REbeL Peer Education: A model of a voluntary, after-school program for eating disorder prevention

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Abstract

Dissonance-based eating disorder prevention leads to decreases in risk factors for these disorders. Although controlled trials have demonstrated that targeted, manualized programs reduce eating disorder risk, concerns regarding implementation and dissemination remain. A primary concern is the difficulty in adapting programs for a high school setting for populations at highest risk: adolescents. This paper describes the REbeL Peer Education model and assesses the initial pilot trials of the intervention. The program is novel in that it utilizes a voluntary, self-selection model that is sustainable in a high school setting, and focuses on empowerment and effective cognitive dissonance based prevention activities. High school peer-educators self-selected into the semi-manualized dissonance based prevention. Group activities were peer led, designed to critique the thin ideal, and designed to empower macro (school and larger community wide) changes in The pilot trial (N = 47) assess the effectiveness and feasibility of the intervention. Results of the initial pilot study revealed preliminary support for the feasibility of the program, increases in feelings of empowerment, and decreases in eating disorder cognitions and behaviors with moderate to large effect sizes. Feedback from participants indicated that the intervention was enjoyable, educational, and empowering. This study is the first to adapt dissonance-based prevention models to a semi-manualized, peer-led, prevention program integrated into high school settings.

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1. Introduction

Eating disorders are one of the most common mental illnesses, affecting upwards of 13% of women between the ages of 15–25 (Jones, Bennett, Olmsted, Lawson, & Rodin, 2001; Stice, Marti & Rohde, 2013; Taylor et al., 2006) and about 4% of young men (Eisenberg, Nicklett, Roeder, & Kitz, 2011). Unhealthy disordered eating behaviors such as extreme dieting or over-exercising, affect one third to one half of adolescent girls and boys (Dianne Neumark-Sztainer, Wall, Larson, Eisenberg, & Loth, 2011). Eating disorders are associated with extremely high health care costs (Sammaliev, Noh, Sonnevile, & Austin, 2014), unemployment (Sammaliev et al., 2014), and poor quality of life (Winkler et al., 2014). Treatment for eating disorders remains a challenge as high rates of chronicity (Crow & Peterson, 2009; Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011), relapse (30–50%) (Guarda, 2008), and mortality (Ackard & Richter, 2014; Arcelus & Mitchell, 2011) exist. Thus, eating disorders and disordered eating behavior are significant public health concerns.

Eating disorder prevention has improved over the past two decades. The most recent review found more than 60 ED prevention programs (Stice, Becker & Yokum, 2013). The effectiveness of these programs has also greatly increased. At least half of ED prevention programs lead to reductions in ED risk factors (Stice, Shaw, & Marti, 2007; Stice, Becker et al., 2013; Ciao, Loth, & Neumark-Sztainer, 2014). Prevention programs, including ED prevention, may be targeted or universal. Targeted prevention aims to decrease ED risk factors, while universal prevention aims to target all individuals and prevent growth in risk factors over time (Wilksch, 2014). Numerous targeted ED prevention programs have been evaluated; however, very few universal prevention programs have been evaluated (Wilksch, 2014).

1.1. ED prevention in high school settings

Although controlled trials have demonstrated that targeted, manualized programs reduce ED risk, significant concerns regarding their dissemination remain. One primary concern is that such programs are not easily adapted to a high school setting. This is important, as adolescence is a critical period for targeting ED prevention (Rohde, Stice, & Marti, 2015; Slade & Klump, 2014). Additionally, group interventions used in school settings are a cost effective and beneficial way to address health behaviors with a limited pool of individuals (Tucker & Oei, 2007).
Targeted prevention programs require a trained individual to identify at-risk individuals, increasing both prevention costs and professional time, which are often unavailable resources at schools (Offord, Kraemer, Kazdin, Jensen, & Harrington, 1998). Second, identifying individuals in schools may stigmatize these already at-risk individuals (Roehrig & McLean, 2010). For example, targeted in-school depression prevention programs increase perceived stigma in comparison to universal programs (Roehrig et al., 2006).

Universal prevention programs offset the concerns outlined above. However, several problems also exist with universal prevention programs for eating disorders. First, universal programs are not voluntary. Among the universal prevention programs for eating disorders that have been evaluated (e.g., Austin et al., 2012; Austin & Kim, 2007; Becker et al., 2010; Becker, Bull, Schaumberg, Cauble, & Franco, 2008; Becker, McDaniel, Bull, Powell, & McIntyre, 2012; Carter, Stewart, & Fairburn, 2001; Neumark-Sztainer, Butler, & Palti, 1995; Vail-Smith, Felts, & Becker, 2009; Wilksch, 2015) none offer a voluntary program. For example, many of the current models of in-school prevention cited above offer the intervention interwoven into a mandated course such as physical education or health class. This universal approach to prevention makes the intervention impersonal, and thus, may reduce motivation to internalize the prevention message and empowerment to make behavioral changes. Finally, some data on eating disorders prevention programs suggests that targeted programs produce greater effects than universal programs (Stice & Shaw, 2004; Stice et al., 2007; Buudeberg-Fischer, Klaghofer, Gnam, & Buudeberg, 1998; Killen et al., 1993; Stewart, Carter, Drinkwater, Hainsworth, & Fairburn, 2001; Taylor et al., 2006; Weiss & Wertheim, 2005). It is notable that the most effective ED prevention programs to date utilize cognitive dissonance, and cognitive dissonance prevention programs are effective only if the subject matter is personally meaningful to participants (Desai & Mahajan, 1998). This may be one reason why universal programs, which enroll all students, regardless of ED risk, are less effective.

To summarize, targeted prevention appears to be most effective at reducing eating disorder risk, yet is difficult to implement in a self-sustaining fashion within a school system. Universal programs are easier to maintain and do not stigmatize individuals, but less likely to motivate and empower adolescents to make the behavioral and cognitive changes necessary to reduce their risk of developing an eating disorder. Thus, the goal of this project was to develop an eating disorder prevention model which addresses these concerns.

The goals of the program, REbeL, described in this study, are as follows. First, we wished the program to function seamlessly within a school system and be self-sustaining, targeting the highest risk group in the most cost-effective manner. Second, we wished the program to be based on empirically supported prevention techniques. Third, we wished to engage students in an empowerment process to work towards feeling empowered. Empowerment in this context was defined as both an active process and outcome (Carr, 2003). For example, the empowerment process was defined as active involvement in developing a participatory strategy for youth-identified issues and gaining knowledge and psychoeducation about these skills, as well as planning and engaging in social action to create a sense of cohesion, efficacy, and perceived influence over their world (empowerment as an outcome) (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004; Wilson, Minkler, Dasho, Wallerstein, & Martin, 2008). Thus, students in the program will move through stages of empowerment, developing skills, understandings, and resources to challenge the thin-ideal or pressure from friends, family, and their society at large and as a result, feel empowered to teach others and stand up against societal pressures. Empowerment has not been examined in previous studies of ED prevention. However, theoretical models of social learning (Bandura, 1997) and empowerment theory (Freire, 1993) provide evidence that individuals will be more likely to take control of their own health if they have control or mastery over their health choices in the context of the social environment. An empowerment model of health promotion has been successfully implemented in substance abuse prevention programs (Tencati, Kole, Feighery, Winkleyb, & Altman, 2002; Thackeray & Hunter, 2010; Wilson et al., 2008). And, we believe that an empowerment perspective complements the current cognitive-dissonance model used in many effective eating disorder programs, which encourage students to challenge the thin ideal (Becker et al., 2008, 2010, 2012; Stice, Rohde, Gau, & Shaw, 2012; Stice, Rohde, Shaw, & Gau, 2011; Stice, Shaw, Becker & Rohde, 2008).

The REbeL program was designed to achieve these goals, as it utilizes a self-selection model of prevention in a high school setting. Individuals apply to be part of an after-school, peer-education program to address body image and disordered eating concerns within their schools. This addresses the issue of integration within the school system, targets individuals who are at risk, and allows the program to be voluntary. The program is a semi-manualized, module-based approach to prevention. The modules are based on techniques that have been empirically supported to reduce ED risk in previously published randomized trials (Ciao et al., 2014; Stice, Martt, Spoor, Presnell, & Shaw, 2008). Drawing from previous successful ED cognitive dissonance (CD) prevention programs, activities within the modules are refined by members and aim to elicit inconsistent, or dissonant, attitudes regarding the thin-ideal standard of female beauty. Cognitive dissonance interventions for EDs have been shown to be efficacious in reducing ED risk factors (Stice, Shaw, Burton, & Wade, 2006) and the onset of EDs (Stice, Martt, Spoor, Presnell, & Shaw, 2008). As the program is module-based, it allows for both participants and leaders to tailor the program to both school and individual needs. A module-based approach allows for the students to play a larger role in the decision-making process which in turn, should increase their likelihood to engage in the behaviors and messages they promote. The name, REbeL, is based on the idea that we are encouraging students to “rebel” against the unrealistic standards for appearance set forth by our culture (i.e., the thin ideal), the diet mentality, and conformity. Also important, is the focus on teaching students to “be” aware, informed, critical consumers, and agents of change in their communities.

This paper will first describe the theoretical framework of the REbeL program. Next, we present data on the initial study assessing the program. We aimed to assess the level of ED risk of individuals self-selecting into the program, feasibility and acceptability of the intervention, and preliminary data on outcomes for the program. We hypothesized that individuals self-selecting into the program would have elevated levels of ED risk factors. Second, ED risk factors would decrease and feelings of empowerment would increase.

1.2. REbeL intervention

1.2.1. Theoretical framework

REbeL was designed to empower individuals to challenge the thin ideal as a group while increasing feelings of self-esteem and positive body image. The program focuses on: 1) Decreasing perceived social and societal pressure to maintain a thin ideal; 2) Empowering members to engage in peer education and activism around body image, disordered eating, and self-esteem; and 3) Working as a group to create an accepting and positive body-image community within the school, social media, and community. Theorists have advocated for a need to work simultaneously with families, peers, and media to most effectively prevent the development of ED (Irving & Piran, 1999; Piran, Levine, & Steiner-Adair, 2013). Thus, REbeL activities are designed with the intent to share information within a systems level, as well as to enable members to serve as advocates on their own social media platforms. The model for youth involvement in programmatic development and execution is based on a combination of three validated models of prevention: the Bolder Model (Irving & Piran, 1999), Positive Youth Development frameworks (Chinn & Linney, 1998) and CD models of ED prevention. Rather than having pre-determined programming, members play a key role in the implementation of school-wide, community, and family education and prevention.

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