



Using participant feedback to improve two selective eating disorder and obesity prevention programs

Heather Shaw*, Paul Rohde, Eric Stice

Oregon Research Institute, United States



ABSTRACT

Objective: To examine qualitative feedback from participants of *Healthy Weight* and *Project Health* eating disorder/obesity prevention programs to guide refinements to increase program efficacy.

Method: Feedback was collected from college students with weight concerns randomly assigned to one of these interventions ($N = 364$, 72% female).

Results: *Healthy Weight* participants reported greater program satisfaction ($p = 0.02$); no other quantitative differences emerged in opinions of the program or leaders. *Project Health* participants most valued goal setting (27%), the group setting (23%), and the provided information (16%). *Healthy Weight* participants most valued the group setting (21%), goal setting (19%), and accountability for behavior change (18%). *Project Health* participants reported home exercises most frequently as least valuable (22%), followed by role-plays (13%). *Healthy Weight* participants most frequently reported “nothing” as least valuable (24%), followed by food/exercise logs (9%). The top suggestion from participants from both groups was to add interactive activities.

Conclusions: Weight gain preventive effects of *Project Health* were stronger, but *Healthy Weight* participants were more satisfied, perhaps because *Project Health* incorporates dissonance-induction strategies which produce psychological discomfort that promotes internalization of health lifestyle goals. Both interventions could be made more interactive by adding group exercises, encouraging group connection via social media, and adding icebreakers.

Healthy Weight, an eating disorder and obesity prevention intervention in which women with body image concerns make gradual lifestyle refinements that bring dietary intake and output into balance, is the only prevention program to significantly reduce future onset of both eating disorders and obesity in multiple trials (Stice, Marti, Spoor, Presnell, & Shaw, 2008; Stice, Rohde, Shaw, & Marti, 2012, 2013; Stice, Shaw, Burton, & Wade, 2006), and has consistently produced significantly greater reductions in body dissatisfaction than assessment only control conditions and alternative interventions, with effects persisting through 3-year follow-up (Stice et al., 2006, Stice et al., 2008; Stice et al., 2012; Stice et al., 2013). We developed a new 6-h intervention (*Project Health*) because we wanted to add activities designed to produce dissonance about engaging in behaviors that contribute to weight gain (e.g., discussing health costs of overeating). Both *Healthy Weight* and *Project Health* participants showed significantly greater eating disorder symptom reductions through 2-year follow-up, and marginally lower onset of future eating disorders over 2-year follow-up relative to educational video controls. *Project Health* participants had significantly smaller increases in BMI through 2-year follow-up and lower overweight/obesity onset over 2-year follow-up than *Healthy Weight* and controls (Stice, Rohde, Shaw, & Gau, 2018).

We collected qualitative data regarding ways to improve the interventions, with the hope this information would allow us to improve the efficacy of these programs. Considering input from key stakeholders fosters a sense of ownership, which is critical for promoting sustainability (Johnson, Hays, Center, & Daley, 2004). A prior paper examining participant feedback to three different delivery methods of the *Body Project* eating disorder prevention program found that group membership was key to participant satisfaction (Shaw, Rohde, & Stice, 2016). The current study is the first to examine qualitative feedback from participants in two programs that have reduced eating disorder and obesity onset. Programs producing effects for both eating disorder and obesity are rare, thus continuing to refine these interventions should facilitate the design of more effective dual-focused interventions.

1. Methods

1.1. Recruitment and Descriptive Information

Participants ($N = 364$) were 261 women (M age = 19.1, $SD = 1.2$;

* Corresponding author.

E-mail address: hshaw@ori.org (H. Shaw).

M BMI = 23.2, SD = 2.7) and 103 men (M age = 19.2, SD = 1.2; M BMI = 24.2, SD = 2.4); 3% were African American, 3% American/Alaskan Native, 15% Asian/Pacific Islander, 68% Caucasian, 0.5% Hawaiian/Pacific Islander, and 11% were Hispanic. College students ages 17–23 with weight concerns were recruited into a study designed to promote healthy lifestyle choices and prevent weight gain. Participants were randomized to *Project Health* (N = 119), *Healthy Weight* (N = 122), or an educational video control condition (N = 123) via a random number table. Both interventions consisted of 6 weekly 1-h group sessions with 6–10 participants and 2 group leaders. Both interventions consisted of 6 weekly 1-h group sessions with 6–10 participants and 2 facilitators. Twenty clinical graduate students or college mental health staff (17 women and 3 men, of various ethnicities) facilitated 29 groups (15 *Healthy Weight*, 14 *Project Health*; mean number of groups led by a facilitator = 2.9, range = 1–6). If a participant missed a session, a brief (10–15 min) individual session was conducted to review material when possible. Facilitators read reports regarding the interventions and the intervention script, and attended a 4-h workshop to role-play sessions and discuss process issues, including homework compliance and retention.

1.2. Interventions

Healthy Weight is described to participants as a body acceptance intervention and focuses on making weekly small, sustainable changes to diet and exercise to balance caloric intake/output. Sessions include a brief review, educational handouts, in-session discussions, review of behavior change goals, and developing healthy behavior change plans for next session. Home exercises include implementing participant-selected diet and exercise goals, and keeping food/exercise logs.

Project Health sessions begin with a verbal commitment to participate, include discussions of home exercises and in-session writing exercises, discussions and role-plays concerning the costs and negative effects of obesity, and conclude with home exercises. Participants are videotaped reading their homework to increase accountability. Activities were designed to produce cognitive dissonance to promote internalization of healthy lifestyle goals. Participants also commit to small gradual improvements to diet and activity. *Educational Video* participants were encouraged to watch a free 51-min video, called *The Weight of the World* focusing on costs of the obesity epidemic.

1.3. Measures

Participants completed a written survey post-intervention including the following three questions: (1) How satisfied were you with your experience in this program; (2) How effective do you think this program would be for someone who has weight concerns; and (3) How much do you think this program will help someone deal with or avoid weight concerns; 1–5 scale, and 10 questions regarding perceptions of group leaders (intelligence, clarity, trustworthiness, skillfulness, preparedness, experience, respectfulness, sincerity, confidence, and topical expertise; 1–5 scale). These 10 questions formed a reliable scale

Table 1

Participant ratings regarding program satisfaction, effectiveness, and whether programs could help deal with weight concerns.

	Group	Percent endorsed					Descriptive stats		t-Tests	
		1	2	3	4	5	Mean	SD	t-value	p-value
Program satisfaction	PH	1.0	6.0	26.0	40.0	27.0	3.86	0.92	2.34	0.020
	HW	0.9	3.8	17.9	33.0	44.3	4.16	0.92		
Program effectiveness	PH	0.0	2.0	27.0	45.0	26.0	3.95	0.78	0.90	0.368
	HW	0.0	1.9	20.8	48.1	29.2	4.05	0.76		
Help w/weight concerns	PH	1.0	1.0	30.0	51.0	17.0	3.82	0.76	1.81	0.072
	HW	0.0	4.7	17.9	48.1	29.2	4.02	0.82		

PH = *Project Health*, HW = *Healthy Weight*.

($\alpha = 0.92$), so an overall composite score was analyzed (mean composite score for *Project Health* = 4.45 (SD = 0.57); mean composite score for *Healthy Weight* = 4.59 (SD = 0.50).

Three open-ended questions asked: (1) What aspects of the program did you find most valuable; (2) What aspects of the program did you find less valuable; and (3) How could we make the program more interesting and enjoyable for future participants? Evaluation data were provided by 107 *Project Health* participants (90%) and 116 *Healthy Weight* participants (95%).

1.4. Data analysis

The frequency distribution, mean and standard deviation of scores are provided for the quantitative items assessing reactions to the intervention, as are the means and SDs for perception of group leaders. Differences in quantitative scores for participants in the two conditions were examined using t-tests. Content analysis was used to analyze the qualitative data as it permits quantifying the frequency of categories and themes (Vaismoradi, Turunen, & Bondas, 2013). The first two authors conducted the analysis, which consisted of reading the open-ended survey responses (which usually consisted of 1–2 sentences), independently generating codes and resolving coding discrepancies through discussion and consensus, developing final codes, and coding the data. Rank order correlations of categories suggested inter-coder agreement: (1) most valuable aspects (Spearman rho = 0.93), (2) least valuable aspects (Spearman rho = 0.79), and (3) suggested improvement (Spearman rho = 0.96). Averages of coding frequencies of the two authors are reported in Tables 1 and 2.

2. Results

2.1. Quantitative ratings of intervention and group leaders

Most participants in both interventions reported positive rating regarding program satisfaction (either a 4 or 5 on a 1–5 scale ranging from not very to very) (77% *Healthy Weight*; 67% *Project Health*); program effectiveness (77% *Healthy Weight*; 71% *Project Health*); and how they felt the program would help them deal with or avoid weight concerns (77% *Healthy Weight*; 68% *Project Health*). One of these differences, regarding satisfaction, was statistically significant; ($t[173] = 2.34, p = 0.02$); e.g., 44% of *Healthy Weight* participants reported being “very satisfied” with their experience in the program compared to 27% of *Project Health* participants. Table 1 shows the breakdown in responses to these questions (and means and standard deviations) by intervention.

Regarding rated perceptions of group leaders, average scores for *Healthy Weight* (M = 4.59, SD = 0.50) and *Project Health* (M = 4.45, SD = 0.57) suggested a trend-level difference favoring *Healthy Weight*; ($t[173] = 1.81, p = 0.073$).

Qualitative Data: Valuable Aspects and Suggested Improvements to Groups.

Tables 2 and 3 report responses to the 3 open-ended questions. Most

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