



Reducing eating disorder risk factors: A controlled investigation of a blended task-shifting/train-the-trainer approach to dissemination and implementation



Lisa Smith Kilpela^{a,*}, Kaitlin Hill^{a,1}, Mackenzie C. Kelly^{a,1}, Joanna Elmquist^{a,2},
Paige Ottoson^{a,3}, Demetra Keith^{a,4}, Thomas Hildebrandt^{b,**}, Carolyn Black Becker^{a,***}

^a Department of Psychology, Trinity University, San Antonio, TX, USA

^b Department of Psychiatry, Mount Sinai School of Medicine, New York, NY, USA

ARTICLE INFO

Article history:

Received 5 August 2014

Received in revised form

11 September 2014

Accepted 15 September 2014

Available online

Keywords:

Train-the-Trainer

Task-shifting

Dissemination

Implementation

Eating disorders

Prevention

ABSTRACT

Recent advances in psychological intervention research have led to an increase in evidence-based interventions (EBIs), yet there remains a lag in dissemination and implementation of EBIs. Task-shifting and the train-the-trainer (TTT) model offer two potential strategies for enhancing reach of EBIs. The Body Project, an EBI found to prevent onset of eating disorders, served as the vehicle for this dissemination/implementation study. The primary aim of this study was to determine if training of peer-leaders for the Body Project could be task-shifted to undergraduate students using a hybrid task-shifting/TTT model. Our secondary aim was to determine if subgroups of participants evidenced different trajectories of change through 14-month follow-up. Regarding the first aim, we found almost no evidence to suggest that a presence of a doctoral-level trainer yielded superior participant outcomes compared to training by undergraduates alone. Regarding Aim 2, almost all classes for all variables evidenced improvement or a benign response. Additionally, for three key risk factors (thin-ideal internalization, body dissatisfaction, and ED symptoms) virtually all trajectories showed improvement. This study provides initial support for the use of a blended task-shifting/TTT approach to dissemination and implementation within prevention generally, and further support for broad dissemination of the Body Project specifically.

© 2014 Elsevier Ltd. All rights reserved.

Researchers have made notable advances in the development and testing of psychological interventions, resulting in a significant increase in evidence-based interventions (EBIs). Yet, one common critique of EBIs concerns the gap between the scientific evidence supporting such interventions and clinical application and/or

utility in community practice settings (e.g., Kazdin & Blase, 2011; Lilienfeld et al., 2013; Proctor et al., 2009; McHugh & Barlow, 2010). In other words, there remains a significant lag in the process of dissemination and implementation following the production and scientific testing of EBIs. This reduces the day-to-day clinical impact of these interventions, despite the fact that providers are increasingly being asked by various constituents to provide EBIs (Proctor, 2004; Proctor et al., 2009).

Kazdin and Blase (2011) and others (e.g., Fairburn & Patel, 2014) have further noted that even if every clinician offered the best available EBI to every client, the field still would be limited in reducing the global burden of mental illness because one-on-one therapy has limited scalability (i.e., limited capacity to be scaled up to reach large populations without losing effectiveness). Simply put, there will never be enough expert therapists to provide services to everyone who could use them, and the one-on-one expert-provider therapy model is too expensive, particularly in resource poor environments (Fairburn & Patel, 2014; Kazdin & Blase, 2011). A number of solutions have been proposed to address the problems

* Corresponding author. Tel.: +1 210 999 8381.

** Corresponding author.

*** Corresponding author.

E-mail addresses: ismith9@trinity.edu (L.S. Kilpela), khill3@hawaii.edu (K. Hill), mckelly4@hawaii.edu (M.C. Kelly), jelmquis@vols.utk.edu (J. Elmquist), paige.e.ottoson@gmail.com (P. Ottoson), demetra.keith@assumption.edu (D. Keith), tom.hildebrandt@mssm.edu (T. Hildebrandt), cbecker@trinity.edu (C.B. Becker).

¹ Present address: Department of Psychology, University of Hawai'i at Mānoa, 2530 Dole Street, Sakamaki Hall C400, Honolulu, HI, USA.

² Present address: Department of Psychology, University of Tennessee, 1404 Circle Dr., Austin Peay Building 204, Knoxville, TN, USA.

³ Present address: Department of Psychology, Palo Alto University, 1791 Arastradero Rd, Palo Alto, CA, USA.

⁴ Present address: Assumption College, 500 Salisbury Street, Worcester, MA, USA.

outlined above. Among these include an increased focus on prevention, task-shifting to less expensive providers, and use of a train-the-trainer model (Fairburn & Patel, 2014; Fairburn & Wilson, 2013; Kazdin & Blase, 2011; Zandberg & Wilson, 2012).

Although prevention historically has received somewhat less attention from mental health specialists, prevention has been used widely in the public health field to reduce suffering in other areas of health care. For instance, public health interventions, which commonly target prevention of health problems, increased the average life expectancy in the United States by 25 years during the 20th century (Centers for Disease Control and Prevention (CDC), 1999). Prevention targets included, but were not limited to, variable risk factors for such health concerns as infectious diseases, foodborne illness, tooth decay, birth defects, lung cancer and emphysema (CDC, 1999). Variable risk factors (e.g., smoking behavior) are risk factors that increase risk for a given disorder and can be manipulated to reduce risk (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004). Variable risk factors, thus, provide targets for prevention efforts. In contrast, fixed risk factors (e.g., gender) help identify risk but do not offer viable prevention targets. As noted by Kazdin and Blase (2011), a reduction in the global burden of mental illness will, at some level, require prevention to reduce the onset of mental illness, which in turn will reduce incidence, and the necessity and cost of treatment.

Task-shifting, which involves delivering EBIs via less expert (and expensive) providers, offers another option for expanding the impact of efforts to reduce mental health suffering (Patel, Chowdhary, Rahman, & Verdeli, 2011). This often consists of shifting from professionals to lay persons as providers, but also can include shifting work from a more expert/expensive professional to a less expert/expensive professional. Therefore, task-shifting both has the potential to markedly reduce the cost of intervention delivery as well as significantly increase the availability of providers. When combined with community participatory research methods (see Israel, Eng, Schulz, & Parker, 2005 for discussion of community participatory research), task-shifting also can increase access to difficult to reach populations by engaging gate-keepers (e.g., community leaders) both as providers and as research collaborators.

Yet another option for improving the impact of EBIs involves a train-the-trainer (TTT) approach (Herschell, Kolko, Baumann, & Davis, 2010; Zandberg & Wilson, 2012). The TTT model typically involves training providers to deliver training in a given EBI to other providers. To some degree this involves task-shifting, usually from a very expert/expensive trainer (e.g., the person who creates a form of CBT for eating disorders) to a moderately expert/expensive provider (e.g., licensed CBT therapist at a mental health clinic). It does not, however, typically involve task-shifting on the scale that might be employed in other settings (e.g., from a professional to a lay person). Although the TTT approach has been found successful for both traditional psychotherapy and guided self-help in a few studies (e.g., Wade, Treat, & Stuart, 1998; Zandberg & Wilson, 2012), it also has been critiqued as insufficiently scalable. For instance, Fairburn and Wilson (2013) note that the TTT approach would take far too long as the primary method of training therapists to implement EBIs aimed at treatment. The typical task-shift from very expensive/expert trainers to moderately expensive/expert providers in the psychotherapy TTT model also limits this approach in terms of financial and human resource costs. It is unclear, however, if the same limitations apply to prevention, where there also is preliminary support for a TTT model (Perez, Becker, & Ramirez, 2010). It is important to note that the discussed solutions should not be viewed as mutually exclusive. In fact, as can be seen from the dissemination case study below, layering solutions often will have a greater impact.

The Body Project: A case example in dissemination and implementation

The Body Project is a 4-h body image intervention that has been found to prevent the onset of eating disorders (Stice, Marti, Spoor, Presnell, & Shaw, 2008; Stice, Rohde, & Shaw, 2013). Based on the dual pathway model of bulimia nervosa (Stice, Ziemba, Margolis, & Flick, 1996), the Body Project targets internalization of the thin-ideal standard of female beauty using a cognitive dissonance-based approach (Stice, Rohde, & Shaw, 2013). Cognitive dissonance is an uncomfortable psychological state that results when an individual's actions conflict with his/her beliefs (Festinger, 1957). In the case of the Body Project, participants are encouraged to voluntarily engage in anti-thin-ideal behavior via speech and action, which conflicts with pro-thin-ideal beliefs resulting in cognitive dissonance and a subsequent reduction in thin-ideal internalization. This reduction in thin-ideal internalization then theoretically cascades into a reduction of numerous variable risk factors for eating disorders including body dissatisfaction, dietary restraint, negative affect and ultimately early stage eating disorders pathology (Jacobi & Fittig, 2010; Stice, Rohde, & Shaw, 2013). The Body Project has been branded under a variety of names for different dissemination efforts (e.g., *Reflections: Body Image Program*; *Succeed Body Image Programme*); because current dissemination efforts largely have coalesced under the Body Project brand, for this paper we use this title.

The Body Project is supported by substantial efficacy and effectiveness research generated by multiple labs (Becker, Bull, Schaumberg, Cauble, & Franco, 2008; Becker, Bull, Smith, & Cio, 2008; Becker, Smith, & Cio, 2005; Becker, Smith, & Cio, 2006; Becker et al., 2010; Matussek, Wendt, & Wiseman, 2004; Roehrig, Thompson, Brannick, & van den Berg, 2006; Stice, Chase, Stormer, & Appel, 2001; Stice et al., 2008; Stice, Mazotti, Weibel, & Agras, 2000; Stice & Presnell, 2007; Stice, Rohde, Durant, Shaw, & Wade, 2013; Stice, Rohde, Gau, & Shaw, 2009; Stice, Rhode, Gau, & Shaw, 2012; Stice, Rohde, Shaw, & Gau, 2011; Stice, Shaw, Becker, & Rohde, 2008; Stice, Shaw, Burton, & Wade, 2006; Stice, Trost, & Chase, 2003). Indeed no other body image intervention and eating disorder prevention program is supported by more research than the Body Project (see Becker, MacKenzie, & Stewart, *in press* for review). The Body Project has been found to yield long-term effects (i.e., 1–3 years) in controlled trials, and efficacy and effectiveness research support its use in both high school and university samples (Becker et al., *in press*). Research also supports the theoretical underpinnings of the Body Project (see Stice, Becker, & Yokum, 2013 for review).

Additionally, research investigating the Body Project has tested some of the approaches mentioned above to improve dissemination and implementation of this program. For instance, community participatory research (see Becker, Stice, Shaw, & Woda, 2009 for additional details) by our lab has demonstrated that delivery of the Body Project can be task-shifted from professional or graduate-level providers to undergraduate peer-leaders (Becker, Bull, Schaumberg, et al., 2008; Becker et al., 2006; Becker et al., 2010; Perez et al., 2010). Relevant to dissemination, we began studying task-shifting because we lacked the financial and staffing resources to implement the Body Project exclusively with higher level/more expensive providers. Also, we have found that many universities prefer the peer-leader approach both for cost reasons and because it provides leadership experience for students.

In 2008, we launched a North American-based Body Project dissemination effort in partnership with the Tri Delta sorority. The aim of the project was to disseminate the peer-led version of the Body Project to Tri Delta university chapters throughout North America as well as to other universities and/or sororities that might

Download English Version:

<https://daneshyari.com/en/article/7262546>

Download Persian Version:

<https://daneshyari.com/article/7262546>

[Daneshyari.com](https://daneshyari.com)