Experiencing Eight Psychotherapy Approaches Devoted to Eating Disorders in a Single Day Workshop Increases Insight and Motivation to Engage in Care

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Research Article

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Abstract

Purpose

For patients with eating disorders (EDs), early engagement in care is usually considered as a positive prognostic factor. The aim of the present study is to investigate how a single-day intervention devoted to an early experiential exposure to a variety of psychotherapy approaches, supports transition to specialised care and commitment to change in patients with EDs.

Methods

One hundred and sixty-nine outpatients newly diagnosed with an ED took part in a single-day workshop for groups of up to 10 patients, where they discovered and experienced eight psychotherapeutic approaches. Motivation to change care, and level of insight were assessed at baseline and 10 days after the intervention.

Results

Motivation and commitment to take active steps toward change (expressed by the “Committed Action” composite score) significantly improved after intervention ($p<0.001$), and a significant number of patients specifically moved from “contemplation” to “action” stage ($p<0.001$). The improvement of motivation to change is significantly associated to an increase of insight capacity ($p<0.001$), and this for almost all dimensions.

Conclusion

A single-day session devoted to experiencing a range of group psychotherapies increased patients’ insight and motivation to actively engage in care. Further studies including different factors and long-term outcomes evaluation may be necessary to better establish which aspects are specifically involved in patients' increased motivation for care and confirm potential longer-term benefits of this intervention.

Level of evidence

Level V: Opinions of respected authorities, based on descriptive studies, narrative reviews, clinical experience, or reports of expert committees.

What Is Already Known On This Subject?

Patients with eating disorders show a lack of insight into their disorders and ambivalence towards care, which prevents them from engaging and staying in care pathways. This adversely affects treatment effectiveness and often results in a severe, *chronic form of the disorder*. In addition, delaying the provision of care for individuals with newly diagnosed eating disorders, mainly due to long waiting

lists, has a negative impact on care outcomes. Early motivational interventions are potentially improving outcomes, but studies on novel, initiatory interventions are still scarce.

What this study adds?

This study adds information about understanding of how to engage newly diagnosed patients in addressing their internal (e.g. ambivalence) and external (e.g. waiting times for access to appropriate treatment) difficulties in engaging in care. Thus, it provides specialized eating disorders units and services with opportunities for continuing to evolve and promote recovery preferences and needs of the individuals they serve.

1. Introduction

Eating disorders (EDs) are serious mental disorders of multifactorial origins that negatively affect patient's physical health and psychosocial functioning. They have high rates of co-morbidity, mortality and health service utilisation [1–6]. The effective treatment and management of these disorders remain unsatisfactory, in particular in patient with anorexia nervosa (AN), and prognosis in adults is poor [5, 7–11].

Eating disorders (EDs) are often characterised by denial of troubles [12, 13], ambivalent motivation for change and treatment, as well as a low rate of help-seeking [5, 13–16], which may be related to a lack of insight [17, 18]. Increasing the focus on motivation to change before treatment, and at the onset of it, in particular during the first three years of the disease, was reported to play a major role in therapeutic engagement, reduced drop-out from psychotherapy and to predict outcome [19–25]. Furthermore, despite the stressed importance of early identification and intervention of EDs, waiting times for access to specialised treatment are often long [26, 27]. Long waitlists result in failure to engage and adversely affect treatment outcome and patients' attitude to their illness [28]. Thus, it seems essential to increase the range of early psychotherapy interventions that allow patients to be rapidly connected to care, with a particular focus on motivational dimensions facilitating early behavioural changes [24, 29–31].

Different psychotherapies enjoying empirical support have been used in eating disorders and could therefore be included in such initiatory intervention. Examples include: Cognitive behaviour therapy (CBT) [21, 32, 33], comprising acceptance- and mindfulness-based interventions [34–37]; Family therapy [38, 39]; Cognitive Remediation Therapy (CRT) [40, 41]; Motivational Interviewing [42]; Psychoeducation intervention [12, 43]; Psychodynamic approach [44] and art therapies [45, 46].

In this perspective, we developed an intensive whole day single-session intervention. Its rationale was to address the need to engage patients in treatment soon (from one to two weeks) after two days of assessment in a specialised outpatient assessment centre for eating disorders and to provide them with the opportunity to experience eight different psychotherapy approaches devoted to eating disorders, while they wait for the organisation of the proposed treatment options. To the best of our knowledge, no prior

studies have examined the impact of a single, stand-alone session, aiming to bridge the gap between the diagnosis stage and the setting up of care.

The goal of the current study was to test such novel intervention assuming that it would be an innovative “first fast” step into care, facilitating access and commitment in specialized treatment of users with newly diagnosed eating disorders. More specifically, we tested if this single-day workshop provides treatment-seeking users a better understanding of their disorder and helps them to move from a "*potential and theoretical interest*" in psychotherapy treatments available in our specialised centre, to a "*concrete decision*" to engage in care, more specifically reflected by the “Committed Action” composite score of the URICA, already used to explore the impact of psychotherapies, including in patients with ED [47, 48]. We therefore generated the hypothesis that (1) the intervention would significantly increase the “Committed action” motivational score; as well as (2) the insight capacity.

2. Materials And Methods

2.1 Participants

The study utilized data collected in routine care. Consecutively admitted patients in a specialised centre for assessment of an eating disorder between 18 November 2018 (launch date of the intervention) and 8 March 2020 (start date of the first pandemic-related lockdown which forced the intervention to be suspended) were assessed for eligibility and enrolled (n=208). Inclusion criteria were: diagnosis of an eating disorder, based on DSM-5 criteria [1], and a Body Mass Index (BMI) >16. Exclusion criteria were: severe malnutrition requiring acute care, and non-French-speaking.

Our study was undertaken according to the Declaration of Helsinki and the French Public Health Code (Article L1121-1). It was registered in the national Health Data Hub (health-data-hub.fr) (D20-R048 - J3 Psychotherapies). Each patient was informed of the objectives of the study and data anonymity prior to the signature of an informed consent form that systematically confirmed their participation.

2.2 Intervention

The single-day workshop

The intervention was organized into two main steps held in a single day (Figure 2). The first step consisted of a group workshop (7 h) devoted to the experience-based knowledge of eight psychotherapy approaches tailored to suit subjects presenting eating disorders, and typically used in specialised centres: CBT, including Acceptance and Commitment Therapy (ACT) and Mindfulness-based cognitive therapy (MBCT); Motivational Interviewing; Psychoeducation; Cognitive Remediation Therapy (CRT); Family Therapy; Psychodynamic approach and art therapies. The second step, taking place at the end of the group workshop, comprised an individual interview with a clinical psychologist. Its purpose was to discuss the day's activities, identify the approach that best fitted the participant and outline a tailored-

made plan for engaging the user in psychotherapy care (individual/group, hospital/community care, public/private practice…) (Figure 2).

The intervention was conducted by eight senior psychologists, experts in one of the proposed approaches. The duration of each approach-specific exploration activity varied between 45 to 60 minutes. The number of participants was limited to a maximum of ten participants to encourage interaction between participants and with the facilitators. The intervention representing the final step of the patient assessment pathway, it occurred every 2 weeks. Patients attended the session typically within 2 weeks after receiving the diagnosis of an eating disorder.

2.3 Clinical assessment and instruments

Participants were assessed before (T_0) and ten days (T_1) after the intervention. Socio-demographical and clinical data of the study population were collected from the participants' medical records.

At T_0 and T_1, we measured:

Motivation and commitment to take active steps toward change

In order to measure the evolution of participants' motivation we used the University of Rhode Island Change Assessment Scale (URICA) [49–51], French translation [52, 53]. This 32-item self-report inventory is widely used in psychotherapy research for measuring disorder-specific stages of change [47]. The URICA is based on the stages of change model which is a central construct of the Transtheoretical Model (TTM) by Prochaska and DiClemente. This model refers to a range of aims and behaviours that a person experience when deciding and deploying action in order to solve a problem [54]. Authors originally identified four different stages of change [51, 55, 56]: "precontemplation" (P) stage (no intention to make a change emerges); "contemplation" (C) stage (the problem behaviour may be acknowledged, but there is not yet commitment to change, to doubts about one's self efficacy, ambivalence about the need for change); "action" (A) stage (active involvement in solving the problem); "maintenance" (M) stage (active efforts to maintain the improvement and prevent relapse). A number of studied adopted the transtheoretical stages of change model in the field of eating disorders, including AN [57–61].

The URICA scale assesses participants' attitudes on 4 subscales reflecting the 4 levels of change. Each item is rated on a 5-point Likert scale that ranges from "strongly disagree" to "strongly agree". Sub-scores are averaged, and thus the scores range from 1 to 5. Scores are calculated cumulatively and range from eight to forty for each of the subscales. The URICA provides four discrete stage scores, with higher scores indicating greater endorsement of particular attitudes or behaviours. In the present study, we employed the generic 'problem' frame for the items and it does not focus on a specific behaviour associated with eating disorders. Participants are instructed that 'for all statements that refer to your "problem", they have to answer in terms of "eating disorders".

We further used the “Committed action” (CA) composite score, calculated by subtracting the “Contemplation” raw subscale score, reflexing a measure of ambivalence, from the “Action” subscale raw score. This score, ranging from -32 to +32, is considered appropriate to assess motivation for change in psychotherapy treatment-seeking populations. This is because it does not include the “precontemplation” (no recognition of the problem or intention to change) and “maintenance” (focus on maintaining improvements and preventing relapse) scales that may be less meaningful at early stages of therapy [47]. The CA composite score proved to be a good instrument to assess in particular the level of commitment to take concrete action and engage actively in psychotherapy care, including CBT [63] and patients who suffer from eating disorders [48].

Insight

Evidence from previous studies suggests that insight is an important aspect of ED psychopathology and a relevant predictor of treatment outcome in patients with EDs. Its impairment may contribute to poor outcome [17, 64, 65]. Participants’ insight before and after treatment was measured using of Schedule for the Assessment of Insight for Eating Disorders (SAI-ED), a validated questionnaire for the disorder specific assessment of insight in EDs. Improvement in insight after treatment may constitute a meaningful indicator of the treatment efficacy. The SAI-ED is a short, self-reported questionnaire consisting of seven items (Q 1-7), evaluating five dimensions (“awareness of psychological changes”, “recognition of illness”, “awareness of psychosocial consequences”, “awareness of need for psychological treatment”, “relabelling of symptoms”) [64, 66]. We used the French version of this scale (EDI-TCA) [67]. Each item is scored either 0 or 1, the total score ranges from 0 to 7.

Subjective satisfaction and outcomes

Participants’ subjective assessment of the workshop was measured using a satisfaction questionnaire (“Single-day workshop Satisfaction Questionnaire”) including three Likert scales (rating from 0% to 100%). The evaluated dimensions notably included the following: the perceived benefits of the intervention; the relevance of being treated for EDs; the feeling of personal competence to change one’s relationship with the disease. Reliability and validity of the Likert scales was not established.

2.4 Statistical Analysis

Frequencies and descriptive statistics was reported using means and standard deviations. Normal distribution of variables was checked using Kolmogorov–Smirnov test prior to analyses. Student T-tests for paired samples were used to compare URICA scores, including the “Committed Action” composite score, and SAI-ED scores before vs after intervention. Pearson’s correlations were used to evaluate correlations between variables. The significance level was set at $p \leq .05$.

All analyses were performed with the SPSS® statistical package for social sciences version 17.0 (IBM).

3. Results

3.1 Descriptive results

Of the 208 participants initially recruited, 7 failed to attend assessment before the intervention (T0), 201 participated in the single-day intervention, 32 failed to attend assessment for the post-intervention evaluation (T1) and 169 participants were included in the final sample (drop-out rate, 18,7%) (see Figure 1).

Mean age on enrolment was 29.8 (SD=9.5, range: 18-64), 95.9% (n=162) were female, and 50.9% (n=86) were diagnosed with AN, 36.7% (n=62) with bulimia nervosa (BN), 7.1% (n=12) from Binge eating disorder and 5.37% (n=9) from other ED. The mean BMI was 20.8 (SD=6.02, range: 16-40). Mean duration of illness was 10.5 years (SD=7.9, range: 0.5-36) (Table 1).

3.2 Changes in motivation to take concrete action and insight

In accordance with our hypothesis, the composite score “Committed Action” to change (CA) significantly improved after the intervention (t_{168}=8.51, p< .001) reflecting that an increased number of participants committed to take active steps toward change. As expected, the “contemplation” score significantly decreased (t_{168}=2.96, p=.003) and the “action” stage significantly increased (t_{168}=5.86, p<.001), illustrating that a meaningful number of patients specifically moves from “contemplation” to ‘action’ stage. Furthermore, the “precontemplation” and “maintenance” scores did not significantly change (t_{168}=0.38, p=.699; t_{168}=0.61, p=.538) (Table 1; Figure 3).

Participants' global insight significantly increased following the intervention (t_{167}=6.99, p<.001), such improvement being observed for 5 of the 7 concerned dimensions (Table 1).

Finally, we aimed to identify which clinical specificities, based on age, BMI or duration of illness is associated with higher benefit of this workshop, as a way to detect more specific profiles. We therefore proposed these three parameters in a linear regression analysis trying to explain the improvement of the committed action score between the two assessments. Neither age (t=-1.114, p=.267), nor illness duration (t=-0.366, p=0.715) were involved, whereas only a tendency was observed for BMI (t=1.732, p=.085), with better results for higher BMI (Table 3).

3.3 Intervention acceptability and preliminary subjective outcomes

With regard to intervention acceptability, the subjective evaluation (satisfaction questionnaire, T_1) showed that the average level of satisfaction was high. 83.3% of the participants stated that the experience of taking part in the workshop was beneficial and they felt more competent in changing their approach to disease. 85.5% of them considered appropriate to start a psychotherapeutic treatment.

4. Discussion

We evaluated the effectiveness of a single-day workshop with early exposure to a range of psychotherapy approaches for outpatients with eating disorders aimed at supporting transition to and engagement in specialised care. This pioneer intervention in France is an embedded part of the patient assessment pathway of a specialized centre.

In line with our hypothesis, the main results of the present study revealed that this intervention significantly improves motivation to change (raise of “Action” score, p<.001), and insight (p<0.001) of outpatients newly diagnosed with eating disorders. And, more specifically, it strongly increases treatment-seeking patients’ commitment to take active steps toward change (“CA” score) (p<0.001) and thus supports engagement in psychotherapy care and transition between the diagnosis and the following steps of the care pathway [17, 68]. The “precontemplation” and “maintenance” scores did not significantly change. This is consistent with the findings of Pantalon et al. suggesting that these dimensions may be less relevant for patients in psychotherapy care [47].

Furthermore, we observed that, although it was only a non-significant trend (p=.085), BMI impacted the improvement of the Committed Action score, with better results for higher BMI.

Our results are also in line with the model of subjective recovery, which defines recovery beyond symptoms and includes in particular empowerment [69, 70] by promoting knowledge on EDs, autonomy and urge to engage in care. These observations further tend to support the relevance of such short early intervention. They corroborate previous research highlighting that motivation to change may reduce impairment associated with treatment seeking [6, 17]. These preliminary results of a non-randomised, single-centre study need to be confirmed, especially using a randomized, multicentre clinical study.

Limitations

This study has several limitations. The first limitation is the lack of a control group, preventing from definitive conclusions regarding the determinants of motivational improvement and the impact of intervention representativeness. Moreover, self-reported readiness and motivation for change and insight, as well as measures based on patient statements, may be vulnerable to social desirability bias. Additionally, although the URICA is a validated widely used measure to assess motivation to change, other assessment instruments were used in previous studies in the context of AN [71, 72], which might hamper the comparability of studies. Furthermore, only a few factors potentially impacting the effect of the treatment (patients' age, BMI, duration of illness, motivation to change and insight capacity) were investigated. Further studies should establish which additional dimensions are involved in response to early intervention (e.g. sex, diagnosis age of onset, severity of illness, comorbidities, quality of social support), in particularly those related to motivation, such as egosyntonicity [73]. It will also be important to identify whether specific diagnosis, subgroups and profile of participants are more responsive to this early intervention [30, 74–76], or have more difficulties engaging in psychotherapy [77].

The second limitation is related to the drop-out rate (18.7%): several patients were lost at pre- and/or post-intervention. The lack of information on the profile of lost patients limits the representativeness of the

final sample. To reduce the dropout rate, it could be interesting to offer patients the opportunity of a discussion with a mental health professional or a peer support worker, prior to the workshop, in order to address any possible ambivalence about their participation.

An additional limitation is represented by the lack of a systematic follow-up assessment precluding to assess whether patients maintained their engagement in psychotherapy treatment over the long term. Further research is needed to assess the longer-term impact of this early intervention on treatment outcome based on a follow-up three-months after the intervention and on larger time intervals (6 and 12 months).

From a clinical perspective, our results suggest possible improvements to the content of the workshop. On the one hand, considering the importance of understanding of the disease and motivation to engage in care, it might be helpful to enhance activities that improve insight, focusing specifically on anxiety and depressive symptoms. Indeed, the literature underlines that the different aspects of anxiety and depression represent the most covarying factors of insight [78] and the strongest predictors of failure to recover in AN [79]. On the other hand, it may be beneficial for patients to implement novel treatment settings and psychotherapeutic contents to support the patient's motivation to stay engaged with care [40] and bridge the gap between the initial intervention (single-day workshop) and their effective access to on-site psychotherapy programme. This is in line with current literature on early interventions and the development of stepped-care approaches in EDs [12, 80], as for other mental disorders [81, 82]. Additional resources might include short distance psychoeducational and motivational modules, up-to date lists of leading EDs apps assessing their strengths and weaknesses, or guided self-help interventions. These contents may help to empower patients to actively engage in their own recovery [83, 84].

Conclusions

To conclude, we found that a single-day workshop devoted to the experiential discovery of different psychotherapy approaches for patients newly diagnosed with an eating disorder is associated with significant pre–post changes in self-reported outcomes. It seems to have a psychoeducational effect on its own and thus, it represents a promising early-stage care pathway option, pending the availability of more conclusive evidence. In hospital settings where professional and financial resources are limited, this brief and modular workshop may enhance the availability of timely interventions for eating disorders, reduce waiting lists, while limiting the increase of clinicians' burden, within a stepped-care model of service.

Declarations

Competing Interests

The authors declare that they have no financial or non-financial interests to disclose.

Ethics approval

This study was performed in line with the Declaration of Helsinki and the French Public Health Code (Article L1121-1). It was registered in the national Health Data Hub (health-data-hub.fr) (D20-R048 - J3 Psychotherapies).

Consent to participate

Each patient was informed of the objectives of the study and data anonymity prior to the signature of an informed consent form that systematically confirmed their participation.

Availability of data and material

The datasets analysed during the current study and that support it findings are available from the corresponding author on reasonable request

Authors' contributions

All authors were involved in study design, had full access to all the data in the study, and provided clinical interpretation of the findings. Elisabetta Scanferla drafted the manuscript. All authors reviewed, edited and confirmed their acceptance of the final submitted version.

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Tables

Table 1: Baseline characteristics of the study sample (N=169)

	Mean	SD	Range	%
Age	29.80	9.50	16-64	
Diagnosis				
Anorexia nervosa				50,9%
Boulimia				37.7%
Binge eating				7,1%
Other				5.3%
Duration of illness	10.50	7.90	0.5-36	
BMI	20.80	6.02	16-40	

Abbreviation: BMI, body-mass index.

Table 2: Comparison of motivation to change (URICA) and insight (SAI-ED) in 169 patients participating in a single-day workshop aimed at experiencing eight different psychotherapy approaches before and after intervention

Parameters	Values before a single-day session workshop (T_0)		Values after a single-day session workshop (T_1)				
	Mean	SD	Mean	SD	t	df	p-value
URICA							
CA score (A-C)	-0.866	0.62	-0.415	0.677	-8.51	168	**< .001**
Precontemplation	1.91	0.649	1.93	0.636	-0.387	168	0.699
Contemplation	5.22	0.565	5.08	0.555	2.963	168	**0.003**
Action	4.36	0.772	4.66	0.625	-5.864	168	**< .001**
Maintenance	4.37	0.899	4.41	0.853	-0.617	168	0.538
SAI-ED	4.54	1.456	4.49	1.211	6.993	167	**< .001**
Insight 1	0.781	0.415	0.799	0.402	-0.538	168	0.592
Insight 2	0.675	0.47	0.799	0.402	-3.143	168	**0.002**
Insight 3	0.746	0.437	0.87	0.337	-3.798	168	**< .001**
Insight 4	0.325	0.47	0.515	0.501	-4.927	168	**< .001**
Insight 5	0.775	0.419	0.101	0.302	17.729	168	**< .001**
Insight 6	0.799	0.402	0.893	0.309	-2.989	168	**0.003**
Insight 7	0.438	0.498	0.515	0.501	-1.833	168	0.069

Abbreviations: CA, Committed Action composite score (A-C); SAI-ED, Schedule for the Assessment of Insight for Eating Disorders; URICA, University of Rhode Island Change Assessment Scale

Notes: * *p* significant ≤.05

Table 3: Results of the linear regression testing the effect of age, BMI and illness duration on the improvement of the "Committed Action" (A-C) motivational composite score between the two assessments (N=169)

		t	p-value
Age	-1.114		0.267
BMI	1.732		0.085
Illness duration	-0.366		0.715

Abbreviations: BMI, body-mass index; URICA, University of Rhode Island Change Assessment Scale

Notes: * *p* significant ≤.05

Figures

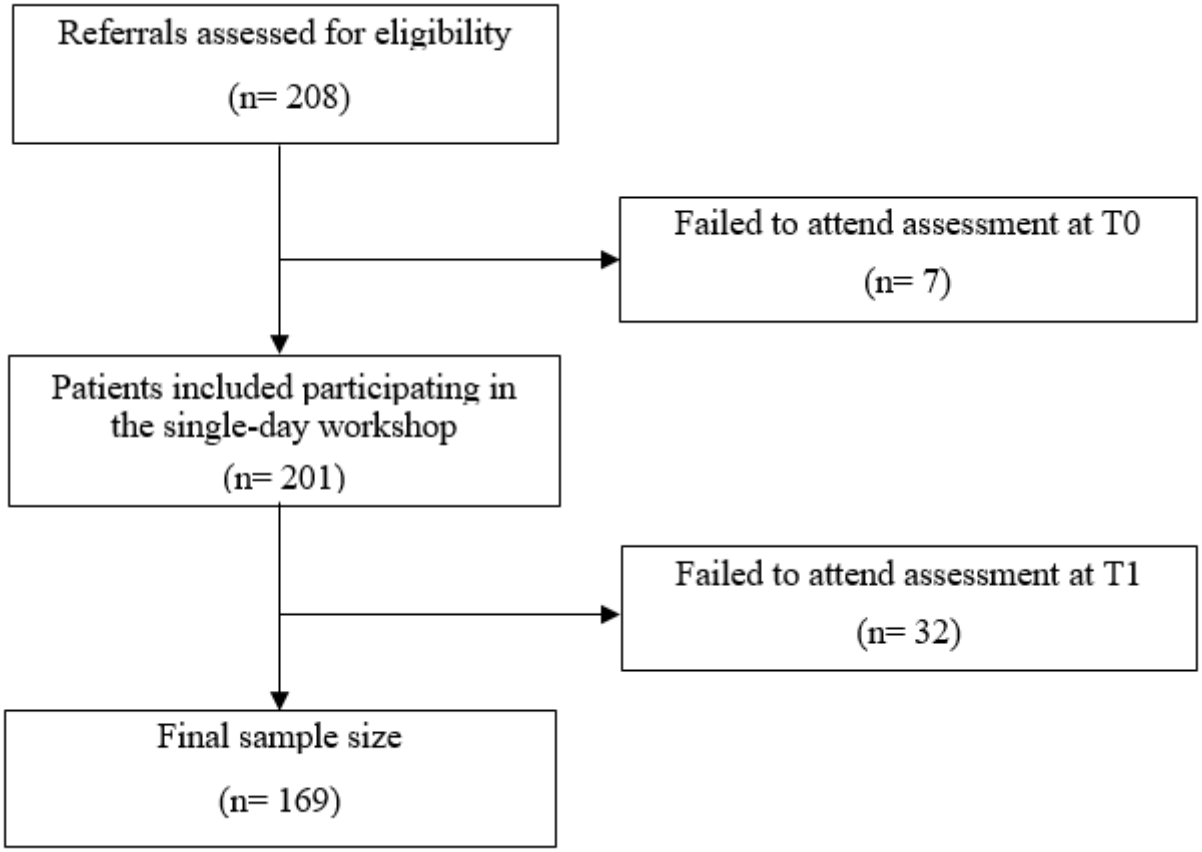

Figure 1

Flow chart of participants' selection

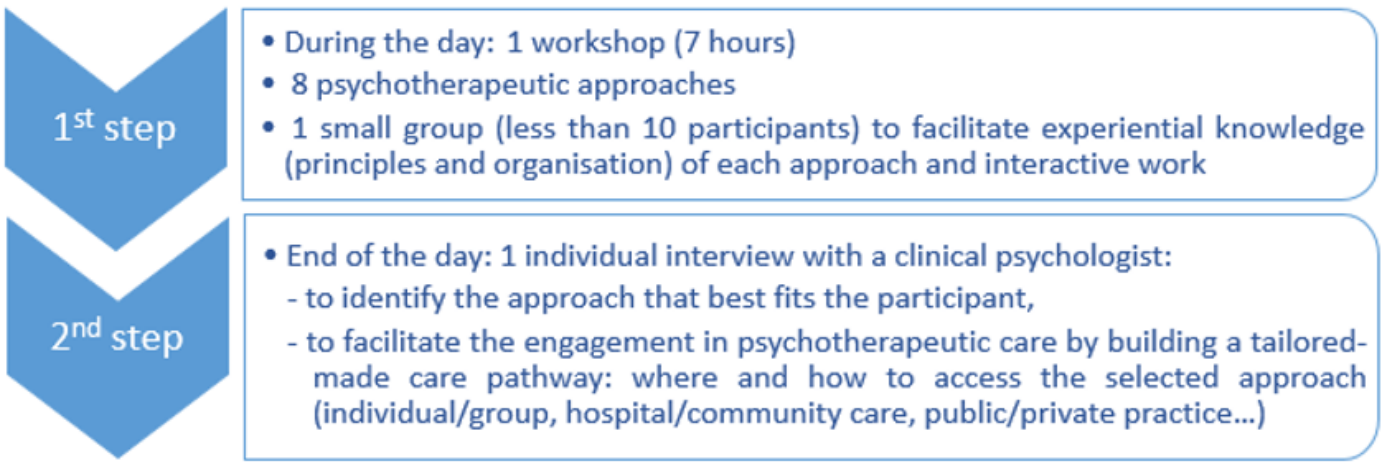

Figure 2

Design of the single-day workshop aimed at experiencing eight different psychotherapy approaches devoted to eating disorders

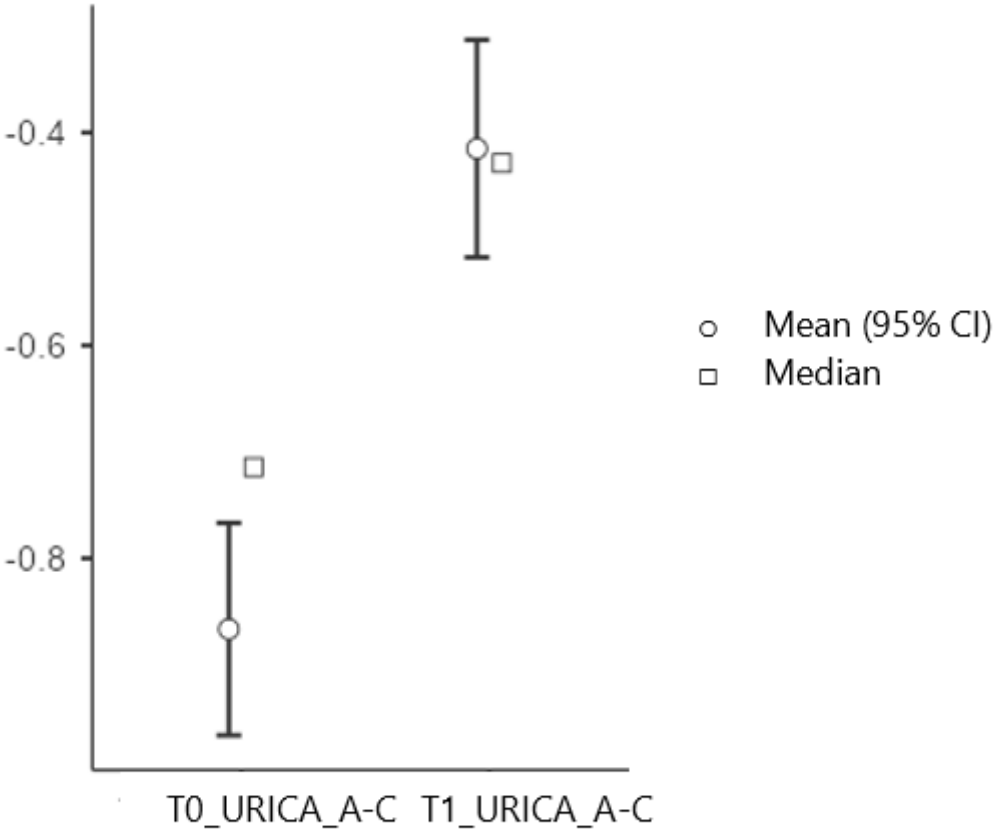

Figure 3

Change of the “Committed Action” (A-C) motivational composite score between the two assessments (N=169)