



A systematic review of the existing models of disordered eating: Do they inform the development of effective interventions?



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HIGHLIGHTS

- Few (18.5%) existing theoretical models have led to the development of effective interventions.
- The initiation of theories in the eating disorder field has often been an end in itself.
- There is a need to consider utilising data from intervention studies to refine existing models before developing new ones.
- Common risk factors are weight/shape concern, emotional regulation difficulties, self-esteem deficits, interpersonal issues.

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ABSTRACT

Despite significant advances in the development of prevention and treatment interventions for eating disorders and disordered eating over the last decade, there still remains a pressing need to develop more effective interventions. In line with the 2008 Medical Research Council (MRC) evaluation framework from the United Kingdom for the development and evaluation of complex interventions to improve health, the development of sound theory is a necessary precursor to the development of effective interventions. The aim of the current review was to identify the existing models for disordered eating and to identify those models which have helped inform the development of interventions for disordered eating. In addition, we examine the variables that most commonly appear across these models, in terms of future implications for the development of interventions for disordered eating. While an extensive range of theoretical models for the development of disordered eating were identified ($N = 54$), only ten (18.5%) had progressed beyond mere description and to the development of interventions that have been evaluated. It is recommended that future work examines whether interventions in eating disorders increase in efficacy when developed in line with theoretical considerations, that initiation of new models gives way to further development of existing models, and that there be greater utilisation of intervention studies to inform the development of theory.

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1. Focus of this review

1.1. The need for the development of effective interventions in eating disorders

The prevalence of disordered eating behaviours and associated problems with body, weight, and shape in society is well-documented (Fisher et al., 1995; Holm-Denoma et al., 2005; Hudson, Hiripi, Pope, & Kessler, 2007; Liberati et al., 2009; Moher, Liberati, Tetzlaff, & Altman, 2009; Vohs, Heatherton, & Herrin, 2001). The consequences of disordered eating can often be serious, including elevated mortality and suicide rates (Crow et al., 2009, 2012), impairments across several health dimensions, and quality of life (Thomas, Vartanian, & Brownell, 2009; Wade, Wilksch, & Lee, 2012). Estimates suggest almost one-quarter of young women have experienced disordered eating (including binge eating, purging, and/or fasting) in the previous 12-month period (Wade et al., 2012), supporting the idea that a moderate degree of disordered eating is now normative among young women. In addition, over the last decade there has been increasing awareness of the existence of eating disorders among men (Dakanalis & Riva, 2013; Tylka, 2011), showing comparable dietary restraint, driven exercise (i.e., exercising in compulsive manner as a means of controlling weight and/or shape) and binge eating rates (Hudson et al., 2007; Lavender, De Young, & Anderson, 2010; Striegel-Moore et al., 2009), as well as levels of clinical impairment (Striegel, Bedrosian, Wang, & Schwartz, 2012), to women. A recent position paper from the Academy for Eating Disorders (Klump, Bulik, Kaye, Treasure, & Tyson, 2009) recognised eating disorders as a serious mental illness warranting attention similar to that of schizophrenia, bipolar disorder, depression, and obsessive-compulsive disorder.

Despite significant advances in the development of prevention (e.g., *the Body Project*; Stice & Presnell, 2007; Stice, Rohde, & Shaw, 2012) and treatment interventions for eating disorders and disordered eating (e.g., enhanced cognitive behaviour therapy [CBT-E]; Fairburn et al., 2009) over the last decade, there remains several sizable gaps with regards to the provision of effective interventions. For example, in the area of prevention, it is still not clear whether universal prevention approaches have the power to reduce onset of eating disorders. In addition, the vast majority of widely disseminated public health approaches are often developed independently of theoretical considerations and lack empirical support, raising concerns about programme effectiveness as well as the potential for waste of resources (Becker, Plasecia, Kilpela, Briggs, & Stewart, 2014). In the area of treatment, there are several notable gaps in our knowledge, including the optimal treatment for adult anorexia nervosa (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007), and knowing which treatment approaches work best for which people (Vall & Wade, 2015). Thus further work is required in the development of effective interventions for disordered eating.

1.2. The relationship between theory and development of interventions

One pathway to the development of effective interventions is through rigorous testing and examination of theoretical models, as described in the Medical Research Council (MRC; Campbell et al., 2000;

MRC, 2000) evaluation framework for developing and evaluating complex interventions to improve health from the United Kingdom. These guidelines have recently been comprehensively revised and updated (Craig & Petticrew, 2013; Craig et al., 2008, 2013). Specifically, the framework is intended to guide: (a) researchers to choose and implement appropriate methods; (b) research funding bodies to understand the limitations on evaluation design; and (c) policy makers, practitioners, and other users of the intervention, in the consideration of the available evidence in light of these methodological and practical constraints.

The framework has been highly influential and widely cited. A recent reflection paper by Craig and Petticrew (2013) reported that citations for the MRC's guidelines had increased between 2001 and 2011, suggesting a sustained growth of interest in such guiding frameworks. Furthermore, the guidance is incorporated in advice given to grant applicants in the United Kingdom (<http://www.nets.nihr.ac.uk/faqs/developing-a-proposal>) and educational materials (e.g., for postdoctoral nursing students involved in cancer research; Senn et al., 2011), and similar guidelines have now been produced for surgical trials (McCulloch et al., 2009), group delivered interventions (Hoddinott, Allan, Avenell, & Britten, 2010), and natural experimental approaches (Craig et al., 2012). A CONSORT extension for complex interventions is now being developed (<http://www.spi.ox.ac.uk/research/site/consort-spi/home.html>). Thus a reasonable body of evidence suggests that researchers have found the guidance useful. In support of the relevance of this framework to the eating disorder field, one meta-analysis has highlighted that more effective interventions are informed by risk factors and theory (Stice & Shaw, 2004). One persistent criticism of eating disorder prevention studies has been the lack of theoretical rationale to guide the content, design and administration of interventions (e.g., Pratt & Woolfenden, 2002); of twenty prevention studies reviewed by Austin (2000), fewer than half clearly outlined a theoretical basis for the chosen preventive approach.

According to the MRC's framework, the process from development to implementation may take a variety of forms. Fig. 1 summarises the main stages and the key functions and activities at each stage, where the arrows indicate the main interactions between the phases. Although it is useful to think in terms of stages, they may not follow a linear or even a cyclical sequence. It is recommended that the best practise is to develop interventions systematically. First, *development*, includes: (a) identifying the relevant existing evidence base (e.g., a systematic review); (b) identifying or developing the relevant theory that informs an understanding of the processes of change; and (c) modelling processes and outcomes described in the theory prior to a development of an intervention. Second, *feasibility and piloting* (preparatory phase), includes: (a) testing procedures for feasibility (e.g., piloting and case series); (b) estimating the likely rates of subject recruitment and retention; and (c) determining appropriate sample sizes. Third, *evaluation*, includes: (a) assessment of effectiveness (see Table 1 for summary of experimental designs for evaluating complex interventions); (b) process evaluation that includes assessment of fidelity and quality of implementation, identification of causal mechanisms, and recognition of contextual factors associated with variances in outcome; and (c) assessment of cost-

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