

The HOPE Program Pilot Project: Supporting Clients who are Ambivalent About Change

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Background

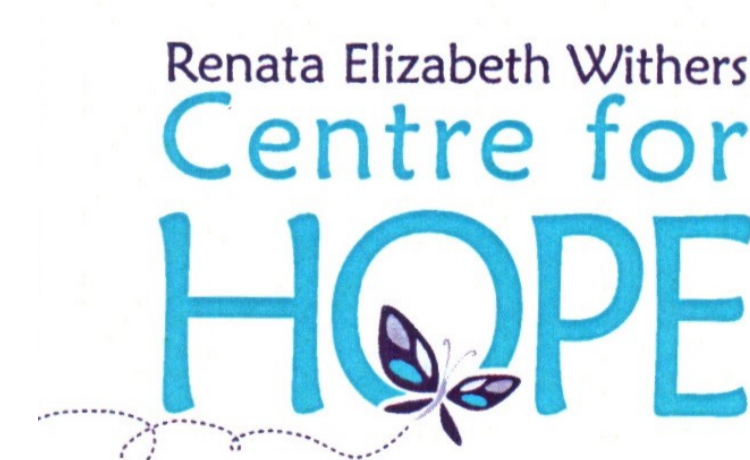
The HOPE Program in St. John's, Newfoundland is a provincial day treatment program, providing group and individual therapy to clients who are in the contemplation, preparation, or action stages of change, as assessed by the Readiness and Motivation Interview (RMI; Geller & Drab, 1999).

Within the past couple of years, it became evident that there was a subpopulation of clients who were not being adequately supported - namely, those in the pre-contemplation stage of change. Typically these individuals are the most ill, often bordering on medical instability, and were not receiving services due to their inability to participate fully in the regular HOPE Program. This left the burden of caring for and supporting these individuals on their primary care physicians and loved ones.

In the Fall of 2011, the HOPE Program began piloting a modified program for individuals with a diagnosed eating disorder who were in the pre-contemplation stage of change and/or bordering on medical instability. The purpose of this program was to provide these individuals with a safe and supportive environment where they could gather information, be supported, and express themselves without experiencing any pressure to change their behaviour from the clinical care staff. In this program, clients were able to discuss not only their reasons for change, but also factors or pressures that kept them from wanting to change. Harm reduction was another component of the program, and focused on helping the client to recognize areas where they could minimize the harmful effects of their eating disorder, even if they were not yet ready to move towards change. The pilot was offered two afternoons a week over a 10-week period in the Fall of 2011, and again in the Winter of 2012.

Study Goals

The current study aimed to explore the impact of the pilot project upon the participants. Using a multi-method approach, this research explored participants' perceptions of the pilot project, as well as the success of the project in meeting participants' needs.



Methods

Information letters were sent to former clients of the HOPE program, as well as to family physicians in the St. John's area. Participation in the pilot was open to clients who were in the pre-contemplation stage, as assessed by the Readiness and Motivation Interview (RMI; Geller & Drab, 1999). Some participants were new to the HOPE program, while others were former clients who were assessed to be in pre-contemplation, and therefore, not ready to participate in the regular program. All participants who took part in the pilot agreed to participate in the research project. Ethics approval was obtained through the Health Research Ethics Authority (HREA).

Although 21 individuals attended the initial orientation session, only 13 attended the pilot on a regular basis (nine in Fall 2011 and four in Winter 2012). Of these 13 participants, nine returned completed pre and post-test measures. Participants ranged in age from 20 to 55, and all but one were female. Body mass index (BMI) was calculated for each participant, and ranged from 16.7 to 22.9. Most participants had at least one comorbid diagnosis, and the duration of the eating disorder lasted anywhere from 1 to 30 years. One participant had spent time in an inpatient program and the rest had varying levels of experience with individual counseling.

There were 3 pre and post measures attached to the pilot project:

- Eating Attitudes Test (EAT-26),
- Eating Disorder Quality of Life Scale (EDQLS)
- Readiness Ruler.

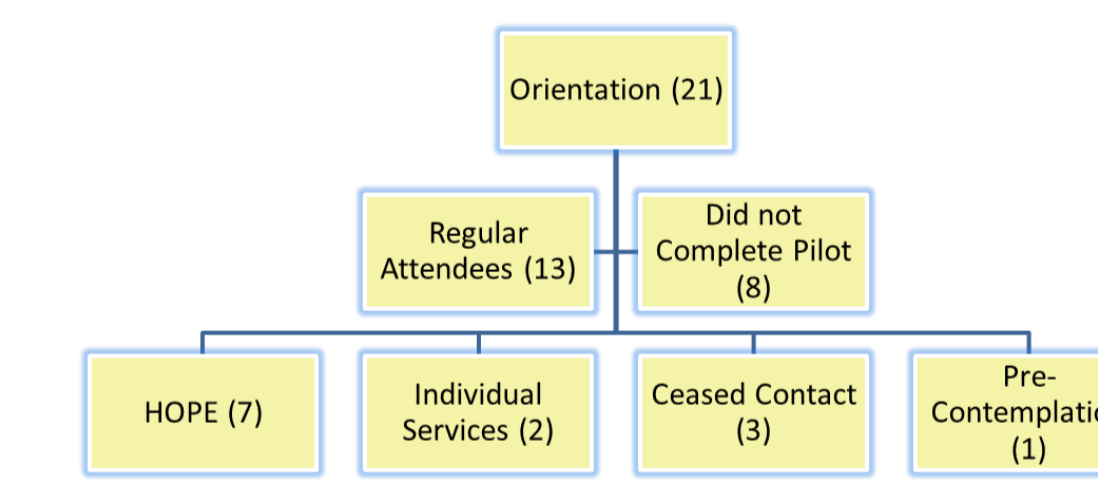
Focus groups were held immediately following the last session of each round of the pilot project. Participants were reminded that their participation was voluntary and that their responses would be kept confidential. Three participants attended the first focus group, and three attended the second focus group. One participant elected to schedule an interview in lieu of participating in a focus group. While certain topics were identified ahead of time as being important to the research study, in all focus groups and interviews, participants were encouraged to discuss any issues that they felt were important. The focus groups and interview lasted between 40 and 60 minutes.

Participant Characteristics	
	Range
Age (years)	20 - 55
Body Mass Index (BMI)	16.7 – 22.9
Duration of Eating Disorder (years)	1 - 30
Co-morbid Diagnoses	1 - 7

Results - Quantitative Analyses

Nine completed sets of data were analyzed. As the aim of the pilot was not to direct change, significant changes in eating pathology, quality of life, and motivation were not expected. However, it was hoped that participation in the pilot would at the very least, not result in negative behavioural or motivational changes. Indeed, significant positive changes were seen in two factors of the Readiness Ruler: Fear and Restricting. No statistically significant changes were observed on any factors of the EAT-26 or the EDQLS.

Mean Pre and Post-Test Scores		
	Pre-Pilot	Post-Pilot
EAT-26 Total	43.2	42.8
EAT-26 Dieting	25.7	25.6
EAT-26 Bulimia	9.5	6.0
EAT-26 Food Preoccupation	8.1	10.4
EDQLS Total	44.3	43.6



Results - Qualitative Analyses

What were Clients' Experiences of the Pilot Project?

When queried about their expectations going into the pilot, participants reported that they were expecting to receive information that would help them to better understand their eating disorder. They were also expecting a 'safe space' where they could ask questions, explore their feelings, and be supported, without being pressured to set goals or commit to change.

Further discussion on their experiences revealed that they did feel supported, and 'safe' while attending the pilot. The staff were perceived to be "genuine" and "personable", and the group format led to participants reporting feeling less isolated and alone with their eating disorder.

Participants also reported that the atmosphere was free of pressure – in fact, some participants noted that they would have liked to have been "pushed" a bit in the pilot. Even without any implicit or explicit pressure for change, several participants reported that they had begun to make small changes in their behaviour, and that they felt that they were more motivated to move into the regular stream of the HOPE Program.

"the pilot project is like kindergarten, and the HOPE program is like actual school. It's a good prep for the program."

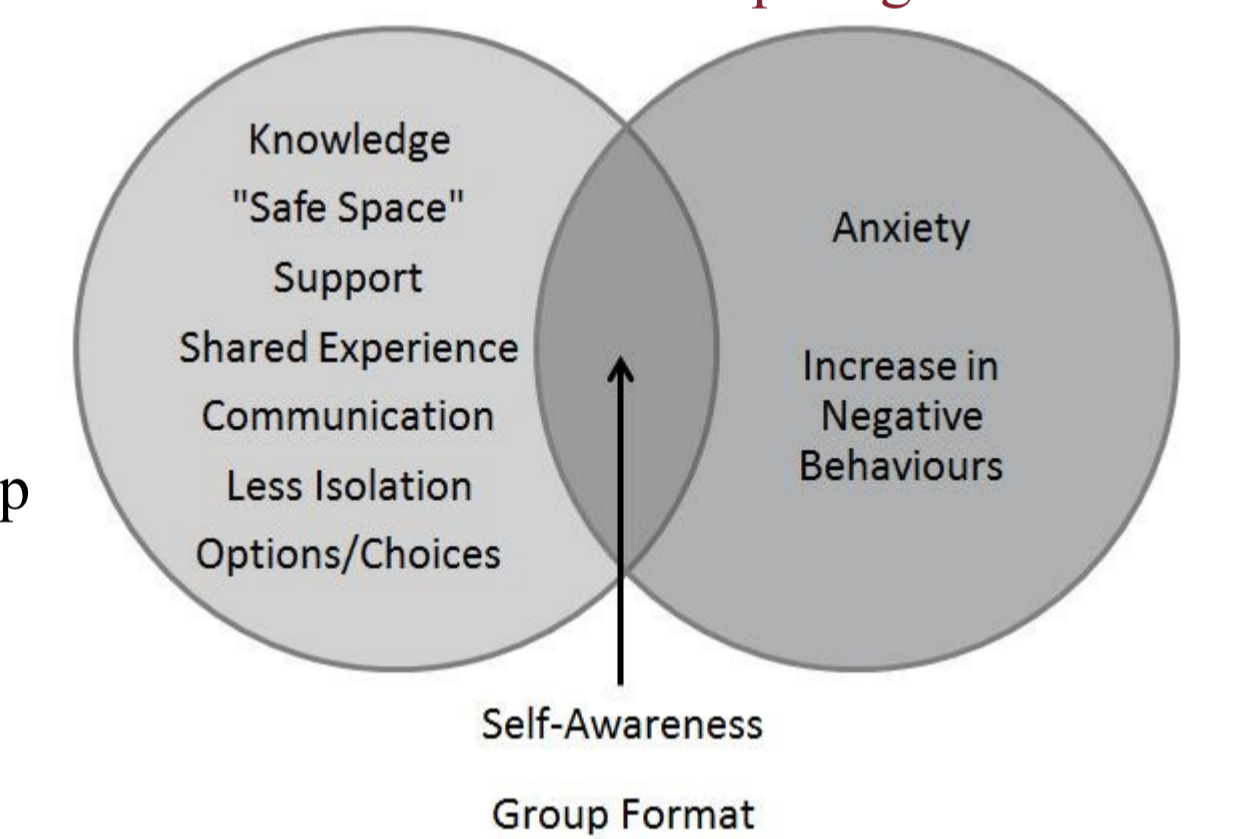
Benefits and Costs to Participating in the Pilot Project

Participants identified a number of benefits and costs to having participated in the pilot project. While several participants reported an increase in anxiety, and "negative behaviours" early in the pilot, all but one reported that this initial anxiety subsided within the first few sessions of the pilot. Participants all reported that they received valuable information about the impact of their eating disorder in various facets of their life, and that this information led to greater self-awareness. The concept of self-awareness was brought up repeatedly in the focus groups. Participants reported that they were better able to identify how their eating disorder impacted upon various aspects of their life - from the way they spoke to their partners, to automatic thoughts and behaviour patterns.

This self-awareness was perceived as both a benefit and a cost to participating in the pilot.

"the anxiety of coming here and having to share things, and also the cost of having the information... the other side of having the information is having it laid out in front of you, and having them be like 'this is what's happening' ... it's kinda hard to see, sometimes"

Benefits and Costs to Participating in the Pilot



Similarly, the group format of the pilot was perceived to be both a benefit and a cost—while they received support, understanding, and feedback from other participants, many of the participants expressed their desire to have more individual, one-on-one time with the facilitators. Having a group format meant that sessions were not tailored to the individual needs of each client, leading some clients to

benefit more than others, depending on their experiences and pre-existing knowledge about eating disorder coming into the pilot. However, all participants reported that they perceived the pilot to be helpful. In fact, several participants expressed feeling sad that the pilot was finished.

Improved communication was another area that participants considered to be a benefit of participating in the pilot. Several participants reported that they were given the tools to disclose their eating disorder to significant people in their lives. Others, whose family members or partners participated in the family support sessions, noted that their loved ones had a better understanding of their illness, and were better able to communicate effectively with them. This was perceived to be a substantial benefit to participating in the pilot, as they felt they no longer had to be as secretive about their illness.

"I hadn't told my boyfriend or anyone before I came here, so I found that being able to tell my boyfriend was a really big deal. They would just give you information and stuff, so that's how I went about it – I just gave him the information."

Discussion

The aim of this research was to explore the impact of the pilot project on those who took part. Thematic analysis of focus groups and an interview revealed that participants, overall, found the pilot to be helpful and were pleased that they had taken part in it. The information they received was perceived to be useful in helping them to better understand the impact of their illness in various aspects of their lives, and they felt supported in exploring their feelings and thoughts around their eating disorder. While statistical significance was not achieved, with a larger sample size, some of the trends that were captured in the focus groups might have been evident in clients' pre-test and post-test scores, as well. Based on the feedback from clients, it would seem that the pilot project was successful in achieving its goal of educating and supporting clients who are in the pre-contemplation stage of change. As this population is traditionally under-served in treatment programs, this research represents an important first step in exploring both the feasibility and suitability of such a program.

"There's something transformative about sitting around with people that you can say your darkest thought, or your lowest moment, or your most screwed-up belief... and someone around that table is going to say 'yes', someone around that table is going to nod in recognition. There's something transformative about that. You can't ever go back to believing that you are completely alone and nobody understands."