Examination of a Mindfulness-based Prevention Program for Eating Disorders and Related Risk Factors

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A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy (Clinical Psychology)

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July 2014

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ABSTRACT

Prevention of eating disorders represents an important goal due to damaging long-term impacts on health and well-being, modest treatment outcomes, and low treatment seeking among individuals at risk. The present research therefore investigated a novel prevention approach based on mindfulness, with the aim of progressing knowledge regarding successful strategies for reducing risk of disordered eating.

This research first sought to investigate individual engagement in metacognitive acceptance, a core concept within mindfulness practice. Female undergraduate students underwent a body dissatisfaction induction procedure, received training in metacognitive acceptance or no training (control), and were assessed on engagement. Non-engagement in acceptance was associated with negative affect, emotion regulation difficulties and avoidant coping. Acceptance training significantly reduced weight and appearance dissatisfaction and negative affect relative to control, with effects moderated by mindfulness, emotion regulation difficulty and avoidant coping. These findings provided support for the short-term efficacy of metacognitive acceptance, and identified the need to cater for those with emotion related difficulty when delivering acceptance-based interventions.

The next objective was to conduct a controlled comparison of a mindfulness-based versus a dissonance-based program with respect to reducing risk of disordered eating in young females. This was conducted initially with a sample of young adult women experiencing body concerns, and due to limitations conferred by a small sample, was also conducted as a class-based intervention with senior female high school students. Regarding the young adults, mindfulness participants demonstrated short-term improvements in weight and shape concern, dietary restraint, thin-ideal internalisation, eating disorder symptoms and related impairment relative to control.

In contrast, dissonance participants did not show significant improvements over control on any outcomes. Within the high school sample, results favoured dissonance with respect to reductions in weight concerns and negative affect; however, the pattern of results was generally weaker across the range of risk factors. In a subsample of students receiving instruction from a facilitator with a higher level of expertise in mindfulness training, positive effects for the mindfulness intervention on key risk factors emerged over follow-up. These findings support the efficacy of mindfulness-based prevention, with stronger effects seen in the older age group.

Due to low recruitment, a further study investigated voluntary participation in selective eating disorder prevention programs and evaluated a motivational approach to increasing participation. Female undergraduate students were randomised to a motivational or control condition, presented with a flyer for a prevention trial and assessed regarding participation. Interest and likelihood of participation was low overall. Lack of time was the most commonly endorsed reason, with participants high on weight concerns more likely to cite the group format of the intervention as a deterrent. Belief in the helpfulness of body image programs and personal ineffectiveness were significant predictors of interest in participation. The motivational approach was not effective in increasing participation. Consequently, future eating disorder prevention efforts relying on voluntary participation may benefit from emphasising specific benefits during promotion and ensuring delivery in a time-flexible format that avoids stigmatisation.

Collectively, these findings provide support for further research regarding the application of mindfulness in a prevention context. Questions that need to be addressed include best practice regarding the optimum population, delivery format and dissemination strategies of various prevention approaches to ensure maximum impact on the prevention of eating disorders.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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ACKNOWLEDGEMENTS

It is important to consider a number of moderating factors on the outcome of this thesis (hopefully in the positive direction!) and thank them for their contribution.

It perhaps goes without saying that first thanks goes to my esteemed supervisor, Professor Tracey "Boss" Wade (Cohen's $d > 1$!). Thanks for being a foundational support: your knowledge, organisation (!), and encouragement have been valuable indeed.

Thanks also to the Butterfly Research Institute for the financial support that enabled me to focus on my research and not scrounging up a dollar for dinner. Being able to attend international conferences was a highlight of my candidature.

A big cheers to those who made this project possible on a practical level: to Ben Maddock, super IT guy, for technical assistance (and patience!) with creating and making endless changes to the online tools; to Anne, Peta, Deb, Amy, Lisa, and Stacey for assistance with recruitment, intervention facilitation, and fidelity assessments; and heartfelt thanks to the participants who took part in the various stages of this research, and the schools for their willingness to be involved.

Finally, thanks to those who made this thesis possible on every other level: my family and friends. Thanks Mum, Dad, Jase, Sam, Tyler, Blake, Maya and Shelly. It has been a topsy-turvy couple of years and I have appreciated your support – despite the infinite jokes about me sitting around doing nothing all day as a uni student! And to "the gang": Anne/Osh, Mike/Moliver, Nicole/Reido, Rach/Hiller, Caitlin/Hitcho, Sam/Sammy. Seriously guys, this adventure would have been a much drearier affair without you all.

GLOSSARY OF ABBREVIATIONS

AN = Anorexia Nervosa

BMI = Body Mass Index

BN = Bulimia Nervosa

CAMM = Child and Adolescent Mindfulness Measure

CBT = Cognitive Behaviour Therapy

CBT-E = Cognitive Behaviour Therapy – Enhanced

CIA = Clinical Impairment Assessment

DERS = Difficulties with Emotion Regulation Scale

DBI = Dissonance-Based Intervention

DSM = Diagnostic and Statistical Manual of Mental Disorders

ED = Eating Disorders

EDE-Q = Eating Disorders Examination – Questionnaire

EDI-BD = Eating Disorder Inventory –Body Dissatisfaction subscale

EDI-IE = Eating Disorder Inventory – Ineffectiveness subscale

EDNOS = Eating Disorders Not Otherwise Specified

FFMQ = Five Faction Mindfulness Questionnaire

MBI = Mindfulness-Based Intervention

PANAS-X = Positive and Negative Affect Scales - Expanded

NA = Negative Affect

USA = United States of America

VAS = Visual Analogue Scale

WCS = Weight Concerns Scale

WOC-EA = Ways of Coping – Escape-Avoidance subscale

WSC = Weight and Shape Concern