Basic principles of Motivational Interviewing in Eating Disorders

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Maudsley Model of Working with Eating Disorders

The model is based on Motivational Interviewing and Expressed Emotion work.

Motivational Enhancement Therapy has been developed to enhance collaboration and change.

The model encompasses working with both the Client and their Carers.
DEFINITION OF MOTIVATIONAL INTERVIEWING

“A directive, client-centred counselling style for helping clients explore and resolve ambivalence about behaviour change.”
The Spirit of Motivational Interviewing

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.
The ‘spirit’ of MI

- Mi doesn’t judge the person to be ill
- An openness to a way of thinking and working that is collaborative rather than prescriptive.
- A willingness to suspend an authoritarian role.
- The model is based on normal health behaviour change.
The Spirit of MI

- The therapist believes the patient will come up with the solutions.
- The therapist does not give solutions or identify problems to work on.
- The therapist supports the client to see themselves as worth investigating.
- The language used is positive.
The ‘fabric’ of MI- OARS …

- Open questions
- Affirmations
- Reflections: repeating
  - rephrasing
  - paraphrasing - infers meaning
  - ... of feeling
  - double sided
  - over/undershooting
- Summaries
Facilitating Change

The righting reflex - a desire to put things right when they are awry

Many people in the helping professions have a desire to put things right

This creates difficulties when a person is ambivalent

If a therapist campaigns for change then the patient will defend the status quo - they ACT OUT the ambivalence
The patient will no longer be in two minds about change - they are in one mind and so is the therapist - polarised views

We need to avoid being caught in this dynamic – if the dynamic is present there will be arguments.
Stages of change model-
Prochaska and DiClemente ‘94

- Relapse
- Precontemplation
- Maintenance
- Contemplation
- Action
- Preparation
- Permanent exit
Readiness for treatment in EDs

*Blake, Turnbull and Treasure ‘97*

- 50% of AN patients in precontemplation and contemplation stages
- 80% of BN patients in action stage
- Stage of change will also vary between different aspects of the problem and a linear progression is not proved.
How do you get people to move through the stages?

- This is where motivational interviewing comes in.
- MI is a way of being with people:
  - aim: to ‘create a positive interpersonal atmosphere that is conducive but not coercive to change’
Precontemplation

- Person not currently considering change:
  - 'I don’t have a problem’
  - 'There’s nothing wrong with my eating’
What happens when you work with people in precontemplation?

Confrontation ↑ resistance, ↑ drop out ↓ outcome
Contemplation

- Person begins to evaluate considerations for and against change:
  - ‘Maybe I do have a problem’
  - ‘Perhaps there are some harmful things about my eating that I could really do without’
Preparation/Determination

- Person plans and commits to change:
  - ‘Right, I’m going to do something about this’
  - ‘I’m going to stop bulimia from running my life and make some changes’
Action

- Person makes specific behavioural changes:
- E.g.
  - regulation of eating
  - reduction of bingeing and vomiting
  - dealing with interpersonal/family difficulties
  - actively learning and practicing new ways to cope with emotions
Maintenance

- Person works to sustain long-term change:
  - E.g.
    - maintenance of therapeutic gains after therapy
    - re-engagement in social relationships
    - expansion of range of activities
Relapse

- People sometimes need to go through repeated cycles of the stages before exiting completely
- ‘I’ve completely messed up and totally failed’
- Going back and forth between stages is common, e.g.:
  - contemplation → decision → contemplation
  - maintenance → relapse → contemplation
Essence of a Good Motivational Session

Client does >50% of talking
Therapist focuses on listening
Majority of therapist interventions are summarising with a few open ended questions
Confrontation minimised (base rate 15%)

The patient feels that the therapist respects them enough to value and trust their decision making ability.
Underlying Theory of MI

- Clients are ambivalent
- Counselors advocacy for change evokes a reaction “reactance” from the client
- Resistance predicts lack of change
- Evoking the client’s own change talk will enhance behavior change
What is important

- To explore both the importance and confidence in changing behaviours relating to self care.
- To elicit from the patient why change might or might not be important for them.
- To shape and nurture the sense of mastery that change can be planned and implemented by them.
Ambivalence

- A normal aspect of human nature
- A natural part of the change process
- Being in 2 minds about something ...
- Approach- avoidance: attracted to and repelled by the same behaviour
- The ‘yes ... but ...’ situation
- “Ambivalence is a reasonable place to visit, but you wouldn’t want to live there”
Decisional balance

Costs of status quo
Benefits of change
Benefits of status quo
Costs of change
General principles of MI

- **Interpretation** of what the patient says is on the side of eliciting their ‘mastery’ of changing or is neutral – no blame.
- Also a belief that the client can find the answers to develop their own change plan.
Building the relationship

What are your aspirations for your client?

What can a client expect from you?

What do you expect from your client?

Book reference:
Motivational Interviewing: preparing people for change.
By William R. Miller & Stephen Rollnick 2nd Edition
“It is the truth we ourselves speak rather than the treatment we receive that heals us.”

O.HOBART MOWRER (1966)  Pg. 85
Self-motivational statements

- There are 4 categories:
  - Problem recognition
  - Expression of concern
  - Intention to change
  - Optimism about change
Content of change talk

- DARN C
- DESIRE
- ABILITY
- REASONS
- NEED
- COMMITMENT

{ to change }
Develop discrepancy

- The ‘distance’ between where you are and where you want to be.
- Overlap between discrepancy and ambivalence.
- An uncomfortable place to be in.
- Invokes an emotional reaction.
- Emotional reaction (feels uncomfortable) to this can motivate the patient to change.
Reflections

- Simple reflections:
  Repeating back in the clients own words

- Paraphrasing:
  Emphasising the emotional content of the clients words
Other types of reflection

- Double-sided reflection - Captures both sides of the ambivalence (... AND ...)  

- Amplified reflection - Overstates what the person says....  
  “so you think that nothing in your life ever changes”  

- Underplay the negativity :  
  eg “I have no friends”  
  “You have fallen out with your friends at the moment”
Measuring

- Use a motivational ruler to measure change

- On a scale of 0 – 10 where would you put yourself?

- Why would you give yourself one point less or one point more?

- Small steps particularly when in precontemplation.
A tool to measure readiness with level of help

Not ready to care for nutritional needs

“I am interested that you have given yourself that score. What makes you score that rather than say 0” or a score of 10.”
“Is there any help I can give that would enable you to move nearer to the 10”

Fully competent to care for nutritional needs

0  2  3  4  5  6  7  8  9  10
Roll with reactance (resistance)

- At times people can paradoxically increase their attachment to a behaviour when the negative consequences increase or when someone else is pushing for change.

- The person then practises arguing for the status quo. The more they do this the more they start believing that change is not for them.
Resistance

- Avoid argument - ‘dancing not wrestling’
- Invite new perspectives
- Emphasis on the client to finding their own solutions - people are better persuaded by their own reasons than by ours.
Giving Feedback

- Ask permission
- Explain meaning, norms and range, based on data from patient.
- Patient can agree/disagree take note.
- Give one fact at a time.
- Reflect on subject response.
- Do not blame or sound critical.
Some Advice – are you ready?

- Keep to a minimum talk about
  Food
  Weight
  Shape
- Increase talk about
  Underlying emotions
  Core beliefs

Give attention to the behaviours you want to increase not to the behaviours you want to decrease.
Advice Giving – pros and con’s

- The therapist is wise and sensible whereas the person with E.D. is a ‘case’ who cannot get their life together.
- It undermines the essence of the relationship as a partnership.
- The energy of the person with E.D. can get focussed on repelling the advice rather than dealing with the issues leading to the “why don’t you?” “yes but” game.
- Discourages people from taking responsibility for themselves.
Ten Things that MI is Not

- Not based on the transtheoretical model – TTM is a comprehensive theory of change
- Not a trick – honours individual autonomy – cannot remove choice, can’t manufacture motivation, MI is not a verb.
- A technique – not a specific procedure (see one, do one, teach one) MI is more complex ‘spirit’ is emphasised. Beware structured MI therapist manuals – loses flexibility
What MI is not

- A decisional balance – routinely exploring the cons of change is not MI, need to stick with ambivalence
- Assessment feedback – MET 4 session specific = MI + assessment feedback
- A form of Cognitive behavioural Therapy – CBT generally provides something the client is presumed to lack (deficit model) MI is more akin to humanistic psychotherapy.
MI is not.....

- Just client-centred therapy – directive component makes it different (socratic method) MI is consciously directed towards a goal. Specific guidelines in MI for what and how to ask – differentially reflecting change talk.
- Not Easy – complex style and set of skills
- What you were already doing – zero correlation of self-report proficiency and actual proficiency
- Not a panacea – not a comprehensive psychotherapy

Not appropriate when client is already sufficiently motivated or committed to change.
‘Broadening the Emotional Base of MI’ by Wagner & Ingersoll

- Focuses on the potential that positive emotions may play in MI.
- The idea that positive emotions elicited by thoughts of change may provide positive reinforcement for change.
- ‘Positive emotions of interest, hope, contentment and inspiration….’ ‘envisioning a better future, remembering past successes, and gaining confidence in their abilities to change their lives – all increase the chances of change’

Some Monty Roberts Quotes

“If all learning is zero to ten, then the most important part of learning is zero to one.”

“If you can use your skills as a trainer to open a door that a horse wants to go through, then you have a horse as a willing partner instead of your unwilling subject.”

[describing his response to a horse’s sudden outbreak of violent “resistance”]: “there should be a complete lack of urgency in any situation like this. Horses need patient handling. Act like you’ve only got fifteen minutes, it’ll take all day; act like you’ve got all day, it might take fifteen minutes”
Sources


www.motivationalinterview.org

www.eatingresearch.com