Clinician's Guide

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getting better bit(e) by bit(e)

a survival kit for sufferers of bulimia nervosa and binge eating disorders

Clinician's Guide to *Getting Better Bit(e) by Bit(e)*

A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders

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Clinician's Guide to *Getting Better Bit(e) by Bit(e)*

INTRODUCTION

After the publication of our self-help book *Getting Better Bit(e) by Bit(e): A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders*, we were approached by several therapists who told us that they used *Bit(e) by Bit(e)* as a basis of their treatment. We also were using it in our practice. We were therefore interested in finding the optimal method of training our colleagues so that they could use it as part of guided self-care.

The research we had done using the book gave us lots of ideas. With the help of the Mental Health Foundation and the British Council we investigated the effectiveness of *Bit(e) by Bit(e)*. We found that approximately 1 in 5 people with bulimia nervosa could benefit from the manual alone. Another 2 out of 5 benefited if the manual is given in conjunction with therapy.

One of the main factors that limited the use of the manual in our study was poor compliance. For example, only 6 out of 10 people given the book read more than half of it. Only 5 out of 10 people completed 3 or more of the exercises, and less than 4 out of 10 people shared the book with a friend. The group that actively used the book in this way had a much better outcome than those who didn't. Forty percent of those who actively worked with the book became abstinent from all symptoms compared to 5% of those whose compliance was poor.

We were intrigued by these findings. Beforehand, when there was a therapeutic failure we had a tendency to blame ourselves:

- Perhaps we didn't explain ourselves clearly enough?
- Perhaps we were too hard or too soft on our patients?
- Perhaps we didn't provide enough structure or too much, and so on?

Now we could clearly see that a major factor in the success of therapy was the clients' motivation to engage in treatment.

We therefore started to explore ways of increasing motivation. We became interested in the work of Prochaska and DiClemente (1986), two American psychologists who had addressed this issue in the context of various behaviours that raised health concerns (smoking, alcohol). These authors examined the processes by which people change behaviours. Their model fitted theoretically into the style of therapy (motivational interviewing) described by Miller and Rollnick (1991). Miller and Rollnick described how the behaviour of the therapist had a marked effect on compliance with treatment. A confrontational style led to resistance and non-compliance, whereas a supportive empathic response improved compliance. They therefore developed a therapeutic style of interaction which aimed to maximise the clients' motivation to change. This treatment method has been further refined in the field of addiction into motivational enhancement therapy (Miller, Zweben, DiClemente, & Rychtarik, 1992).

The Workbook, *Motivational Enhancement Therapy* (see Appendix, p.CG76), is an excellent supplement to self-care and can provide a framework for "guided self-care". It is aimed at providing the theoretical rationale and practical details of motivational enhancement therapy for bulimia nervosa.

THE THERAPEUTIC RELATIONSHIP

Clients with bulimia nervosa are often markedly ambivalent about treatment. Although they admit readily that their symptoms, particularly the bingeing, cause them distress, there is often reluctance to change, especially if they are asked to contemplate giving up their maladaptive weight control methods.

As a therapist you need to be warm and empathic. Indicate that you want a collaborative relationship. You will need to stress that you will give and want feedback in the sessions. Working with *Bit(e) by Bit(e)*, opens the way for choice. The client can take responsibility for decision-making.

The client with bulimia nervosa may seem open, vulnerable, engaging and charming, and an exciting prospect to work with. However, before

you get seduced into complacency think about the interpersonal schemata that are common in these women. Often, these include polar opposites including the drive to please and rebelliousness, mistrust of others and childlike dependence, and putting people on a pedestal or denigrating them.

At the beginning of therapy, or even throughout the whole of therapy, the client may try to please you and bring back perfect diaries. If the diaries almost seem too good to be true it is worth saying something like: "I have frequently come across clients who try so hard to please the therapist, that they try not to upset them by bringing diaries which show that they haven't been eating regularly or that they have been bingeing frequently. I don't want our relationship to be like that. I will need you to give me accurate feedback on how you are doing. Also, I will want you to do this in the sessions we have together. I may say something that gets you irritated or sad and I hope you will be able to point out if I have stepped on a 'corn' or misunderstood you."

However, the client can quickly switch to another state either within or between sessions when she will become angry, rebellious and non-compliant. At times the client may present like a distraught child begging you to do something; however, in the next session they can appear contemptuous of the suggestions made to help. The therapist can feel exasperated when homework is not done or when the client sneers or complains about the therapeutic strategies. For example, they may bitterly carp on that keeping a food diary will only make their eating worse. They may fail to show up for sessions or phone with last minute excuses. It is all too easy to be cast in the role of a vengeful, persecuting bully. Stop if you feel yourself getting angry or starting to retaliate. Draw back from entering the field as a victimiser. Stop if your patience is being stretched beyond endurance by trying to accommodate erratic sessions or long, frequent phone consultations. There is no need for you to play the role of a resentful victim.

It is important to set the limits of your therapeutic relationship at the beginning. Come to an agreement on how your sessions will be spaced out. Explain to your clients how they can leave messages if a session needs to be cancelled. Let them know that it may take a few days before you can return a telephone call. Be clear about the rules. For example, if they fail to attend for a session without cancelling, then that session will be lost to them.

Understanding the transference and counter-transference is an important part of management. It is important to realise that resistance and denial result from the interpersonal relationship between you and your client and you can do something about it.

INTRODUCING *BIT(E) BY BIT(E)*

The way that you introduce *Bit(e) by Bit(e)* to your client and the way that you use it can be very important. Discuss your mutual expectations about the book. For example, you might want to say something like: "This book describes people who have similar experiences to you. It describes the skills that they have learnt and used to get over their problems. It also includes advice and information that others have found helpful. Many people find it helpful to read it as it stops them feeling all alone." You want to raise their curiosity about how others have coped but not to imply that there is only one way and that they must take your advice and do exactly what you and the book say. Leave an element of choice for the client.

Some of the advantages that they can get from using the book are that they can pace the rate of learning and can make an informed decision about whether or not they are ready for change. Also, the book will be on hand when difficulties arise. Prepare them to be realistic in their expectations about the course of their treatment. Often it is bumpy. They may do very well initially and be full of enthusiasm, but will be blown off course by the next crisis that they encounter. One way to get across this idea is to ask them to consider their eating disorder as an Achilles heel. It is their weak point in response to stress. This does not mean that they are defective in some way. Normalise the stress response for them. For example you can say: "People respond to stress in different ways, some secrete more acid in their stomachs and get ulcers, others may fur up their coronary arteries, yet others use alcohol." You can suggest that unlike people with other stress-related problems they at least have an external marker or sign that they are in difficulties and can do something about it, rather than suddenly collapsing with a heart attack. Thus, the book should always be kept at hand for them to deal with lapses and relapses and should be read at times when they feel that they are slipping.

It is then important to go over some practical details. How much reading will your client be able to do? Will there be difficulties in having time or a place to read the book? Can she set aside some time every day or on certain days of the week? Will she want or be able to show it to a friend or a member of the family? Also, you need to indicate that the book will be an integral part of the next session. Tell her that you will review the workbook exercises with her the following week. Ensure that in your sessions you will review all the homework, jottings and ideas that they have had over the week. It is important to familiarise yourself with the content of *Bit(e) by Bit(e)* so that you can tailor your assignments to the client you are working with. It is important to adjust

the chapters and activities in the book to the stage of motivation of your client (see later).

THEORETICAL BACKGROUND ABOUT BEHAVIOUR CHANGE

An influential concept that has emerged from observations of the process of behaviour change is the transtheoretical model of Prochaska and DiClemente (1986). According to this model, behaviour change is conceptualised in two dimensions: the motivational aspect or "stages of change", and the activities brought into play to achieve the goal, so-called "processes" of change. These authors have defined five stages of change:

- precontemplation;
- contemplation;
- preparation/determination;
- action; and
- maintenance.

These represent various levels of motivation. Thus *precontemplators* are not interested in considering change and indeed fail to acknowledge that they have a behaviour which needs to be changed. At this stage, information rather than advice on action is appropriate. Parents may ring up in distress and crisis because they have noticed that their daughter is vomiting. Occasionally, these clients then get brought to the clinic by their families.

In the *contemplation* stage individuals are willing to examine the problems associated with their eating disorder and consider the implications of change, but are unlikely to take action. At this stage, they are more open to education. However, they need to resolve the ambivalence they have about wanting to change. This means identifying the negative aspects of their present behaviour and making sure that they are willing to give them up. This stage can lead into the *preparation / determination* stage in which there is readiness to change, a desire for help but often difficulty in knowing what to do.

In the *action* stage, the individual has made a commitment to change and may have begun to modify her behaviour. This is a time of great stress and there is a need for support and encouragement from professionals and from their social network. Relapse prevention techniques are useful once an individual is in the *maintenance* phase.

The actual process of change is not a simple linear progression as just described; instead, individuals oscillate between stages. Prochaska and

DiClemente (1992) use the model of a revolving door with some individuals going around several times before achieving their long-term goals.

FACILITATING CHANGE

Pitching Your Interventions at the Right Level

This model has implications for treatment, in that it is important to match your intervention to the client's stage of change. For example, it is no use offering a client with bulimia nervosa advice on how to eat regularly unless she has reached the action phase. A mismatch between the intervention promoted by the therapist and the stage of change of the client leads to resistance (Rollnick, Kinnersly, & Stott, 1993).

Motivational enhancement therapy addresses where the client is on the cycle of change and assists the person to move through the stages toward successful sustained change. For this approach the contemplation and determination phases are the most critical. The objective is to help clients address two basic issues:

- The first is how much of a problem their bulimia poses for them and how it is affecting them both positively and negatively. Tipping the balance of the pros and cons of bulimia towards change is essential for movement from contemplation to determination. In the contemplation phase, the client assesses the possibility of change and the costs/benefits of changing the problem behaviour. Clients consider whether they will be able to make a change and how that change will affect their lives.
- The second is that individuals who have made unsuccessful attempts in the past need encouragement to go through the cycle again. In the determination stage, clients develop a firm resolve to take action. This resolve is coloured by past experiences with attempts at change.

Understanding the cycle of change can help the therapist remain empathic rather than frustrated about the level of clients' motivation and it also provides a rationale to help them provide direction in their interventions.

Other Factors

Not only do we need to consider how motivated people are to change but how confident they feel in their ability to undertake the work that is necessary to bring about change. Clients who have very low self-esteem have difficulty thinking that they can do anything about the situation. If people have been brought up to have very little autonomy in their lives

they may find it difficult to believe they have the skills and confidence to do anything about it. If people have clinical depression they may lack the judgement, motivation and skills to make progress.

ESSENTIALS OF MOTIVATIONAL INTERVIEWING

Several observations have suggested that therapists can and do influence motivation to change. Therapist expectancies for client change have been shown to influence client compliance and outcome. Therapists differ markedly in their "client retention rates". When clients are randomly assigned to therapists, their outcomes differ substantially depending on the therapist to whom they are assigned. By changing their therapeutic style between confrontational and client-centred approaches, therapists can drive client resistance both up and down. Client-resistance behaviour is in turn predictive of failure to change.

Simple actions such as a follow-up note or phone call by therapists can double the probability that clients will return for further treatment after an initial or missed session. Therapist empathy is associated with more favourable client outcomes. Therefore, motivation can be thought of not as a client attribute but as an interpersonal process between therapist and client. In conclusion, research clearly demonstrates that the interaction between therapist and client powerfully influences client resistance, compliance and change.

Miller and Sanchez (1994) reviewed many different forms of brief therapies and found that six components were common to them all and these could be subsumed under the acronym FRAMES.

F-Feedback Personal feedback regarding the client's individual status rather than blanket summaries.

R-Responsibility An emphasis on the individual's freedom of choice. "It's up to you: you're free to decide to change or not. You're the one who has to do it if it's going to happen."

A-Advice Clear recommendation or advice on the need to change in a supportive and concerned rather than authoritarian manner.

M-Menu A variety of options or solutions offered to the client.

E-Empathy An empathic, reflective, warm and supportive counselling style.

S-Self-efficacy A style that reinforces the expectation of change.

Also, most brief interventions include follow-up contacts which may reinforce change even if solely conducted for research.

In part, some of the lessons from this meta-analysis have been incorporated into motivational enhancement therapy. This in turn uses motivational interviewing as the form of therapist-client interaction. An

outline of the essentials of motivational interviewing is shown in the following section.

GUIDELINES FOR MOTIVATIONAL INTERVIEWING

General Principles

1. The goal is to improve intrinsic motivation to change rather than impose change externally.
2. Develop a discrepancy between present behaviour and broader goals; between self-concept and behaviour.
3. Express empathy and acceptance by selective reflective listening.
4. Support self-efficacy, hope or optimism.
5. Improve self-esteem.
6. Readiness to change is a product of the therapist and client interaction.
7. The therapeutic relationship should be collaborative.

Do

1. Let the client present the arguments for change by articulating and resolving her ambivalence.
2. Start with the client's (not the therapist's) concerns.
3. Focus on eliciting the client's concerns.
4. Emphasise personal choice and responsibility for deciding future behaviour. Negotiate goals and strategies.
5. Explore and reflect the client's perceptions.
6. Use empathic reflection selectively with a spin towards change.
7. Reflect feelings, concerns and self-motivational statements.
8. Reflect with a statement starting with "you" as the subject.
9. Summarise periodically.
10. Make a short summary of sessions at the beginning and end of each session.
11. Offer advice and feedback where appropriate.
12. Use positive restructuring of the client's statements to improve self-esteem and self-efficacy.

Don't

1. Argue, lecture or persuade with logic.
2. Assume an authoritarian or expert role.
3. Give expert advice at the beginning.
4. Order, direct, warn or threaten.
5. Do most of the talking.
6. Get into debates or struggles over diagnostic labelling.
7. Make moral statements, criticise, preach or judge.

8. Ask questions to which the client gives short answers.
9. Respond to a client's response to an open-ended question with another question.
10. Ask a series of questions (three or more) in a row.
11. Tell the client that she has a problem.
12. Prescribe solutions or a certain course of action.
(Adapted from P. Hayward personal communication.)

One of the principles of this approach is that head-to-head conflict is unhelpful. What is more helpful is a collaborative, shoulder-to-shoulder relationship in which you and the client tackle the problem together. The client's motivation to change can be enhanced by using a negotiation method in which the client, not the practitioner, articulates the benefits and costs involved. Education and confrontation can lead to resistance, whereas empathy and support can facilitate the behaviour change.

THE GOAL OF THE THERAPEUTIC ALLIANCE

One of the first steps is to establish where exactly your client is on the road to change. Does she understand what change might entail? Is she willing to accept some costs? For example, a client with a strong genetic predisposition to obesity who maintains her weight in the normal range only by tightly restricting her diet and vomiting, may be prepared to sacrifice her health to prevent herself becoming obese. She will be reluctant to give up the methods of weight control she has discovered.

Your job is to try to gently lead your client along the pathway of change. As a guide or teacher it is useful to remember a philosophical point noted by Pascal and observed by educationalists since this time, "people are generally better persuaded by reasons they have discovered themselves than by those given by others". Your task as a therapist is therefore to act as a facilitator to help the sufferer discover for herself the reasons why she might want to change and perhaps, just as importantly, the reasons why she may not want to change.

Progress can only take place when you have helped your client resolve this ambivalence. This is the subject of chapter 1 of *Getting Better Bit(e) by Bit(e)*, which is called "The Way Forward".

A motivational enhancement therapy approach has the assumption that the responsibility and capability for change lie within the client. Your job as a therapist is to mobilise the client's inner resources as well as those available within the client's natural helping relationships.

As a therapist you need to use the five basic motivational principles as defined by Miller and Rollnick (1991):

1. Express empathy
2. Develop discrepancy

3. Avoid argumentation
4. Roll with resistance
5. Support self-efficacy

1. *Express Empathy*
The relationship with the client should communicate respect. Although at times you will need to act as a knowledgeable consultant for the most part you will need to be a supportive companion. The emphasis is on the client's decision to change or not, although you should provide a subtle undertow in the direction of change. Reflective listening underpins this component of therapy.

2. *Develop Discrepancy*
The drive to change can be fuelled when the client recognises a discrepancy between where she is and where she wants to be (i.e. *vis-à-vis* her personal goals and aspirations). Motivational enhancement therapy aims to enhance and focus the client's attention on to such discrepancies. You probably will need to develop a discrepancy by helping the client to become aware of the consequences of her abnormal eating pattern.

3. *Avoid Argumentation*
Handled poorly, ambivalence and discrepancy lead to defensive coping strategies such as stubborn negativism. So, having friends and family who critically point out to a sufferer what she is doing to herself may not be helpful. Your job and skills should be to let the client voice the adverse effects of bulimia and to devalue the positive effects.

4. *Roll with Resistance*
Resistance will emerge time and time again. Don't try to fight it down, rather try to explore in more detail the underlying ambivalence by reflective listening.

5. *Support Self-efficacy*
Try to foster an environment that nurtures optimism so that change can occur. Emphasise environmental or prognostic factors that engender hope. If you do not provide this a discrepancy crisis will lead to defensive coping (rationalisation or denial). This is a natural and understandable protective process. If one has little hope that things can change, there is little reason to face the problem.

Reflective Listening

This is an essential skill in motivational interviewing. It is the foundation upon which all other skills are built and is a safe fall-back whenever you are stuck. When done well it looks deceptively easy but

it is a demanding skill. It involves having a hypothesis-testing approach to listening. A good listening response tests your hypothesis. However, the best type of reflective listening response is a statement although this may seem presumptuous and strange at first. The best word to help you get started with reflection is "you". For example, use the following stems at first:

- So you feel...
- It sounds like you...
- You're wondering if...
- You....

However, motivational interviewing differs from client-centred counselling in that you are trying to put a spin on your reflections so as to point your clients into the direction of change. You want to help them discover the negative aspects of their behaviour and come up with self-motivating statements. You want to help them explore the positive reinforcers and to see whether they might be able to think of alternative ways of getting the same effect.

THE FIRST MEETING

There are two phases to treatment: building motivation for change and strengthening commitment to change. Even if your client appears to be committed to change it is worthwhile going through all the initial stages so that you can see the strength of the motivation and consolidate the commitment.

This phase is to tip the motivational balance in favour of perceived benefits of changing eating patterns. One of the major strategies is to elicit self-motivating statements.

Self-motivating Statements

Motivational psychology has found that if people are enticed to speak and act in a new way their beliefs and values shift in the direction. Thus, one of the first steps to get change is to foster an environment in which the client will be able to articulate her desire to change. This has some grounding in self-perception theory, which suggests that people learn what they believe by hearing themselves talk (Bem, 1967).

It may be helpful to start the interview by using some of the following questions to get the client to define her problem. However, it is not a good idea to just have a battery of questions which you fire at your client like a machine gun. Reflective listening is important after each question. This will help the client know that she is understood. Therefore, after

the answer in each domain either repeat, paraphrase or summarise her response. Whenever possible try to capture the emotional tone as well. Avoid, whenever possible, asking more than three questions in a row.

1. *Problem Recognition*

- What do you think is your problem?
- Are other people worried about you?
- What are they worried about?

2. *Concerns*

The following are the stem questions that can be helpful in structuring the beginning of your interview:

It helps me if I can break up your concerns into small areas.

- In what way has your eating disorder affected your physical health?
- In what way has your eating disorder affected your psychological health?
- In what way has your eating disorder affected your family life?
- In what way has your eating disorder affected your social life?
- In what way has your eating disorder affected your romantic life?
- In what way has your eating disorder affected your education and career?
- In what way has you eating disorder affected your financial security?
- Some people find that their eating disorder gets them into trouble with the law. Has that happened to you?

Here is an example of an extract of dialogue:

Therapist: Do you have any concerns about how your physical health may have been affected by your eating disorder?
Client: Well, there is the problem about my teeth.
Therapist: You are concerned about them. (STATEMENT)
Client: Well yes, I am aware that I have had problems for several years, they have been very sensitive to cold drinks. Over the last few months I have had two or three fillings drop out. I have been to the dentist and I have two to three hundred pounds' worth of work that needs doing.
Therapist: Your teeth have suffered the effects of your eating disorder. (STATEMENT) What do you think will happen if you don't make a change?

If there are difficulties in eliciting clients' concerns you may find it helpful to be the devil's advocate and take the voice of your client's resistance.

Therapist: Can I tell you one concern I have? This treatment requires a fair amount of motivation from people and frankly I'm not sure from what you have told me that you are motivated enough to go through with it. Do you think we should go ahead now or wait a little until you have had time to reflect more about it?

Listening with Empathy: Reflective Listening

The foregoing details how you can encourage your client to start talking, but how you respond to her is of great importance. The therapeutic skill of accurate empathy (Rogers, 1957) is of great importance. The therapist listens carefully to what the client is saying and then reflects it back, often in a modified or reframed form with some acknowledgement of the client's expressed or implicit emotion.

This skill of reflective listening has many advantages. It gives the client feedback that she has been listened to and understood. This technique can build up empathy and lead the client to feel supported. This builds up a good working alliance. This method also acts to clarify what the client has said and so can reinforce ideas put forward by the client. The key element of motivational interviewing is to put a spin on the reflection by using it selectively. You can reinforce certain statements and ignore others. You will obviously want to highlight the statements that tip the balance towards change. Thus, clients will not only hear themselves articulate a self-motivating statement, but also, they will hear you saying that they said it and perhaps also see it written down in a feedback letter. If the client is very ambivalent you need to address this with a double-sided reflection acknowledging the other side of the balance. If possible use the word "and" to join the two statements rather than "but". Here are some double-sided reflections:

- Your bulimia gives you a sense of being in control and at the same time you recognise that you are getting further into debt.
- It is confusing, you are aware of the dangers to your health arising from your bulimia and you worry what would happen to your weight if you gave it up.

Reflective listening in this manner is not easy. Perhaps the use of the word "reflective" is poor as it implies that you are being a blank mirror