation (Ward et al 1996). The decisional balance and the processes of change showed similar stage matched profiles to those found in other conditions.

What do we know about readiness to change in bulimia nervosa?

Using the same measures, many more of the patients with bulimia nervosa were in action. However, the situation in bulimia nervosa is more complex and fluid because people want to stop their binges but they are much less willing to change their weight control strategies (Blake et al 1997).
The use of Motivational Interviewing for eating disorders

The ambivalence and overt negative reaction to treatment in anorexia nervosa means that it is a suitable case for motivational interviewing treatment. There are some case reports (Treasure & Ward, 1997). Motivational enhancement therapy for bulimia nervosa has been manualised (Schmidt & Treasure 1997) and is in the process of evaluation (Treasure et al 1999). The concepts of a motivational approach for parents are introduced in Self/Carer help guides for anorexia nervosa (Treasure 1997, Treasure 2007). A metaphor that we use to convey the spirit of Motivational Interviewing when we are introducing the concepts to the parents is one of Aesop’s fables. ‘The sun and the wind were having a dispute as to who was the most powerful. They saw a man walking along and they challenged each other about which of them would be most successful at getting the man to remove his coat. The wind started first and blew up a huge gale; the coat flapped but the man only closed all his buttons and tightened up his belt. The sun tried next and shone brightly making the man sweat. He proceeded to take off his coat.’

An up to date account and a detailed description of this approach for eating disorders has been included in the latest book on Motivational Interviewing (Treasure and Schmidt 2008). The Maudsley model of individual therapy for eating disorder is underpinned by a motivational style.
Limitations and difficulties of motivational strategies for patients with eating disorders

We have successfully introduced a motivational style of approach to all our service setting, inpatient, day patient and out patient in our NHS unit in south London. Nevertheless, there are some difficulties working with this patient group. The style of Motivational Interviewing sits most comfortably when there is an equal balance of power between client and therapist. Children and adolescents find this assumption somewhat alien and threatening. These patients often have very low self-esteem. They have dismissive attachment styles and avoid revealing themselves to others. Adults are not seen as peers. In this context the therapist may need to give more structure to the session. Commonly adolescents with anorexia nervosa are wary and suspicious. During the information exchange process the person with anorexia nervosa will form a judgement as to whether the therapist understands the problem. Thus the therapist needs to subtly reveal his or her expertise. Thus in the initial phase you need to open up avenues of eating disorder specific problems to break the ice. One of the tenets of Motivational Interviewing is that the client is able to choose whether he or she will decide to change. In the case of anorexia nervosa this freedom is limited. It is physiologically impossible to choose not to eat for longer than 2-3 months. In most countries, mental health legislation can override an individual's decision. It is still possible to work in a motivational way if these limits are conceptualised as part of a higher power or authority, constraining the actions of both therapist and patients. The therapist does not have to use confrontation or coercion directly, but can be an indirect conduit of society's rules.

Theoretical Considerations

Patients with anorexia nervosa have poor reflective functioning (a conceptual measure, which is thought to represent metacognitive ability and is derived from the adult attachment interview). Motivational Interviewing may work by modelling this capacity by the therapist.

Also patients with eating disorder have an informational processing style which is characterised by a superior attention to detail which can be at the expense of the bigger picture. One of the key aspects of Motivational Interviewing is to step back from the current behaviours and to see the present within the context of a life story perspective. This reframing encourages the individual to take a more global perspective.

Training

We run training in using motivational approaches for eating disorders. For further details contact Gill Todd, g.todd@slam.nhs.uk.
References


