Engaging stakeholder communities as body image intervention partners: The Body Project as a case example

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ABSTRACT

Despite recent advances in developing evidence-based psychological interventions, substantial changes are needed in the current system of intervention delivery to impact mental health on a global scale (Kazdin & Blase, 2011). Prevention offers one avenue for reaching large populations because prevention interventions often are amenable to scaling-up strategies, such as task-shifting to lay providers, which further facilitate community stakeholder partnerships. This paper discusses the dissemination and implementation of the Body Project, an evidence-based body image prevention program, across 6 diverse stakeholder partnerships that span academic, non-profit and business sectors at national and international levels. The paper details key elements of the Body Project that facilitated partnership development, dissemination and implementation, including use of community-based participatory research methods and a blended train-the-trainer and task-shifting approach. We observed consistent themes across partnerships, including: sharing decision making with community partners, engaging of community leaders as gatekeepers, emphasizing strengths of community partners, working within the community’s structure, optimizing non-traditional and/or private financial resources, placing value on cost-effectiveness and sustainability, marketing the program, and supporting flexibility and creativity in developing strategies for evolution within the community and in research. Ideally, lessons learned with the Body Project can be generalized to implementation of other body image and eating disorder prevention programs.

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In a seminal 2011 paper, Kazdin and Blase argued that psychotherapy needs to be “rebooted” if the field ever hopes to address the global burden of mental illness. They noted that expert-led psychotherapy, the dominant form of mental health intervention, is too expensive to address the needs of everyone with mental illness, even if every therapist worldwide only delivered empirically supported interventions. They proposed several solutions including: increasing focus on prevention, addressing the continuum of care, using task-sharing/shifting with layperson providers, and increasing cross-disciplinary partnerships.

As Kazdin and Blase (2011) note, prevention already leads treatment in addressing their concerns. For instance, prevention more explicitly addresses a continuum of care via classification of interventions as universal (i.e., to an entire population), selective (i.e., to those at risk), and targeted/indicated (i.e., to those expressing early symptoms: Mrazek & Haggerty, 1994). Yet, both the eating disorders prevention and body image intervention fields, which often target similar psychosocial influences, also fall prey to various traps described by Kazdin and Blase. Specifically, most of our interventions use an expert-led approach targeting a limited range of high-risk individuals, typically young women with pre-existing body image concerns.

The Body Project (TBP) is a body image intervention with extensive empirical support (see below). Although much of the research supporting TBP (e.g., Stice, Rohde, Butryn, Shaw, & Marti, 2015; Stice, Rohde, Shaw, & Gau, 2011; Stice, Shaw, Burton, & Wade, 2006) is selective, TBP also has been implemented with lower-risk populations. For instance, some studies and dissemination efforts targeted mixed-risk groups (e.g., those with low and elevated body image concerns: Becker, Bull, Schaumberg, Cauble, & Frano, 2008; Becker et al., 2010); adolescent girls in western and non-Western countries (http://www.free-being-me.com/); and males (Brown & Keel, 2015; Jankowski, Diedrichs, Fawkner, Gough, & Halliwell, submitted for publication; Kilpela et al., submitted for publication). Further, TBP community has embraced other suggestions proposed by Kazdin and Blase, including task-shifting to lay providers.
and utilizing community participatory research (CPR) methodology to foster effective partnerships with stakeholders.

Herein we aim to describe the diverse stakeholder partnerships that have advanced the research and dissemination/implementation of TBP worldwide so as to help other intervention developers establish effective partnerships. We first briefly review the empirical evidence supporting TBP because all current partners report finding the strong evidence base, as well as program acceptability, critically important; we also describe our current leadership structure. We then provide a background on CPR. Next, we discuss key partnerships that have played a critical role in the study and implementation of TBP and highlight lessons learned from each partnership. Although we have tried to avoid redundancy, common themes in the lessons learned (e.g., creating mutual benefit and return on investment) are underscored.

Kazdin and Blase (2011) argue that cross-disciplinary partnerships are essential to reducing the burden of mental illness. Our experiences suggest that such partnerships bring new ideas to the table, elucidate novel avenues for implementation, and create opportunities for changing behaviors at a macro/community level. We hope this paper facilitates dissemination and implementation of other empirically supported prevention programs.

1. Body Project empirical support and leadership structure

TBP is a cognitive dissonance-based intervention in which young women voluntarily critique the thin-ideal standard of female beauty via verbal, written, and behavioral exercises. This theoretically creates the uncomfortable psychological state of cognitive dissonance, which prompts participants to reduce thin-ideal internalization because people are motivated to align their attitudes with their behaviors (Festinger, 1957). Reduced thin-ideal internalization putatively decreases body dissatisfaction, eating disorder symptoms, and eating disorder onset (Stice, Becker, & Yokum, 2013). TBP has produced larger reductions in thin-ideal internalization, body dissatisfaction, dietary restraint, and eating disorder symptoms than assessment-only control conditions and alternative interventions in multiple efficacy trials with a range of follow-up times out to 3-years (Becker, Smith, & Ciao, 2005; Green, Scott, Diyankova, Gasser, & Pederson, 2005; Halliwell & Diedrichs, 2014; Matussek, Wendt, & Wiseman, 2004; Mitchell, Mazzeo, Rausch, & Cooke, 2007; Stice, Trost, & Chase, 2003; Stice et al., 2006, 2010). TBP also yielded a 60% reduction in eating disorder onset relative to assessment-only at 3-year follow-up in the largest efficacy trial (Stice et al., 2008). Furthermore, effectiveness research indicates that TBP can be successfully delivered by undergraduate peer-leaders (Becker, Smith, & Ciao, 2006; Becker et al., 2008, 2010).

Research supports the theory underpinning TBP. Reductions in thin-ideal internalization mediated the effects of TBP on symptom reductions in Seidel, Presnell, and Rosenfield (2009) and Stice, Shaw, and Marti (2007) and participants assigned to high- versus low-dissonance induction versions of TBP show greater symptom reductions (Green et al., 2005; McMillan et al., 2011). TBP also eliminated negative effects of exposure to thin models on body dissatisfaction (Halliwell & Diedrichs, 2014). Lastly, TBP participants showed a greater pre–post-reduction in fMRI-assessed reward region (caudate) neural responsivity to thin models and attention region (anterior cingulate) response to thin-ideal statements than controls (Stice et al., 2013).

TBP is currently implemented worldwide and is supported by a global community of researchers, clinicians, stakeholder organizations, and body image activists. We maintain a loose leadership structure. More specifically, anyone can study and implement TBP simply by buying the official manual or by downloading free scripts from www.bodyprojectsupport.org. Despite this, we strongly recommend (but don’t require) that new members to our community receive training to maximize program effectiveness, particularly when working with lay providers (e.g., peer leaders; teachers); we also request that people keep Drs. Becker and Stice informed as to their work with TBP. There is no formal mechanism for people to do this, however; rather stakeholders stay in touch to the degree they desire via email and at conferences. In 2012, we established the Body Project Collaborative (BPC) to create training infrastructure. The BPC consists of highly experienced TBP trainers and researchers. To simplify language, we will describe current partnerships as occurring between the BPC and other organizations for the rest of the paper.

2. Community participatory research (CPR)

In contrast to traditional research, in which researchers develop an idea and then recruit participants, CPR engages community stakeholders in sharing decision making and power (Israel, Eng, Shulz, & Parker, 2005). CPR seeks to improve problem solving and increase knowledge by integrating multiple perspectives (Israel et al., 2005; Shoutltz et al., 2006). We use the term CPR to describe how we approach partnerships regardless of whether or not we expect them to be focused primarily on intervention implementation, research, or both. Israel et al. (2005) describe nine major facets of CPR. These include: acknowledging that communities consist of individual members who have connection to the community; building on community strengths; developing equitable and collaborative partnerships; advancing capacity building and co-learning for all; balancing joint demands of creating new knowledge with providing useful intervention; recognizing that health problems are currently troublesome for communities; engaging in a collaborative, cyclical and iterative process; sharing results in a way that respects stakeholders and provides useful information; and developing long term commitment to the project, community and sustainability.

2.1. Partnerships

2.1.1. Universities

Universities represent one of the largest cohorts of TBP implementers. In this section, we describe several university-focused partnerships to illustrate how a variety of collaborations enhance TBP implementation.

2.1.1.1. Sororities. TBP global community is the culmination of over 10 years’ evolution, integrating CPR methodology and scientific rigor. Our partnerships with sororities highlight the critical importance of CPR methods and the importance of creating sustainable strategies for implementation. The initial partnership was developed with local sororities (i.e. exist only at one institution) at a small university in 2001, with the goal of replicating Stice, Mazotti, Weibel, and Agras (2000) early TBP findings. Working with gatekeepers (i.e., individuals who belong to and can access members of a community), we conducted a pilot trial of TBP with sorority members who screened for elevated body dissatisfaction (Becker, Julik & Polvere, 2002). After the trial, in what turned out to be our first step using CPR methodology, we invited former participants to offer feedback and suggestions. Participants reported wanting more sorority members to complete the program. Accordingly, we eliminated the screening procedure and tested whether TBP yielded positive effects when implemented universally. At the time, some researchers were concerned about universal implementation (e.g., Mann et al., 1997). Results from the second trial demonstrated that TBP was beneficial regardless of risk status (Becker et al., 2005).

During the next feedback session, community members requested broader implementation. Of note, we conducted this sorority research without substantial funding or sufficient expert providers to deliver TBP. Thus, we faced our first mismatch between community needs and available resources. To address this, we used task-shifting, which involves delivering interventions via non-expert providers (Patel, Chowdhary, Rahman, & Verdeli, 2011). Specifically, we task-shifted implementation of TBP to trained undergraduate peer-leaders. Thus, CPR methodology (Becker, Stice, Shaw, & Woda, 2009) played a critical role in the evolution of TBP; several studies subsequently demonstrated...
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