Stages of change in eating disorders: considerations about its conceptualization and assessment

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Estadios de cambio en los trastornos de la conducta alimentaria: consideraciones sobre su conceptualización y evaluación

Dear Editor:

In relationship to the interesting article of Beato Fernández and Rodríguez Cano[1] on the development of a questionnaire on attitudes towards the change in eating behavior disorders (EBD) following the transtheoretical model (TTM) of Prochaska and DiClemente, we want to make the following comments.

Relapse in the context of TTM stages of change

According to the TTM of Prochaska and DiClemente, the structure or time or evolution dimension of the change process is represented by the following five stages: precontemplation, contemplation, preparation, action and maintenance. However, given that one of the main difficulties in the change process of any problem behavior is that of high relpase rates, the TTM stresses, as mentioned by Beato Fernández and Rodríguez Cano[1], the fact that most of the individuals do not progress linearly through the stages of change, as there are often setbacks between stages. A relapse is one of these setbacks and occurs when the stabilization, maintenance or consolidation strategies of the change performed fail. In this sense, a relapse may occur, therefore, both in the action stage as well as in that of maintenance. However, contrary to that which can be understood from the Beato Fernández and Rodríguez Cano study[1], the MTT does not conceptualize the relapse as a stage of change *per se*.

Although the relapse phase in the initial versions of TTM was potentially conceptualized as a well-defined and differentiated stage, in 1984, Prochaska and DiClemente[2] had already stated that the relapse could represent a separate stage of change or a movement towards another stage of change. After, as the data related to the use of the different change processes by the persons with relapses were explained, many studies showed that the relapse should be conceptualized, not as a differentiated stage of change but as the transition to another one. Thus, all the persons with relapses could be categorized in terms of their present stage of change. So, according to the TTM, a relapse usually implies a movement to a pre-action stage (essentially contemplation or preparation). In this sense, Prochaska et al.[3] report that approximately 15 % of smokers with relapse fall back to the precontemplation stage, while most return to the contemplation and preparation ones. The moderately elevated positive correlations found by Beato Fernández and Rodríguez Cano[1] between the contemplation and relapse subscales on the one hand, and between those of decision (preparation) and relapse on the other, could be interpreted as one more piece of information in this sense.

However, the consideration of the relapse by Beato Fernández and Rodríguez Cano[1] as a differentiated stage would guarentee the inclusion of this study (table 1) together with those of other authors (for example, Freeman and Dolan[4]) in the groups of studies that propose to review and modify the TTM.

The University of Rhode Island Change Assessment scale and the assessment of the stages of change in EBD

Beato Fernández and Rodríguez Cano[1] state that most of the instruments used to assess the motivation or attitude towards change in EBD are adaptations of questionnaires designed for addictive behaviors and other problem behaviors, citing the study of McConnaughy et al.[5] regarding the University of Rhode Island Change Assessment (URICA) scale as the first reference.

The URICA[5,6] scale is a self-report originally aimed at evaluating the stage of change regarding the modification of any disorder or problem behavior. Thus, although it has been widely used in samples of smokers or of persons dependent on other psychoactive substances, it is not a self-report designed for addictive behaviors or for other specific problem behaviors. In fact, as it is a self-report in which the formulation of each one of the different items does not refer to a specific problem behavior but rather generarically to the term problem that the rater would have previously defined with the patient based on the disorder that he/she has (for example, pro-

TABLE 1. Stages of change according to the TTM and other authors

Prochaska et al.[3]*, 1992*	*Freeman and Dolan*[4]*, 2001*	*Beato Fernández and Rodríguez Cano*[1]*, 2003*
—	No-contemplation	—
—	Anticontemplation	—
Precontemplation	Precontemplation	Precontemplation
Contemplation	Contemplation	Contemplation
Preparation	Action planning	Decision
Action	Action	Action
Maintenance	Maintenance	Maintenance
—	Pre-relapse	—
—	Relapse	—
—	New-relapse	Relapse

blem = restrictive anorexia; problem = binging), the versality of this scale is manifested. It may be used without major difficulties to assess the motivation or attitude toward the change in the EBD area, as is reflected in different studies[7-11]. However, as shown by the authors of one of these studies[11], in the case of the evaluation of the attitude towards change of the bulimic symptoms, it seems to be recommendable to not define the problem globally (i.e. problem = bulimia nervosa) and to administer the scale twice, one refferring to the binges and another referring to compensatory behaviors, since the motivational disposition to change each one of these problem behaviors does not have to be the same.

The explanations given in this letter are not an obstacle to be able to state that the study of Beato Fernández Rodríguez Cano[1] is a significant contribution, very probably a pioneer in the Spanish state, to the references on the evaluation of the motivational disposition or attitude towards change in patients with EBD, that the professionals interested in this subject cannot obviate.

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RESPONSE

Dear Director:

We are grateful for the comments of Joan Trujols et al. on the conceptualization and assessment of the stages of change in eating behavior disorders (EBD) that manifest their extended knowledge of the subject as well as the interest that they have shown for the Attitudes Towards Change in Eating Disorders (ACTA) questionnaire. We are delighted that, based on the publication of the development and psychometric properties of the ACTA[1], the authors stress the existence of the conceptual and methodological difficulties that we have mentioned in it. Due to the need to describe the elaboration and validation process of the question in detail, the presentation of the theoretical debate was not the main objective of the mentioned article. Thus, we consider that the explanations of the authors are very appropriate. We also want to mention that the methodological difficulties and conceptual controversies as well as the instruments available to assess motivation to change in patients with EBD have been the object of a recent review included as a chapter in a book on bulimia nervosa that will be published soon[2]. In this study, the URICA (University of Rhode Island Change Assessment Scale) stands out among the most widely used instruments of EBD. In fact, it is a very versatile instrument that assesses four components (precontemplation, contemplation, action and maintenance) in any behavior that needs a change. Thus, it can be applied to the EBD. However, it has also been seen that the use of this questionnaire could overestimate

willingness to change of the patients with EBD[3]. In our opinion, this bias could be attributed to the fact that the interviewed subject would choose to evaluate only some «problem behavior», among the varied psychopathological expression and multiple behavioral alterations present in these disorders. With its 59 items, our questionnaire presents a large variety of common «problem situations» in patients with EBD and that refer to four different areas (cognitive, affective, conductual and relational). Thus, the final score will give us a global idea of the general attitude that the subject has to change.

In regards to the debate on whether «Relapse» should be assessed as a movement to a pre-action state or should be considered separately, following that stated in the motivational interview suggested by Miller and Rollnick[4], we have considered it as a differentiated element in the evaluation of motivation for change in EBD although with an independent behavior from the rest of the subscales. As Trujols et al. point out, from the conceptual and statistical point of view, relapse is related with contemplation and decision. This is demonstrated by the positive correlations found between the ACTA subscales and the fact that the correlation pattern of these three subscales with the scores on the questionnaire that evaluate eating psychopathology (EAT, BITE, BSQ and tendency to thinness on the EDI) was similar. Detailed analyses of these data show us some differential aspects between contemplation and relapse: in the multiple regression that controls the effect of the result of the subscales, of the disorder evolution time, and of the previous treatment time, the subscale that only was associated with feelings of depression, measured with the BDI (Beck Depression Inventory) was that of contemplation ($\beta = 0.540$; $p = 0.000$L; $F = 16.88$; 29.2% of the variance). Equally, contemplation and no relapse were associated with feelings of greater anxiety-state, measured with the STAI (State-Trait Anxiety Inventory) ($\beta = 0.410$, $p = 0.001$; $F = 12.127$; 16.8% of the variance). This association was maintained at six months of treatment. The finding that the patients with high scores in relapse present significantly lower anxiety and depression than those with high scores in contemplation could be related with the belief that it would be feasible to reach the previous achievements again in the solving of the problem behavior.

Thus, and from the point of view of clinical utility of our scale, it was to our interest to include «relapse» defin-ed as the subjective assessment of worsening that the subject makes of his change process. Identifying the feeling that this situation includes (of failure or, of hope to be able to reach the same achievements again) may supply valuable information on the planning of therapeutic strategies. The possibility that the ACTA question provides us to present high scores on two subscales simultaneously allows us to assess the motivational state along with the perception of the backward movement by the subject

Finally, we repeat our thanks to J. Trujols et al. for their interest and adequate specifications made on a controversial subject that is difficult to conceptualize.

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