Stages of Change: Guiding Clinical Work and Promoting Clinician Self-Care in the Treatment of Eating Disorders
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Objectives
• Overview of Stages of Changes and ways to utilize in the assessment process of eating disorder treatment.
• Clinical interventions to utilize in eating disorder treatment targeting each Stage of Change.
• Utilizing Stages of Change to reduce compassion fatigue.

Experiential Activity
Overview of the Stages of Change

History of Stages of Change

- This trans-theoretical model was originally developed in the late 1970’s/early 1980’s by James Prochaska and Carlo DiClemente as part of a smoking cessation study.
- It was noticed that change did not happen in one step but that the change process could be categorized into stages. This becomes a framework utilized in our work for how to work with the process of change.

Processes of Change (Prochaska)

- Consciousness Raising (Increasing Awareness)
- Dramatic Relief (Emotional Arousal)
- Environmental Reevaluation (Social Reappraisal)
- Social Liberation (Environmental Opportunities)
- Self Reevaluation (Self Reappraisal)
- Stimulus Control (Re-engineering)
- Helping Relationship (Supporting)
- Counter Conditioning (Substitution)
- Reinforcement Management (Rewarding)
- Self Liberation (Committing)
Self-efficacy and Motivation

• Self-efficacy is your belief you have about your ability to achieve X result and motivation is related to your desire to achieve X result (drive).
• In ED work, you can see a client come in with a high level of motivation for recovery. However, what is their self-efficacy?
• WARNING! You might have a highly motivated client with a high level of self-efficacy but…what do their labs say/daily decisions around food and what does this mean for assessing the appropriate level of care?

Moving From One Stage to Next

A visual...

Stages of Change

• Pre-contemplation:
  - What problem? Oh...that little thing?
  - Others see it and express concern. Present to treatment based on some external pressure or imposed consequence. Change might be evident while pressure from others is “on.” However, behaviors will return once the pressure is no longer present. Generally, no intention to quit within the next six months.
Stages of Change - cont.

• **Pre-Contemplative - cont.**
  
  In ED work, you start to work to:
  
  - Build Mind/Body Connection
  - Noticing Contrast: noticing when a behavior does not meet a goal/when not-engaging in a behavior was “not so bad”
  - Identifying discrepancy: Finding “the buts”
  - “Going With”: Understanding ED motivation
  - Finding other values
  - Validate where they are at
  - Defensive/Resistant as a persona—who is the real person?
  - Connecting to group

  *Be careful not to “push” (comes from our emotion). Heighten awareness. Coordinate with other providers/supporters of treatment.

Stages of Change - cont.

• **Contemplation:**
  
  - “Teeter/Totter”
  - Able to identify that there is something you would like to change but not yet ready. Starting to think of the pros and cons to the problem and/or change and will tend to overvalue the benefits of the problem or overvalue the risks of change. There is an intention to quit but generally not within the next 30 days.
  - Assess the areas they might be willing to commit to in order to start change. In ED work, it’s important to set some structure/expectations, but allow flexibility within that.
  - Avoid cheerleading: Use a paradoxical intervention when defense around change comes into the room.

Stages of Change - cont.

• **Preparation:**
  
  - “I am ready! Let’s go! Wait...I’m nervous.
  - A combination of intention to change with small behavioral changes being made, for example, in substance abuse work, you might see a reduction in use. In eating disorder work, you might see them start increasing variety of foods consumed. Intention to quit in the next 30 days
  - In ED work, starting to learn new coping skills/start hearing about application, build a support system, starting to grocery shop, might start reporting less intense active ED behaviors.
**Stages of Change - cont.**

**Action:**
- “The Little Engine that Could.”
- Involves a modification of behaviors, experiences, and the environment as part of putting intention for change into action. This phase can occur from someone who is able to alter a behavior for one day up to 60 days.
- In ED work, successfully implementing skills into practice to shift away from behaviors. In ED work, you often see “body image” trying to pull the train backwards down the mountain. You will start hearing about motivation from values other than ED values. You will start to see an individual connect to their “observer self” - noticing ED and recovery voice. (authenticity).

**Stages of Change - cont.**

**Maintenance:**
- You have learned to “surf.”
- This is not a static phase or abstinent of change. It is a constant continuation of change. It typically occurs after six months in the action phase and can occur indefinitely.
- In ED work, you start to assess that the ED part is shrinking. Meal plan is being followed consistently, self-image is more consistently neutral or positive with an overall ability to tolerate struggle. You are working with someone who can identify as a 500 piece puzzle vs. a 30 piece puzzle.

**Stages of Change - cont.**

**“Spiral Pattern of Change”**
- The Stages of Change can be misunderstood as a linear model. However, the model has evolved to account for relapse and how this can be conceptualized as part of the model. After relapse, some individuals return to pre-contemplation, for various reasons (shame, guilt, frustration, rewards, new trauma, etc.) while others return to another Stage of Change.
- ED starts to “speak up” again. No longer is ED a passenger in the car; ED starts to drive again.
Case Review
A 31 year-old Caucasian female presents to treatment with an eating disorder; restricting, binge/purge, over-exercise, excessive caffeine consumption, and laxative use. She reports that she recently stepped down from a higher level of care. She has a history of self-harm and substance abuse with neither of those “coping skills” being utilized in the last 2-3 years. She reports that she has not binged and purged in the last 2 months as she sees these behaviors as “bad.” She is following her meal plan about 50% of the time (not restricting) generally saying her meal plan is “too much” but aware that is ED talking, regularly engaging in compulsive movement (“no big deal”), and using caffeine daily (“I know the dietitian does not like it”).

- How would you describe her overall Stage of Change/specific Stages of Change?

What Constitutes a Relapse in ED and a Reassessment of the Stage of Change?

- This can sometimes be tricky in ED work! Can be a variety of behaviors. Examine the thoughts/intentions/motivators around behaviors.
  - Why did someone not follow the meal plan?
    - EX: An extra cookie looked good vs. lack of control/restricted all day so body was desperate for food.
  - Some indicators of relapse:
    - Starting to determine own meal plan (negotiation).
    - Increased obsessive thoughts about food/body.
    - ED starts to take on more “value” over other values.

ASSESSMENT
What Does Assessment of Stage of Change Look Like in ED Treatment?

• Upon intake:
  ➢ What brought them into treatment?
    ▪ Internally or externally motivated?
      – It could be both, and, in addition, the Stage of Change could be different for different behaviors. i.e., motivated to stop purging but not restricting. Conceptualize the work looking like a “decision tree.”
      – Utilize the external motivation to help build the internal motivation. Oftentimes, in ED treatment, children start as the motivator for treatment.

What Does Assessment of Stage of Change Look Like in ED Treatment?

• In ED treatment, it can be easy to see the “sickness” and refer too quickly to a higher level of care, and lose the client from treatment completely (particularly first time treatment seekers) without being willing to start to work with them where they are at (internal motivation).
  – Ex: Husband wants wife to stop purging, and wife wants to feel better about her life.
  – Utilize support of a medical doctor and dietitian to help determine how long you can work with a person to help them build their motivation for more intensive care.

“Miss” Assessment Factors

• Client is under-aware or unaware to the extent they are ambivalent.

• A great desire for support/help = pressure for expression of more readiness for change.

• Readiness for change might differ by behavior.
**Initial Phase of Treatment**

- If they are stepping down from a higher level of care, pay attention to picking up on the Stage of Change they want to be at, and the reality. “Perfectionism” can create a disconnect with reality.
- If they are “new” to treatment, they often need more structure provided in treatment and psycho-education about ED regardless of motivation.
- Work with them to start to create space between their authentic self and the ED as part of the change process.
  - Which side of brain does ED speak from?
- Remain cautious about moving too quickly with people in the preparation phase.
  - This phase of change can be underestimated.

**Ongoing in Treatment**

- Constant assessment of Stage of Change.
- Constant assessment of medical risk (with collaboration of dietitian and medical doctor).
- Be careful about getting complacent based on how they presented yesterday or last week. The “slippery slope” can start quickly, particularly because they are changing their relationship with their “drug of choice” not abstaining from it.
- Continual assessment of awareness of risks/benefits/plan around taking the next steps in recovery.
- Assess the core: perfectionism, shame, control, care-taking, fear, trauma...

**Assessment Tools**

- Scaling Question
  - 1-10 with 10 being strongly motivated for change
  - What keeps it from being a 10?
  - What makes it a “3” and not a “1”
- URICA-Psychotherapy Version: 32 items/free and on the public domain/need to be clear as to the “problem.”
- “Readiness and Motivation Interview” by Geller and Drab
- Interviewer Stance: Acceptance and Curiosity
CLINICAL APPLICATION

Clinical Application: Pre-contemplation

Clinical Interventions:

- **Building Awareness**
  - Readings: Facing Codependency by Pia Mellody, Life Without ED by Jenny Schafer
  - Goals and Commitments/DBT HW/Content vs. processed oriented while tailoring reflections to help connect emotion to acting out on ED.

- **Creating Emotional Arousal**
  - Externalizing ED
  - Body scan/emotion check-in (‘I don’t know’ is a common answer)
  - Building connection
    - Small group work/meetings
    - Intentional seating arrangements

- **Environmental Evaluation: Impact of ED on self and others**
  - Life Story
  - Family group work/family sessions
  - Grief Work
  - “Noticing” Activity between sessions

Clinical Application: Contemplation

- Regularly explore emotions/ambivalence/beliefs that dissuade change.
- Practice skills in session.
- Allow for “coaching” in between sessions.
- Work with individuals to develop an “observer self” and maintain hope for recovery despite struggles through parts work.
- Work with individuals to learn ways to describe their experiences while shifting away from judgment. Judgment feeds ED.
- Create awareness of “wounded child/adapted adolescent/functional adult” and ED self split from recovery self.
- Clinical Interventions: DBT/ACT-Skills training, pros/cons work, “A year in my life in recovery” (creating positive outcome expectations).
Clinical Application: Preparation

- Exploring expectations around change. (ED motivated or recovery motivated)
- Buffer up resources. (internal/external)
  - Guided imagery, internal connection to values etc...
- Preparing for ED's voice to start yelling! (Body image)
  - Mountain Analogy
- Strengthening individual’s connection to emotion/distress tolerance skills and recovery voice.
- Working with an individual to “embrace” the emotion ED will trigger vs. react to it.
- Clinical Interventions: Internal resourcing, fear “ladder”, shame work. (scales)

Clinical Application: Action

- It is not as easy as it looks!
- Perfectionism for the client can re-trigger/fear of “failing” at recovery, so it remains important to check-in about struggles. This phase is not struggle free.
- Normalize struggles that might come up. Normalize that the ED voice is still present.
- Re-label understanding of urges to engage to ED.
- You can start to really “dig in” to core struggles and traumas that helped create ED, as appropriate, while maintaining awareness of where ED is at in the room. You will start to see them create change around core struggles.
- Strengthen awareness around the positive payoffs being experienced (internal and external)
- Clinical Interventions: Trauma timeline, letter to “Wounded Inner Child,” Empty Chair work (exercise), Top ten list (body image).

Clinical Application: Maintenance

- Operate from a framework of relapse prevention.
- Stay connected to client’s history/triggers to ED and bring to awareness any “blind spots.”
- Prepare for potential triggers:
  - Weddings, pregnancy, transitions...
- Be aware of your own relationship with food and body to avoid pushing a client to what maintenance “should” look like around normal eating.
- Normalize/Encourage check-in with motivators/skill reinforcement.
- Interventions: Relapse Prevention Plan, Recovery Advocate (letters/in person), Strengthening of engagement in recovery values.
The Processes of Change

Processes of Change – cont.

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<th>Tasks</th>
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<td>Dramatic Relief, Emotional Experience</td>
<td>Life Story, Body Scan, Reflect emotions (infer)</td>
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<td>Social Liberation, Awareness of how others support recovery</td>
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<td>Stimulus Control</td>
<td>Stimulus Control, Reminders/Cues for Recovery, Promote self-awareness</td>
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Reflective Statements

- What is reflection?
  - Rephrase
  - Infer
  - Analogy
- You are attuned to the client. You get them. Conversation is deepening.
Case Example

- A 19 year-old college athlete presents to treatment because her team and her medical doctor have concerns about her health and have stated that she cannot return to playing her sport until she receives treatment. She expresses anger about being asked to be in treatment. Some of her initial statements include:
  - I am tired of everyone telling me what to do.
  - I am getting mixed messages from different providers, and X provider is telling me that I am fine to play my sport.
  - I don’t want to be here.

ART WORK

“Road Map” to recovery (body image)
SELF-CARE

Clinician Self-Care Through the Stages of Change

• What are some factors, in being human beings, that get in the way of providing effective care?
  – Judgment
  – Counter-transference
  – Emotions (overwhelmed/frustrated)
  – Our language: Resistant, Manipulative, not motivated, etc.
  Now we feel stuck!

Clinician Self-Care Through the Stages of Change - cont.

• First step:
  – What “Stage of Change” is this individual in, and what “Stage of Change” do I want them in?
  – What motivates this disconnect in ED work?
    • Fear for client’s life
    • Overwhelmed by client’s treatment needs
    • Responsibility for client’s recovery (not to recovery)
    • Counter-transference
    • Hope for client’s life
Clinician Self-Care Through the Stages of Change - cont.

- Clinician “Role”: How are you “being” in what you are “doing.”
  * There are 3 entities in the room—you, the Stage of Change, and the client.*

- Pre-contemplative:
  * Detective: Listening for the barriers to change/blocks/possible motivators to change.
  * Curious George: Approach from a place of wondering.
  * The “mirror” in Snow White: Reflection as a way to build awareness.

Clinician Self-Care through the Stages of Change - cont.

- Contemplative:
  * Pendulum: Go with the movement of the client.

- Preparation:
  * Financial Consultant

- Action:
  * Coach

- Maintenance:
  * Supporter

How is This Helpful?

- Creates a safe therapeutic environment. Clients with ED often have a high frequency of being/feeling “controlled” through others and ED.
- Creates attunement between yourself and the client.
  — A high level of “being alone”/“nobody gets me.”
- Creates an authentic relationship.
  — ED is about lack of authenticity.
- Creates the ability to work flexibly vs. rigidly.
  — ED is rigid!
- This sounds like an enjoyable working environment!
Preventing Compassion Fatigue

1. Know your own relationship with food and body.
   - “FORCH”
   - What Stage of Change do I want them in/where are they?
2. When you feel a disconnect, where is that coming from?
3. Reconnect with your “role”/identify what role you have taken on (caretaker, fixer, listener, etc.).
4. Shift away from a need to “do” and work to “be.”

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References

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