OVERVIEW OF THE GROUP PROGRAM

Background

Recent research has indicated that patients with eating disorders are often resistant and/or unwilling to change their eating behaviour (e.g. Rieger et al, 2002). Resistance is a central feature of the presentation of Anorexia Nervosa,
however, ambivalence is also marked in sufferers of other eating disorders, for instance, those with bulimic symptomatology who are desperate to stop bingeing, but are not willing to stop dieting, and subclinical cases who have similar issues to patients with clinical disorders, without low weight status (Bemis-Vitousek, 2000). People with these low levels of motivation are unlikely to take action to change their current situation. This is problematic for traditional cognitive behaviour therapy, which is generally utilized in treatment, as it requires a high level of commitment and determination from the patient (Blake et al, 1997).

Motivational Enhancement Therapy (MET) is a method for fostering intrinsic motivation to change by investigating and resolving patient ambivalence to change (Burke, Arkowitz & Menchola, 2003). MET has mainly been utilised in the field of addictions, in which it has had generally positive results (Miller & Rollnick, 2002). Despite the motivational concern in eating disorders, there are relatively few studies evaluating MET in this patient population (Burke et al, 2003). Those few studies that have focused on MET for eating disorders have had mixed results. Treasure and colleagues (1999) found that MET as a prelude to further treatment was not generally superior to CBT in terms of reducing behavioural symptoms of patients with Bulimia Nervosa, increasing therapeutic alliance or increasing readiness to change. However, Treasure et al used questionable methods for measuring stage of change, there were no attempts to assess treatment fidelity and only patients with Bulimia Nervosa were included. An uncontrolled study by Feld and colleagues (2001) found that eating disorder patients’ motivation to change, self efficacy and self esteem increased, and depression decreased, following a four session MET intervention which was run prior to other treatment, but there was no change in eating disorder behaviours and physical symptoms.

The current manual was developed for use in a research program to further investigate the use of MET, in particular, its use with inpatient sufferers of eating disorders in a private Sydney hospital. The program runs concurrently with standard treatment, rather than existing as a prelude or as a stand alone therapy as it has in previous studies (e.g. Treasure et al, 1999; Feld et al, 2001). This concurrent approach was chosen for a number of reasons. For instance, the patients are medically at need of more targeted behavioural treatments which are unable to be delayed and the MET approach is perhaps best conceived of as a stance applied throughout treatment, as it may be unable to sufficiently produce symptom change alone in this population (Geller, 2002).

Aim of the Current Program

The specific aim of a MET program, as outlined in Miller’s manual of MET with Drug Abusers (1995), is to address the symptom of ambivalence to change. By supporting and fostering this intrinsic motivation for change, the therapist helps the patient to initiate, persist in and comply with behaviour change efforts.
The Theoretical Basis
MET seeks to evoke from clients their own motivation for change. The theoretical underpinning of this approach is the self-perception theory proposed by Bem (1967). Bem proposed that people learn what they believe by hearing themselves talk. When people publicly take a position, their commitment to that position increases. The more a person argues for that position, the more they commit to it.

Leader
* The group is designed to be facilitated by one intern clinical psychologist
* The facilitator has 2 years of therapy experience from a CBT perspective
* The facilitator has received specific training in MET, which includes an intensive 2 day training workshop and attendance at a number of seminars about the use of MET with various patient populations.
* The facilitator receives ongoing supervision in MET by an experienced Clinical Psychologist.

Structure of the Current Program
* Groups run for four sessions that are held weekly.
* Each session is generally 1 - 1.5 hours in duration. A brief break can be taken during the session if required
* The sessions are incorporated into the inpatient group therapy program, with all patients attending. However, only those patients who sign consent forms are incorporated into the research study.
* All patients who consent to the research component will complete a battery of psychological measures prior to entering the group, again at completion of four sessions and after a six week follow-up period.
* Once an individual has completed the four sessions, s/he is unable to continue to attend the groups, whether or not s/he is a participant in the research study.
* The groups are open, in that all patients enter the group during their first week in hospital and complete four sequential groups. Hence, different patients complete the program in different orders depending on the week they commence the session.

Participants
* All patients in the inpatient eating disorders unit are eligible to attend the groups (see caveat below).
* All those patients entering the program will therefore have met criteria for a primary diagnosis of any eating disorder (Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder Not Otherwise Specified (EDNOS)). It is
also common for patients to have co-morbidities, for instance, depression, anxiety disorders, substance abuse and personality disorders. Patients with these (and many other) co-morbid diagnoses are not excluded from the groups. However, in line with hospital policy, patients who are experiencing severe medical complications due to their condition, are detoxifying from drugs/alcohol or are acutely psychotic are excluded from the groups.

* Group size generally ranges from 5-10 participants.

**Group Arrangements**

* Groups are incorporated into the timetable of group therapy sessions.
* Groups are run in one large therapy room with a whiteboard.

**Overview of Standard Inpatient Treatment**

The MET intervention runs concurrently with the standard inpatient treatment at a private Sydney hospital. This standard program is structured around group therapy sessions run by a multidisciplinary team. Psychotherapy groups address direct eating disorder variables, as well as varying types of problems such as self esteem, interpersonal and family relationships. The primary therapeutic approaches are Cognitive Behavioural Therapy, Dialectical Behaviour Therapy and Psychodynamic approaches. Creative expression groups, planning groups and nutrition groups are also run. Additionally, patients have individual meetings with a dietician; psychiatrist and/or psychologist weekly and nursing staff closely supervise their meals. Staff communication is achieved through a comprehensive multidisciplinary ward round that takes place weekly and informal daily communication as relevant.

**Assessment**

According to Miller and Rollnick (2002), a strength of most MET studies, is the use of multi-modal measurement. This tradition will be continued in the proposed study, which intends to utilise the following reliable, well-validated (where available) self-report questionnaires assessing a number of realms, as well as physical measures to evaluate treatment outcome.

**General data:**
- Diagnosis as determined by the treating psychiatrist
- Comorbid diagnoses
- Demographic data including number of previous hospitalisations for a mental illness, estimated duration of illness, age, education, marital status, employment status, ethnicity, family structure etc.

**Weekly measures:**
- Physical variables e.g. weight, BMI
- 3 Contemplation ladders assessing areas of potential change (based on Rieger et al, 2000)
Pre and Post Treatment measures:
- Physical variables e.g. height, weight, BMI
- Eating Disorder Inventory II (EDI-II Garner et al 1991)
- Eating Disorders Examination – Questionnaire (EDE-Q; Fairburn & Beglin, 1994)
- Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Rieger et al, 2000)
- Beck Depression Inventory II (Beck et al, 1996)
- Decisional Balance Scale for Anorexia (Cockell, Geller & Linden, 2002)
- Self Efficacy Scale (based on the work of Rieger et al, 2002)
- Likert scales of treatment engagement (based on Rieger et al, 2002)
- Working Alliance Inventory – modified (WAI; Horvath & Greenburg, 1989 – administered post only)

Six week follow up:
- Physical variables e.g. height, weight, BMI
- Eating Disorder Inventory II (EDI-II)
- Eating Disorders Examination Questionnaire (EDE-Q)
- Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ)
- Decisional Balance Scale for Anorexia
- Self Efficacy Scale

Reading


---

**OVERVIEW OF THE GROUP - SESSION BY SESSION OUTLINE**

**General Tone of the Current MET Program**

In addition to the particular strategies outlined in the session guide, the MET approach relies on particular therapeutic principles which underpin all assessment and therapy sessions. Miller and Rollnick (2002) described the fundamentals of the motivational approach as incorporating a collaborative partnership between the therapist and client; eliciting, rather than attempting to
instill motivation within a client; and affirming the client’s right to autonomy. The authors also described the four broad principles that underlie such a method:

1. Express empathy and acceptance through reflective listening
2. Develop discrepancy between present behaviour and general goals, between self concept and behaviour
3. Roll with resistance
4. Support self efficacy, hope or optimism

Details about these principles, which are adhered to throughout the assessment and therapy program, can be found in Miller and Rollnick (2000).

Treasure and Ward (1997, p.104) in their paper about the practicalities of motivational interviewing in the anorexia population provided the following therapeutic guidelines:

<table>
<thead>
<tr>
<th>DO</th>
<th>DON’T</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Let patients present the argument for change</td>
<td>• Argue, lecture or persuade with logic</td>
</tr>
<tr>
<td>• Start with the patient’s (not the therapist’s) concerns</td>
<td>• Assume an authoritarian or expert role</td>
</tr>
<tr>
<td>• Focus on eliciting patient’s concerns</td>
<td>• Give expert advice at the beginning</td>
</tr>
<tr>
<td>• Use open ended questions</td>
<td>• Order, warn or direct</td>
</tr>
<tr>
<td>• Emphasise personal choice and responsibility</td>
<td>• Do most of the talking</td>
</tr>
<tr>
<td>• Negotiate goals and strategies</td>
<td>• Get into debates or struggles</td>
</tr>
<tr>
<td>• Explore and reflect patient’s perceptions</td>
<td>• Make moral judgements, preach or criticize</td>
</tr>
<tr>
<td>• Use empathetic listening selectively</td>
<td>• Ask closed ended questions</td>
</tr>
<tr>
<td>• Reflect feelings, concerns and self motivational statements</td>
<td>• Ask a series of questions in a row</td>
</tr>
<tr>
<td>• Reflect by paraphrasing and summarizing</td>
<td>• Tell the patient that s/he has a problem</td>
</tr>
<tr>
<td>• Reflect statements, rather than questions, starting with ‘you’ as the subject</td>
<td>• Prescribe solutions or a certain course of action</td>
</tr>
<tr>
<td>• Make a short summary of sessions at the beginning and at the end</td>
<td></td>
</tr>
<tr>
<td>• Offer advice and feedback as appropriate</td>
<td></td>
</tr>
<tr>
<td>• Use affirmation and positive restructuring of the patient’s statements to improve self esteem and self efficacy</td>
<td></td>
</tr>
</tbody>
</table>

Table 1

The current program aims to adhere to these guidelines within the group setting.

Session Outline

The following is an overview of each of the four group sessions. The reasons for using these particular sessions will be outlined in detail in the thesis accompanying this research. The accompanying booklet contains all relevant handouts.
Each session spells out the procedure for running the program during a given week. Details on the background and principles of the various techniques are not included.

**Session 1:** (Targeted process of change: consciousness raising)
- Discussion of the stages of change model
- Homework: Exercise about how they have changed in the past

**Session 2:** Understanding (and undermining the) Functions of the Eating Disorder

**Session 3:** (Targeted process of change: consciousness raising and self evaluation)
- Values exploration card sort task
- Values assessment worksheet – ammended to – how does this fit in with the...
- Homework: Death bed question: If you were on your death bed thinking about your life, what experiences do you think would stick out as most meaningful to you? Is your ED involved in these experiences?

**Session 4**
(Targeted process of change: consciousness raising and self evaluation)
- Decisional balance exercise about eating disorder with group discussion
- Homework: expand upon decisional balance exercise through the writing of letters to the eating disorder.
- Letters to the Eating Disorders as a friend and enemy.

**Session 5:** (Targeted processes of change: consciousness raising)
- Decisional Balance task about change as a group task.
- Group discussion of fears about change and fears of staying the same.
- Exploration of willingness and confidence to overcome the ED
- Homework: Use act stuff here.

**Session 6:** (Targeted processes of change: consciousness raising, self re-evaluation)
- Chairs exercise
- Homework: Looking forward exercise
- Homework: expand upon exercise through writing a letter to a close friend about the future
Session 5: () Physiological Barriers to Change. – Overview of the Keys studys.

Session 6: () Change Plan

Session 7 (Data gathering and review)

Alternatives to the functions of the eating disorder
Functions of the eating disorder – promises of the ed group.
Initial Assessment

Aim:
To explain the rationale for the research, to gain consent and to complete pre-treatment assessment measures.

Materials required:
* Participant information sheet (and parent information sheet if participant under 18 years old)
* Participant consent form (and parent consent form if relevant)
* Pre treatment assessment battery

Points of the session:
Once a patient has consented to participate in the study, the researcher should meet with them to discuss the rationale for the study. Acknowledge the difficulty in overcoming an eating disorder and the confusion and indecisiveness they may be feeling. Briefly discuss how MET has been used in the past and its underlying principles which place the responsibility for change on the patient, not the therapist. Describe how MET is used as a way of the patient investigating their reasons for changing, as well as staying the same, in order to make some decisions about what they wish to do.

An example of what you might say is as follows:

"I appreciate you taking the time to meet with me today. I imagine that it may have been a bit of a struggle adjusting to hospital. Have you managed to have a look at the information sheet? (If not, go through the sheet with them). I guess briefly the purpose of these sessions is not to change you. But I hope that they will help you think about your present situation and consider what, if anything, you might want to do. Nobody can tell you what to do or make you change. I'll be giving you some information and we'll be doing a number of exercises in group. They'll also be some brief exercises for you to do outside of group. Do you have any questions about the groups or the research?"

Ideally, the consent form would already be signed by the patient and/or guardian, however, if it has not been signed, ask the patient to sign the form now.

Explain the questionnaires and encourage them to be open and honest in their responses. Highlight that they should answer with the first answer that comes to mind, rather than deliberating over the responses. There are no right or wrong answers and their individual answers are not going to be discussed with the treatment team (unless legally required e.g. information about the patient being of harm to others or themselves e.g. suicidal). Then leave them for half an hour to complete the questionnaires. On return, check that they are all completed and thank the participant for taking the time to answer them.
Remind the participant of the time and place of the first session. Following the meeting with the participant, the researcher should access the participant’s medical file to obtain demographic, diagnostic and physical measures.

Once the assessment is complete, handwriting a follow-up note to the participant. An example of such a note is as follows:

Dear ________,
I just wanted to let you know that I enjoyed seeing you today and thank you for taking the time to complete all the questionnaires. It took a lot of patience and honesty. I look forward to having you in the groups and hope that they will be helpful for you. The next group is on __________. See you then!
____________ (Therapist)

If the assessment takes place immediately prior to the first group that the participant attends, do not give the letter, but convey this information at the conclusion of the assessment process.
Session 1

Aim:
To introduce the Stages of Change (Prochaska & DiClemente, 1992) and for patients to complete a staging exercise to determine their own stage of change.

Materials required:
* Tape recorder
* Whiteboard and whiteboard marker
* 1:1 Handout on the stages of change model
* 1:2 Handout of staging vignettes
* 1:3 Previous change handout
* 1:4 Handout “Where am I now?”
* Contemplation ladders

Points of the session:

Check homework
* Spend a short period reviewing the self-evaluation exercise. If there is a new group member, briefly explain that this is a task that everyone was given last week, and that when they do that group, they will have more of an understanding about this. Apologise for any confusion that they may currently have about the exercise when people talk about it.
* The task was the death bed question (see session 4).
* Ask “What stood out as being the most important thing/s that you wanted to be remembered for?” “Do the things that you want to be remembered for match what you are currently struggling with and beating yourself up about?” If no, “Is it fair to say that what some of the things that are really important to you at the moment, are not actually the things that you hold to be important in the big scheme of things?”

Introduction to the Stages of Change Model
* Distribute Handout 1:1
* The Transtheoretical model is explained with words and diagrams on the white board. One way to introduce the topic is as follows¹:

Draw the following diagram on the board as you explain the stages:

---

I want to talk a little with you about the way people change their behaviours. Can anyone think of a specific problem that they’ve resolved in the past? Chances are that you’ll remember that the resolution didn’t happen immediately or all at once, but that the solution took time and changed over time. Perhaps for a while you ignored the problem, then you considered tackling it, after that you made definite plans to change. Then once you’d got together all your resources – mental, physical, and social – you acted on and began to struggle with the problem. If you succeeded, you worked at maintaining that and if you failed, you probably gave up for a time, then went back to the drawing board.

In or out of treatment, people seem to pass through similar stages as they work on making changes. This goes for many kinds of changes. The same stages seem to apply to people who want to stop smoking, stop their drinking, or to normalize their eating. All of these stages are predictable and well defined. They each include a series of tasks that need to be completed before someone is ready to move onto the next stage. It is also possible for people to become stuck at a certain stage. However, it is useful to understand these stages so that you can gain control over the cycle of change and move through it more efficiently. As we go through these stages, I want you to think about a behaviour that you successfully changed on your own and remember how you went through the various stages.

The first stage of change is called the “Precontemplative stage”. During this stage people are not thinking about making a change. They are either unconvinced that they have a problem, or are unwilling to consider changing it. Often people in this stage may deny or not be aware that there’s any problem even if their families, friends, doctors and therapists can see that there’s a problem.
Often people in this stage would prefer to change the nagging from the people around them, rather than changing themselves. They don’t want to think, talk, or read about their problem.

When people start thinking about their situation, they begin the second stage called the "Contemplation Stage." During this stage, people are "unsure" about what to do. People in this stage also struggle with the good and not-so-good things that might come with change. They are considering the possibility to change, but are not ready to take action just yet.

At some point, when people have been thinking through whether or not to change, they may come to feel that the reasons for change outweigh the reasons not to change. As this evidence increases on the side of change, the person becomes more determined to do something. This is the beginning of the next stage, called the "Preparation Stage." During this stage, people begin thinking about how they can go about making the change they desire, making plans, and then taking some action toward stopping old behaviors and/or starting new, more productive behaviors.

During the next stage of change called the "Action Stage" people begin to implement their "change plans" and trying out new ways of being. Often, during this stage people let others know what's happening and look for support from them in making these changes. This is the stage that requires the greatest commitment of time and energy.

Once people have succeeded in making and keeping some changes over a period of time they enter the "Maintenance Stage." During this stage, people try to sustain the changes that have been made and to prevent returning to their old ways. This is why this stage is also known as the "Holding Stage." Many times the person is able to keep up the changes made and then makes a permanent exit from the wheel (or spiral) of change. During this stage it is also common for people to have some "slips" or "lapses" where old habits return for a short time.

There is some pretty good evidence that people shouldn't skip stages. Someone that jumps right into the action stage may not spend enough time preparing for change. The result is they have trouble in keeping the changes they've made. For this reason, it is important for you to know which stage you're in and what things you need to do to move to the next stage.

- Reinforce the idea that it is possible to be in multiple stages at once. Validate the difference of the action orientated stance and the difficulty that that must place them in if they are not in the action stage for certain symptoms.

Staging vignettes

Distribute Handout of vignettes. Ask for a volunteer to read each vignette. After each scenario, ask group members which stage they think applies. Give hints as needed and refer them to the diagram on the white board and on Handout 1:1.

1. Jane gets tired of everyone nagging her to stop smoking. "Why don’t you leave me alone?” she says. It’s bad enough that they made cigarettes so expensive, and now she can’t smoke in restaurants either. At work she has to go outside to smoke and she thinks, “I can’t get any work done without a ciggie. How do they expect me to finish this project on time if I have to keep coming outside to think?” [Precontemplation]

---

2 Taken from Velasquez et al (2001).
2. Joseph is proud of himself. He has gone 2 weeks without a drink. He has started hanging out with new friends who don’t drink either, his work has improved and his boss has even noticed a difference. When he threw out all the alcohol from his house a couple of weeks ago, he wasn’t sure he’d last. Even though he’s tempted to go to the bar, so far he’s resisted the urge. [Action]

3. Maria wonders whether the info that caffeine can hurt your baby is true. She has been drinking 5 cups of coffee a day forever. It hasn’t done anything to her before. Still, she hasn’t been able to sleep properly since she became pregnant, and her stomach gets nauseous after one cup of coffee. She thinks that maybe she should consider cutting down. [Contemplation]

4. Mike has been thinking about becoming more fit, but he hasn’t been able to start exercising like he used to. He has done a few sit ups a few mornings over the past couple of weeks, and he has pumped up the tires on his bike. He has asked some friends who go to the gym what their routine is. After lunch today, though, he took a nap rather than working out like he’d planned. [Preparation]

* After the explanation, ask whether the Stages of change model makes sense. Ask for the patients’ reactions to the explanation about the stages of change.
* Ask participants if the model is applicable to how they identify their readiness to change with regard to their eating disorder.

Exercise on a behaviour changed in the past

* Distribute Handout 1:3 and ask patients to think of a time where they changed a behaviour in the past. It might have been a difficult situation e.g. changing jobs etc.
* Ask patients to fill in their behaviours and attitudes at each stage
* Invite patients to share their examples with the group

Group discussion of stages of change for various ED behaviours

* Participants are asked to consider which stage of change corresponds to their present situation. Explain that they may be at various stages for different behaviours e.g. they may be in Action to stop vomiting, but in contemplation regarding dieting. This section may take some time and can be completed as a group brainstorming exercise.
* Ask patients to list some of the things that they are required to change in hospital. Various symptoms to focus on include weight gain, binge eating, eating normally, purging (decrease or abstain), preoccupation with food and excessive exercise.
* Instruct patients to read the cues on the handout to decide which stage (or stages) they are in for each symptom
* Lead a group discussion about patients’ reactions to this exercise. Remember to roll with resistance, avoid argumentation or persuasion and express empathy.

Distribute Homework exercise
• Distribute the handout 1:4 and explain the task

**Group closing**

Participants should be asked the following questions in turn.

Can you think of one thing that you learnt during that exercise?
One thing that you want to remember and keep hold of?
Session 2

Aim:
To foster an awareness of the incompatibility between current eating disordered behaviour and more deeply held values.

Materials:
* Tape recorder
* Whiteboard and whiteboard marker
* 2:1 Values list handout
* 2:2 Homework Decisional balance handout
* 2:3 Homework letters task handout
* Small coloured cardboard cards (5x4 cm each – 11 per patient)
* Contemplation ladders

Points of the session:

Check homework
* Spend a short period reviewing the self-evaluation exercise. If there is a new group member, briefly explain that this is a task that everyone was given last week, and that when they do that group, they will have more of an understanding about this. Apologise for any confusion that they may currently have about the exercise when people talk about it.

Values Task
* Introduce the topic of values by asking patients what they think personal values are. Explain that the things people value can be thought of as being the things that are most important in their lives, or the things they hold most dear. Point out that what is valued by one person, may be of little importance to another.
* Distribute Handout 2:1

* Patients are asked to make a list of the ten most important things they want in their life including values and goals.
* Some examples include a family, good career as a ________, travel, honesty, integrity. Ask the patients to list their values in as concrete terms as possible.
* Handout ten coloured cards to each patient and ask them to write one value on each card and place the cards in order of importance
* Ask patients to discuss with the group the reason why they chose those values and goals
* Ask “Is there anything missing from these values?” “Could they be improved in any way?”

Adapted from Feld et al (2001)
* If patients can think of ways to improve, then the improvement is added merely by them being aware of it i.e. it is obviously something that they do value. This reinforces the idea that all our values are acceptable.

* After this, give the patients the final card and ask them to write down what their eating disorder represents to them e.g. control, escape, thinness etc.
* Instruct patients to place this final card amongst the other cards based on its importance.
* Lead a group discussion about their current value-behaviour consistency, and the patients’ evaluations about the role that the ED plays in achieving and/or preventing value-behaviour consistency.

* Discussion prompts include:
  “How will you be able to fulfill your goals and values on the course that you are on?”
  “If you believe that there is a connection between losing weight and attaining your other goals, how does it work out in practice?”
  “Is thinness achieving these goals now?”
  “Where does this leave you now?”
  “Where do you go from here?”
  “What opportunities do you have to make your behavior become more in line with your values?”

* [It is important to note that in EDs, it may be relevant to support the patient’s ED goal e.g. attractiveness, control, however, it may be useful to make clear that it is the means, rather than the ends, which are at issue (Killick & Allen, 1997).] i.e. Are there other ways of achieving this?

The following exercise can be done in session, if time, or moved to homework:

**Decisional balance exercise about the pros and cons of the eating disorder**

* Distribute Handout 2:2
* The therapist should introduce this exercise to the group. The following lines of inquiry may be useful:

I imagine that there are a whole lot of things that the ED helps you with. It makes sense that it would develop because it is useful in a way. Let’s try and come up with a list of some of the ways that the eating disorder has helped you in your life. (write “The good things about the ED” on the white board and probe patients for responses. You may need to prompt with questions like
In what ways has your ED helped you physically?
In what ways has your ED helped you emotionally?
In what ways has your ED helped you with relationships?
In what ways has your ED helped your family life?
In what ways has your ED helped with other difficult problems in your life?
In what ways has your eating disorder helped your social interactions?
What other ways has the ED helped you?
* After a number of the pros of the ED have been generated, the therapist should summarise and reflect the points. Each participant is asked to write the group points on their handout and rate each benefit on how important it is to them on a scale of 0-5 (0 = least important and 5 = most important). The group is then asked to brainstorm a number of the “not-so-good things” about having an eating disorder”. The therapist should write these on the board. The less good things are explored in more detail with requests made for examples of Less Good behaviour.


For example, “(Name), you said that your ED has affected your family. Can you share with the group a time when that happened?”

* The therapist summarises and reflects the “not-so-good” features of the ED. Following this, each participant then rates the group’s points using the 0-5 point Likert scale.

* The following discussion should be held about the “package deal” of the ED. So, we’ve acknowledged as a group that there are some good things about the ED AND that there are some other, not so good things about the ED. I wonder where this leaves each of you now? (pause). So, when you take all of these into account, I want you to have a think about how the ED is as a “package deal”. It may be a pretty good package deal, or it may be a not so good package deal. If it is not looking so good as a package deal, are the not-so-good things enough to make you want to change at the moment? And if you think that it is a good package deal, that’s okay, it may be that it is working for you. Is anyone in this boat? And if the ED is working for you, I’d like to pose another question: Would you be pleased if your own daughter someday, decided to live the same way? Why?

* If the participants disagree with this question, the following statement could be made:

So it’s not that you think this is necessarily the right or the best way to live, it’s just that, all things considered, it seems to beat the other alternatives that are available at the moment.

* Each group member is then asked to reflect on this exercise and the therapist should provide reflection and summaries of the discussion.

Self reflection task for between session completion:

* The homework exercise expands on the decisional balance group exercise. It should be introduced as follows:

I imagine that most of you would both agree and disagree with some of the good things and not so good things that we discussed as a group and I also imagine that there are other good things and not so good things about your ED that you did not share with the group for a number of reasons. They may be private, they may have seemed silly, and they may be embarrassing or something else. Other patients have found it useful to think about the good things and not so good things privately on their own. A way of doing this, that is, a way of thinking about how the
ED affects you is to write two letters to your ED. Firstly write a letter to it as a friend. Then write a letter to your ED as your enemy. You can share these letters in our next session if you wish to talk about it, or you could discuss it with your doctor, or you can choose to keep them totally private. Also, it may be helpful to conduct a pros and cons list on your own, just like we did as a group. Any questions?

* Distribute sheets for letters exercise (Handout 2:3).

Group closing

Participants should be asked the following questions in turn.

Can you think of one thing that you learnt during that exercise? One thing that you want to remember and keep hold of?
Session 3

To examine future plans in order to see how the ED fits with those.

Materials required:
* Tape recorder
* Whiteboard and whiteboard marker
* Handout 3:1
* Handout 3:2
* Contemplation ladders
* Three chairs

Session details:

Check homework
* Spend a short period reviewing the self-evaluation exercise. If there is a new group member, briefly explain that this is a task that everyone was given last week, and that when they do that group, they will have more of an understanding about this. Apologise for any confusion that they may currently have about the exercise when people talk about it.

For those of you who were in this session last week, I asked you to write two letters. Does anyone have any comments or questions about that? It is great that you took the time to do that, as it may have been a difficult experience, but it’s great that you put in that effort to think about the possibilities and functions. After writing these, how convinced are you that you ED is your friend or enemy?

Three Chairs exercise – past, present and future
* Place one chair in the centre of the room and ask for a volunteer
* The chair represents the “here” or “present” of that person’s situation regarding their eating disorder.
* The individual’s understanding is then elicited through the use of MI strategies (e.g. Reflections and summaries) and with the addition of bringing in the other group members’ input
* Prompting questions include:
  - Can you tell me a little about where you feel that you’re at? How is it for you currently in terms of your ED? Prompts may include asking them about various aspects of their life e.g. physically, emotionally, relationships, family life, value-behaviour consistency, problems in life, social life.
  - Is this how it is for the rest of you?

* Then place a second chair some distance to the side of the first and invite (not tell) the patient to move to that chair. This chair becomes the “past”. That is, a time before the ED became a major factor in their life or when

---

4 Adapted from Farrell (2001) The use of motivational interviewing techniques in offending behaviour group work. *Motivational Interviewing Newsletter, 8,1, 8-12.*
things were going well. The goal is for the patient to gain some perspective from the immediacy of her current circumstance and to observe how things have changed over time.

* Explorations of this chair include:
  What is the time gap between this chair and the present?
  What was it like in the past when the ED was not an issue?
  What do you remember about this time?
  What good memories, hopes, dreams and plans did you have?
  What are the differences between there and the present chair?

* If the individual’s history is very negative, it is still useful to explore what it was like, to establish the situation prior to the ED. MI strategies can be used to reflect on this time, e.g. “it must be difficult for you to imagine what it might be like without the ED. You’re afraid that it may be like it was before.”

* The individual then moves back to the present and a brief summary, with group participation, follows.

* The patient is then asked to move to a third chair, the “Future”
* In the spirit of MI, the given the choice of discussing a future with the ED or without the ED. Following their first explanation, they then complete a discussion about the alternative (ie with / without ED). Note: If the patient’s goal is to become the best anorexic patient ever or if they are unable to imagine a future without the ED, use MI strategies to reflect and summarise.
* A further exploration is facilitated before returning to their Present and a brief summary of the exercise follows.
* The participant is thanked for being so open and helpful with the group.

Homework - Future times letters or goal exercise
* Distribute Handout 3:1 – Looking forward and Handout 3:2
* Introduce the homework task as a way of further thinking about where you might want to be in the future and explain the task as per instructions on handouts.
* Patients are encouraged to complete one or both of the two exercises. If they like lists, then they may want to do Handout 3:1, but if they prefer the emotions of a letter, they can complete the exercises on Handout 3:2.

Group closing

Participants should be asked the following questions in turn.

Can you think of one thing that you learnt during this session?
One thing that you want to remember and keep hold of?
Session 4

Aim: To examine the costs and benefits of changing the ED and to explore both importance and confidence in changing.

Materials required:
* Tape recorder
* Whiteboard and whiteboard marker
* Handout 4:1
* Handout 4:2
* Handout 4:3
* Contemplation ladders

Points of the session:

Check homework (10 min)
* Spend a short period reviewing the self-evaluation exercise. If there is a new group member, briefly explain that this is a task that everyone was given last week, and that when they do that group, they will have more of an understanding about this. Apologise for any confusion that they may currently have about the exercise when people talk about it.

Decisional balance exercise about change (40 min)
* Introduce the exercise as follows:

I guess that at the moment, you are struggling with the decision about whether or not you want to change your current ED situation. This choice is yours, and yours alone to make. Other patients have told me that they often have important reasons to fear changing their familiar ED way of life AND that at the same time a part of them is desperate to shake themselves out of the pattern that keeps the ED going. It is impossible to keep of these thoughts and ideas together in our head since our memory has limits and so there’s a tendency to swing from one side of the argument to the other. Today we will work through a balance sheet to see systematically whether you are ready to take the journey to change. Everyone struggles with these reasons, and you may decide, after examining the reasons, that change is not necessarily worth it at the moment. That’s okay, but the use of this exercise is to make sure that the decisions that you make are weighed up and thought about carefully.

* Hand out balance sheet (Handout 4:2) to each participant and write the following on the white board.
Disadvantages of change and recovery


Reasons to give up ED


* Allow patients 15 minutes to fill in the handout
* Examples of answers on the balance sheet taken from Schmidt and Treasure (1999) include the following:

<table>
<thead>
<tr>
<th>Reason to give up ED</th>
<th>Disadvantages of change and recovery</th>
</tr>
</thead>
</table>
| Practical gains for self  
I will look healthier | Practical losses to self  
I will become very frightened about my weight |
| Practical gains for others  
I will be able to concentrate and do a better job at work  
I will be less irritable | Practical losses to others  
My mood may swing more  
I will need support from parents |
| Self approval  
I won’t have to lie about food and how much I eat | Self disapproval  
I will hate my body |
| Social approval  
My parents will stop worrying that I’ll die | Social disapproval  
I may become assertive and that could disrupt the status quo of my relationships |

* Prompt group for their answers to each of these. Summarise and reflect the patients’ comments as appropriate.

Exploring importance and confidence about change (30 min)

* The therapist should draw the following scale on the board:

```
0  1  2  3  4  5  6  7  8  9  10
```

* Then ask the group “at this very second, how much out of 10 are you wanting to completely overcome your ED?
* Ask for feedback from each member and write their name above the corresponding number.
* Use this number to elicit change talk by asking them why they chose a given number and not a lower one (e.g. why 6 and not 4?)
* Ask them if they have ever been at 0 or 1 and ask what is different now.
* If a patient is at 0, reflect the difficulty of them being in an action oriented program and ask them if they have ever been higher in willingness to lose the eating disorder. Ask them when this was and what was different to now.
* Ask patients who are at higher levels to discuss what has made them increase in motivation
* Ask them what they might need from themselves, their family, friends, doctor, therapist, nurses etc to move their willingness higher.

* Then re-do the exercise with “confidence” to change should they decide that they want to.

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Not at all confident</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Prompt questions include:
  o “Can you see yourself being more confident in the future? How will that happen?”

* Review the rationale for the exercise as follows:

Two useful concepts that help people decide to make a change is that they think that it is important to change and that they are confident that they can change if they chose to do so. I don’t know whether or not you have made any decisions about changing your eating disorder, and I’m not here to force you to change, but I do know that previous patients have found it helpful to have a think about these two concepts of importance and confidence of change in order to help them make informed decisions either way.

**Homework exercise (5 min)**
- Distribute Homework sheet Handout 4:3 and explain the exercise.
Death bed question: If you were on your death bed thinking about your life, what experiences do you think would stick out as most meaningful to you? Is your ED involved in these experiences?

**Group closing (5 min)**

Participants should be asked the following questions in turn.

Can you think of one thing that you learnt during that exercise?
One thing that you want to remember and keep hold of?
Post Treatment Assessment

**Aim:**
To complete post-treatment assessment measures.

**Materials required:**
* Post treatment assessment battery

**Points of the session:**
The participant should be thanked for continuing to take part in the research study.

An example of what you might say is as follows:

"I appreciate the time that you have put into attending our groups. I hope that have been useful in helping you to think about your present situation and consider what, if anything, you might want to do."

Explain that you have some questionnaires for them to complete again. Explain each questionnaire and encourage them to be open and honest in their responses. Highlight that they should answer with the first answer that comes to mind, rather than deliberating over the responses. There is no right or wrong answers and their individual answers are not going to be discussed with the treatment team (unless legally required e.g. information about the patient being of harm to others or themselves e.g. suicidal) and leave them for half an hour to complete them. On return, check that they are all completed and thank the participant for taking the time to answer them. Remind them that you will post them some further questionnaires for them to complete in 6 weeks with a freepost reply envelope.

Following the meeting with the participant, the researcher should access the participant’s medical file to obtain further diagnostic and physical measures.
Handout 1:1
The Stages of Change

- **Precontemplation**
  - “I don’t think that there’s a problem”

- **Contemplation**
  - “I want to stop feelings so stuck and confused”

- **Preparation**
  - “I’m getting ready to change”

- **Action**
  - “I’m working hard to change”

- **Maintenance**

- **Relapse**
Handout 1:2

What stage are the following people in for their behaviour according to the Stages of Change Model?

1. Jane gets tired of everyone nagging her to stop smoking. “Why don’t you leave me alone?” she says. It’s bad enough that they made cigarettes so expensive, and now she can’t smoke in restaurants either. At work she has to go outside to smoke and she thinks, “I can’t get any work done without a ciggie. How do they expect me to finish this project on time if I have to keep coming outside to think?”

_______________________

2. Joseph is proud of himself. He has gone 2 weeks without a drink. He has starting hanging out with new friends who don’t drink either, his work has improved and his boss has even noticed a difference. When he threw out all the alcohol from his house a couple of weeks ago, he wasn’t sure he’d last. Even though he’s tempted to go to the bar, so far he’s resisted the urge.

_______________________

3. Maria wonders whether the info that caffeine can hurt your baby is true. She has been drinking 5 cups of coffee a day forever. It hasn’t done anything to her before. Still, she hasn’t been able to sleep properly since she became pregnant, and her stomach gets nauseous after one cup of coffee. She thinks that maybe she should consider cutting down.

_______________________

4. Mike has been thinking about becoming more fit, but he hasn’t been able to start exercising like he used to. He has done a few sit ups a few mornings over the past couple of weeks, and he has pumped up the tires on his bike. He has asked some friends who go to the gym what their routine is. After lunch today, though, he took a nap rather than working out like he’d planned.

_______________________
Over the next week, it may be useful to take some time to consider where you are at in regards to changing various aspects of your eating. Use the diagram below as a guide. Consider why you may be willing to change some things and not others. If you are wanting to change some factors, what do you need to do to instigate that change? You may wish to brainstorm ideas on the back of this sheet.

**Precontemplation:**
- Not thinking of changing
- Feel that things are fine
- Do not see a problem

**Preparation:**
- Have a plan to change
- May have made some changes
- Can see the benefits of changing the ED

**Contemplation:**
- Thinking of changing
- Wondering how I affect others
- Maybe trying to make small changes

**Action:**
- Have stopped restriction / bingeing / vomiting / excessive exercising etc
- Am avoiding triggers
- Asking others for support

**Maintenance:**
- At a normal weight
- Accepting myself
- Eating "normally"

---

5 Adapted from Velasquez et al (2001).
Handout 1:3

Can you think of a time when you changed a behaviour? You probably moved through all of the Stages of Change and are now in maintenance. For instance, some people go through the stages of change a number of times before they quit smoking. Other examples might be changing the amount of effort that you put into your school work or breaking up with a boyfriend.

In order to see how that process worked, fill in the diagram with the different thoughts and behaviours that you exhibited at each stage of the change process. Refer to handout 1:1 and 1:3 for details.

Behaviour changed: ____________________________________________

Precontemplation:
______________________________________________________________
______________________________________________________________
______________________________________________________________

Contemplation:
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Maintenance:
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Action:
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Preparation:
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
Write down your top 10 values. That is, the qualities that are most important in your life, or those that you hold most dear. What is valued by one person, may be of little importance to another. There are no right or wrong answers - it's up to you. (They don't need to be in order)
Handout 2:2

Other patients have told me that there are some really good things about having their eating disorder and that there are also some “not so good” things about having it as well.

Take some time to consider those things now and write them down below.

The good things about the ED  The not-so-good things about the ED
Your eating disorder can sometimes feel like a boa constrictor that has you in a strangle hold. It can affect your physical health, your psychological health, your social life, your family life, your romantic life, your education and your career.

There are probably some things that your eating disorder helps you with and makes easier.

AND

There may be some things that your eating disorder makes harder or ruins.

Reflection Task:

1. Write a letter to your eating disorder as your helpful friend
   Next, write a letter to your eating disorder as your enemy.

AND

2. Spend some time on your own to complete two lists of the good things and the not so good things about the eating disorder. You may use Handout 2:2 as a starting point.
Handout 3:1

Looking forward

Consider the following questions.

1. Where do I want to be in 6-12 months time? Look at a variety of aspects of your life including social life, working life, emotions etc

2. What is important to me about these things?

3. Why aren’t I there now? What’s holding me back?

4. How is it holding me back?
Handout 3:2 – Looking Forward Letters

Your eating disorder can sometimes feel like a boa constrictor that has you in a strangle hold. It can affect your physical health, your psychological health, your social life, your family life, your romantic life, your education and your career.

How will you cope without your boa constrictor around you? Is it possible for you to imagine life without an eating disorder? What will have happened to your physical health, your psychological health, your social life, your family life, your romantic life, your education and your career?

If you didn’t have the boa constrictor around your neck, who would you be? What do you really believe in? How do you want to live your life? If you had a magic wand, what would you want to be?

Exercise:

1. Write a letter to a good friend, to whom you can be completely honest, five years in the future as though you are free of the eating disorder boa constrictor. Describe how all aspects of your life will be.

2. Now write a letter to your good friend, five years in the future, as though you still have your eating disorder. Describe how all aspects of your life will be.

Adapted from Schmidt and Treasure (1997) – Getting Better Bit(e) by Bit(e)
Handout 4:1
Are you ready to take the journey?

You may have important reasons to fear changing your familiar eating disorder behaviour, and yet part of you may be desperate to shake yourself free from the eating disorder. It is impossible to keep all of those thoughts and ideas together in your head, so there is a tendency to swing from one side of an argument to the other.

Writing a balance sheet will help you to deal with all of your thoughts.

<table>
<thead>
<tr>
<th>Disadvantages of change and recovery</th>
<th>Reasons to give up the Eating Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical losses for myself</td>
<td>Practical gains for myself</td>
</tr>
<tr>
<td>e.g. I will feel bloated and too full</td>
<td>e.g. I will look healthier</td>
</tr>
<tr>
<td>Practical losses for others</td>
<td>Practical gains for others</td>
</tr>
<tr>
<td>e.g. My mood may swing more</td>
<td>e.g. I will be able to concentrate and do better at work</td>
</tr>
<tr>
<td>Disadvantages of change and recovery (continued)</td>
<td>Reasons to give up the Eating Disorder (continued)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Self disapproval</strong></td>
<td><strong>Self approval</strong></td>
</tr>
<tr>
<td>e.g. I will out of control of my life</td>
<td>e.g. I won’t have to lie to people about my eating</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social disapproval</strong></td>
<td><strong>Social approval</strong></td>
</tr>
<tr>
<td>e.g. I may become more assertive which may disrupt my current relationships</td>
<td>e.g. my parents will stop worrying that I’m going to die</td>
</tr>
</tbody>
</table>
Sometimes we get stuck on the merry-go-round of life and keep going as things are without considering what is important to us. It is useful to stop and take some time to think about this issue. By considering the following question and making some notes about your answer below, you will be able to take a step back from that merry-go-round to re-evaluate how things are.

“If you were on your death bed thinking about your life, what experiences do you think would stick out as most meaningful and important to you? Is your Eating Disorder involved in these experiences? If so, how?”

Make some notes about your thoughts below: