

Application of Prochaska's transtheoretical model of change to patients with eating disorders

Gregor Hasler^{a,*}, Aba Delsignore^a, Gabriella Milos^a, Claus Buddeberg^b, Ulrich Schnyder^a

^aPsychiatric Department, Zürich University Hospital, Zürich, Switzerland

^bDivision of Psychosocial Medicine, Zürich University Hospital, Zürich, Switzerland

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Abstract

Objective: Although eating disorders cause severe somatic and psychological sequelae, a majority of affected patients are not motivated for treatment. The aim of this study was to assess stages of change in patients with eating disorders and to analyze their correlations with clinical characteristics and treatment processes using Prochaska's transtheoretical model of change. **Methods:** A consecutive sample ($N=88$) including outpatients suffering from anorexia ($n=29$), bulimia ($n=32$), and eating disorders not otherwise specified ($n=27$) was recruited from an eating disorders clinic with a low-threshold access. The patients' readiness to change their eating behavior was assessed by a self-rating scale (URICA), and a score for each participant on each subscale (precontemplation, contemplation, action) was derived from the scale. Patients were introduced to a set of eight treatment processes over the course of four treatment sessions. During the four sessions, therapists rated whether or not

patients appeared to be using each of the treatment processes. **Results:** While diagnostic subtype, age, illness duration, and previous treatments were not associated with motivational stages, self-referral was positively correlated to treatment motivation. Emotional involvement, specific behavioral change processes, and beginning a continuing treatment were correlated with more advanced stages of change. **Conclusion:** This study supports the notion of the stages of change as an independent dimension that is relevant for the treatment of eating disorders. The lack of impact of previous, presumably nonspecific treatments on the stages of change underlines the importance to assess and to improve specifically patients' motivation. Therapeutic work towards the mobilisation of emotions with regard to their eating problem as a means to improve readiness to change should be examined in future studies.

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Introduction

One of the most striking phenomena in patients with eating disorders is their lack of motivation for treatment. Even when confronted with the potentially severe sequelae of their disturbed eating behavior such as retardation of emotional development or osteoporosis, a majority do not show cognitive insight or emotional reactions concerning their physical and psychological health [1]. The impact of this lack of motivation is serious: it is estimated, for example, that over 90% of bulimic subjects are not under adequate treatment [2], whereas anorexic patients were found to be even

less motivated and more often referred by others for treatment than patients with nonanorexic types of eating disorders [3]. Motivation for treatment appears to shift over the course of illness, increasing with age, illness' duration and years of treatment [3]. Although there is a convergence of recommendations for enhancing motivation in the scientific literature including psychoeducation, examination of advantages and disadvantages and exploration of personal values [3], only a few attempts have been made to evaluate those strategies [4,5]. Prochaska's transtheoretical model of change [6] was proposed as one of the most promising theoretical frameworks to develop and test specific techniques aimed at enhancing motivation for change [7].

The transtheoretical model of change [6] is a higher order theory of psychotherapy and recognizes that people do not make a black or white decision to change their behavior. It rather holds that behavior change is a gradual process, divided into phases. These are termed the "stages" of change

* Corresponding author. 15K North Drive, Room 300C, MSC 2670 Bethesda, MD 20892-2670, USA. Tel.: +1-301-594-0234; fax: +1-301-402-6353.

E-mail address: g.hasler@bluewin.ch (G. Hasler).

or “the when to change”. The “processes” of change or the “how to change”, are the overt and covert activities an individual engages in to modify thinking, behavior or affect in relation to a problem. Finally, the “level” of change or the “what to change” describes the kind of psychological problems that are targeted by the processes of change comprising symptoms, maladaptive cognitions, interpersonal and intrapersonal conflicts.

The transtheoretical model has been successfully applied to a variety of health behaviors such as smoking cessation [8], panic disorder [9], weight control [10], fat intake [11], and exercise acquisition [12]. While the concept of the stages of change applies to a variety of health behaviors, no single trajectory of change processes was observed for all health behaviors, and, therefore, process–stage relationships should be examined for each health problem separately [13].

Patients with eating disorders show different levels of motivation to change different aspects of the eating disorder. They may be highly motivated to stop binge eating but not at all prepared to consider changing their strict dieting behavior; this complicates the application of the transtheoretical model of change to eating disorders and the measurement of readiness to change of eating disorders [4,14,15]. Furthermore, the treatment may modify stage–process relationships: a randomised controlled trial on treatment of cognitive–behavioral (CBT) versus interpersonal therapy (IPT) for patients with bulimia nervosa found stage of change as a predictor of the response to IPT, but not to CBT, possibly due to motivation enhancement through directly addressing eating disorder symptoms across the 19 CBT sessions [16]. Interestingly, stage of change did not predict dropout.

The aim of this study was to test whether scores on the various stages of change correlate with use of specific processes of change (e.g., self-reevaluation, feedback, stimulus control) in patients with eating disorders treated in a psychiatric primary care setting. Because treatment has been found to influence the use of change processes [16], we assessed change processes observed under a defined treatment condition. We hypothesized that (1) advanced stages of change would be positively associated with bulimic symptoms, patients’ age, illness duration, previous treatment experiences and self-referral to treatment, and (2) the stages of change would be associated with specific processes of change as predicted by Prochaska et al. [17].

Method

Setting

Subjects were recruited from the eating disorders clinic of the Psychiatric Department of the University Hospital of Zurich, Switzerland. Although this is a specialised facility, a referral by a physician or a psychiatrist is not required to provide a low-threshold access. Patients are typically am-

bivalent with regard to treatment; they are frequently encouraged or even urged by their parents, siblings, teachers, superiors or friends to seek professional help. To strengthen their motivation, they are requested to schedule an appointment for an intake assessment by themselves through a telephone call. The waiting time for the first appointment ranges from 1 to 4 weeks. Treatment costs are fully covered by health insurance, which is mandatory for Swiss residents.

During the first session patients were asked to participate in a four-session program comprising evaluation and treatment components, regardless of their clinical status (in case of emergency they would be referred to their family doctor or to the Emergency Department of the Zurich University Hospital). They were informed that after this program some would not need any further treatment, some would need continuing outpatient treatment, and some would be admitted for inpatient treatment. Patients were also informed that our facility is able to provide both outpatient and inpatient treatment for a limited number of patients (circa 50%) and that we collaborate with other specialised clinics and external therapists to provide adequate treatment for all patients. All patients were aware of the nature of the study and written informed consent was obtained from all participants during the first session.

Sample

We collected a consecutive sample of 96 subjects who went through a routine intake evaluation between June and December 2001. Exclusion criteria were the absence of an eating disorder (two subjects), and insufficient proficiency in German (three subjects). Three subjects refused to participate in the study. Thus, the final sample comprised a total of 88 subjects. For the diagnostic procedure we used a structured interview (see measures) and DSM-IV criteria [18].

Measures

For the *diagnostic evaluation*, two psychiatric residents experienced in the assessment of eating disorders applied a short version of the semistructured therapist interview at the beginning (TIB) developed by experts on the basis of existing measures (EDE, SCID, Disc, SIAB) for the Europe-wide COST Action B6 Project [19]. *Stages of change* were assessed using the 24-item self-report University of Rhode Island Change Assessment Scale (URICA) [20], an instrument designed to measure the precontemplation, contemplation and action stages on scales ranging from 1 to 5. This is a measure developed for use with any problem behavior. In an introduction we explained to the patient that the expression “problem” in the questionnaire referred to the disturbed eating behavior of the individual patient. The English version was translated into German. The psychometric characteristics of the German version of the URICA are described in Ref. [21]. Because of the complexity of eating disorders patients usually have several problems concerning their

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