



How can we improve dissemination of universal eating disorder risk reduction programs?



Simon M. Wilksch

School of Psychology, Flinders University, GPO Box 2100, Adelaide, 5001, South Australia, Australia

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1. Overview

A recent commentary provided an overview of the current state of the eating disorder prevention field, where a case was made for an urgent increase in the output of quality universal prevention research (Wilksch, 2014). Suggested future directions included: an increase in the number of methodologically rigorous efficacy RCTs similar to what the targeted prevention field has done so well in recent years; greater collaboration with obesity prevention researchers to evaluate if programs can prevent both problems; increased collaboration with prevention researchers in related fields (e.g., depression prevention) to see if individual programs can prevent more than one problem; and, an increased focus on younger audiences (specifically pre-adolescents and even pre-school children). In the brief period since, there have been publications in the field that reflect greater attention to most of these areas and this needs to continue (e.g., Fairweather-Schmidt & Wade, 2015; Hart, Damiano, & Paxton, 2015; Wilksch et al., 2015). Two of these three studies focused on much younger children than usually targeted in our field, where Hart, Damiano, Chittleborough, Paxton, and Jorm (2014) evaluated parenting resources for promoting positive body image and healthy eating behaviours for parents of 2- to 6-year olds, whilst Fairweather-Schmidt and Wade evaluated a new program targeting perfectionism in 11-year-olds. Wilksch et al. (2015) completed a large RCT of 3 programs with $N = 1316$ Grade 7 and 8 girls and boys and found one program (*Media Smart*) halved the rate of onset of

clinical concerns about shape and weight at 12-month follow-up compared to control girls, whilst also lowering obesity risk factors such as screen time.

On further reflection, there is also a need for greater attention to be given to the dissemination of universal programs that have been found to significantly lower eating disorder risk over multiple, well-designed RCTs (e.g., random assignment to condition, inclusion of control group, statistical adjustment for baseline levels of eating disorder risk, adequate follow-up of 12-months minimum). Thus whilst the need for increased output in high quality universal efficacy RCTs remains (Wilksch, 2014), we also need to be able to 'offer something now' to schools and other settings who are increasingly desperate to address the issues of body image and eating disorders. Given dissemination research from the medical field suggests an average lag of 17 years to translate original research into routine clinical practice, we cannot afford to wait this long (Brownson, Colditz, & Proctor, 2012).

This paper addresses three areas related to this: a need to rethink some prevention strategies that have been essentially discarded of late but that might make dissemination more readily achieved (i.e., single session programs); the importance of being clear in what our programs seek to prevent (or reduce) and how measurement of clinically relevant features of disordered eating could assist the case for dissemination; and, a discussion of how dissemination could best occur in the universal context.

2. Is there a place for single session programs?

Meta-analyses by Stice and colleagues have been invaluable in guiding the development and evaluation of eating disorder prevention programs in recent years (Stice & Shaw, 2004; Stice, Shaw, & Marti, 2007). These publications have contributed to a notable shift in the overall scientific quality of our field with most researchers now conducting studies that include many features found to be associated with larger effect sizes and thus better outcomes.

One feature of interest from these papers was the finding that single-session programs produce smaller effect sizes than multiple session programs (Stice & Shaw, 2004; Stice et al., 2007). This makes sense given the importance of consolidating learned content, practicing skills, and time for interactive learning activities. As a result of these findings, the field has now largely moved away from evaluations of single session programs.

However, it is important to remember that some of these earlier programs included in the meta-analyses had multiple features that might

E-mail address: simon.wilksch@flinders.edu.au.

have led to smaller effect sizes. For example, the majority of single-session interventions in these reviews were psychoeducational in nature rather than targeting prospective eating disorder risk factors. We know this is associated with smaller effect sizes (Stice et al., 2007). Similarly, many were delivered in a didactic rather than interactive manner, which has also been shown to be associated with smaller effect sizes. Thus there were several aspects of program design and delivery that might have led to less beneficial outcomes.

It is important that the universal prevention field has “another think” about what we are trying to achieve. If we have programs that are known to reduce eating disorder risk but program lengths (or requirements on presenters) are such that schools and other settings are discouraged from taking them on board, then we need to look at ways to improve uptake. One such way is to investigate if shorter or even single-session versions of longer programs that target prospectively identified eating disorder risk factors can actually have a beneficial effect.

A recent trial by Diedrichs and colleagues compared a single 90-minute session that was delivered by teachers versus the same content delivered by expert researchers versus a class as usual control group (Diedrichs et al., 2015). Analyses revealed improvements for intervention students in the teacher-delivered group relative to controls at post-program in body esteem, negative affect, dietary restraint, and for both intervention groups for life engagement. This provided evidence that some immediate benefits can be achieved from a single session, leading the authors to conclude that single session interventions might provide a “more acceptable and feasible intervention option in schools” (p. 100) than longer programs.

In short, just as we should not take the meta-analytic findings by Stice and Shaw (2004) and Stice and colleagues (2007) to mean that only targeted (and not universal) programs, with females-only (rather than both girls and boys) who are 15-years and older (rather than early or pre-adolescents) are worthy of research attention, we need to reconsider if single session (or brief) programs can be of value. It seems that the universal field has yet to rigorously investigate single session programs that are designed in a way that includes other features associated with larger effect sizes, thus maximizing the likelihood of being efficacious. That is: being interactive in learning content; avoiding psychoeducational content about eating disorders; targeting developmentally-relevant risk factors; and evaluated with validated outcome measures. A single-session intervention that has been well evaluated, shown to have benefits and likely increases and organization's willingness to pursue further content, would be a very valuable, pragmatic tool in the overall pursuit of dissemination of evidence-based interventions.

3. Adding clarity to our science: The importance of accurately articulating what universal programs seek to achieve

The terms “body image program” and “eating disorder prevention program” are often used interchangeably in the universal field. To some degree this is not of concern, body image and eating disorders are clearly related and indeed all scientific efforts to develop efficacious programs should be welcomed. But it does provide a hint of a more broad issue: what are our programs seeking to achieve - Improving body image? Reducing eating disorder risk? Preventing eating disorders?

Whilst a widely used shorthand phrase, the use of the term “eating disorder prevention” programs in universal settings is still fraught as no universal program has been found to significantly reduce eating disorder onset. This is an issue that Carolyn Black-Becker has recently written about and has helpfully recommended the term “eating disorder risk factor reduction trials” for those RCTs that measure prospectively identified risk factors but not diagnostic criteria (Becker, 2015). This seems a very appropriate recommendation and one that the field would benefit from using.

Also at the core of this discussion are the risk factor targets of our programs. Weight concerns is widely considered the most proximal eating disorder risk factor (Jacobi & Fittig, 2010) after being identified in a number of high quality prospective risk factor studies (e.g., Cooper & Goodyer, 1997; Killen et al., 1996). The concept of weight concerns differs in a subtle but important manner from body image and body dissatisfaction more broadly. Whilst body image could be thought of as one's perception of one's physical body and often includes items such as “I think that my thighs are too large” (Garner, 1991), weight concerns contains a more evaluative component (e.g., “Has your weight influenced how you think about (judge) yourself as a person?”: Fairburn & Beglin, 1994). It has been proposed that body dissatisfaction is heavily influenced by mood and is thus of a more labile nature whilst weight concerns are a more stable construct that includes the value placed on one's body weight and shape to an individual's self-worth (Cooper & Fairburn, 1993). Finally, weight concerns and overvaluation of weight and shape are clinical and diagnostic features of patients with an eating disorder.

It is of course clear that poor body image is associated with many negative outcomes such as lower mood, depression, unhealthy weight control practices, disordered eating (Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006) and that poor body image conveys suffering in its own right and is thus a worthy target of prevention programs (Wilksch, 2014). However we do need to remember that many people who experience body dissatisfaction will never progress to developing an eating disorder. Cognitive behavioral models would posit that this is due to having sufficient other components to self-worth (e.g., friendships, academic, other interests etc.) that prevent an excessive importance being placed on one's shape and weight despite having moments of not liking aspects of one's body (Fairburn, Cooper, & Shafran, 2003). In essence it seems that this is the message that is seeking to be taught in current efficacious universal programs – that simply there is more to our individual value than our weight and shape and to thus be skeptical of messages that place great importance on these elements (Wilksch & Wade, 2009).

Thus whilst all prevention efforts in our field should be encouraged, the universal field is more likely to gain greater scientific traction and thus increased likelihood of wide scale dissemination if a stronger scientific case can be made that our programs reduce the onset of the core features of the illnesses we are seeking to prevent (Wilksch et al., 2015). As such, it would be valuable for all universal programs to include a weight concerns measure, most likely from the EDE-Q (Fairburn & Beglin, 1994), to further improve the clinical relevance of outcomes. This would also allow an investigation of if universal programs can prevent the onset of clinical levels of concern of weight and shape as was the case in a recent RCT at 12-month follow-up (Wilksch et al., 2015). Indeed it would be valuable to take this further and to include all four EDE-Q scales (Restraint, Eating Concern, Shape Concern, Weight Concern) to obtain a Global EDE-Q score as an indicator of disordered eating (Fairburn & Beglin, 1994). Given relevant prospective risk factor research (Jacobi & Fittig, 2010; Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Stice, 2002), it would be prudent to also measure negative affect, perceived pressure to be thin (or muscular for boys), media internalization, and, weight-related comments. Whilst body image programs are valuable in their own right, we cannot assume that they are having flow on benefits to key eating disorder risk factors and indeed clinical concerns without measurement of these features. Thus we need both greater clarity in the terminology used to describe our programs, and increased use of clinically relevant outcome measures.

4. How should dissemination occur?

Prevention scientists are in a constant tension between pursuing methodologically rigorous scientific research whilst also being well aware of the ‘real world’ limitations in which this work is conducted. Nowhere is this more apparent than in universal, school-based research.

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