Shelly Russell-Mayhew

Nancy Arthur

and

Carol Ewashen
University of Calgary

Community Capacity-Building in Schools: Parents' and Teachers' Reflections From an Eating Disorder Prevention Program

A pilot research study to examine the effect of a wellness-based intervention on improving students' body image, personal attitudes, and eating behaviors highlighted the importance of a healthy school environment. Parent and teacher focus groups were conducted to explore the perceived influences of wellness-based interventions designed for parents, teachers, and students. Results support movement toward wellness-based programming and suggest that school-community capacity-building may be a worthwhile framework for continued study in relation to programming to prevent eating disorders. Excerpts from focus group data illustrate key themes in relation to change and demonstrate the importance of capturing both the content of the wellness-based interventions and the process of interaction in the schools. This pilot study found that interventions in schools that focus on wellness and target parents, teachers, and students are effective in terms of building capacity for promoting positive change in students' attitudes and behaviors.

Une étude pilote sur l'effet d'une intervention reposant sur l'amélioration de l'image de soi des élèves, d'attitudes personnelles et de comportements liés à l'alimentation a souligné l'importance d'un milieu scolaire sain. Des sessions avec des groupes de discussion impliquant des parents et des enseignants ont permis d'évaluer les perceptions quant aux influences des interventions reposant sur le mieux-être et visant les parents, les enseignants et les élèves. Les résultats appuient les efforts pour établir une programmation reposant sur le mieux-être et permettent de conclure que le développement de ressources scolaires et communautaires pourrait s'avérer un cadre utile pour poursuivre l'étude et y incorporer une programmation destinée à empêcher les troubles de l'alimentation. Des extraits provenant des discussions de groupe illustrent des thèmes-clés par rapport aux changements et démontrent l'importance d'exploiter tant le contenu des interventions visant le mieux-être que l'interaction dans les écoles. Cette étude pilote a permis de conclure que les interventions scolaires visant le mieux-être et impliquant les parents, les enseignants et les élèves constituent un moyen efficace de développer des ressources qui favorisent des changements positifs dans les attitudes et les comportements des élèves.

Shelly Russell-Mayhew is an assistant professor in the Division of Applied Psychology. Her research interests focus on the prevention and treatment of weight-related issues including eating disorders and obesity, interprofessional collaboration, and social justice.
Nancy Arthur is a professor in the Division of Applied Psychology and Canada Research Chair in Professional Education. Her research and teaching interests focus on career development, multicultural counseling, and issues in professional education.
Carol Ewashen is an associate professor of nursing.

Building Capacity Through Wellness Interventions

In contemporary health and education literature, community capacity-building is increasingly advocated as important to sustain wellness-based change in targeted populations. Hawe, King, Noort, Jordens, and Lloyd (2000), in a comprehensive literature review, identify three distinct dimensions of capacity-building. First, *infrastructure building* refers to the establishment of structures, skills, and resources. Second, *creating sustainability* refers to the ability to maintain a program or service or build on it. Third, *problem-solving capability* refers to the ability of a community to address issues appropriately as they arise. Programs that are based in a community capacity framework are complex because each community is unique and brings with it different contexts. Increasingly, schools are targeted as sites for wellness-based programs with "creating community capacity-building" as a preferred approach to sustainable change (Bond, Glover, Godfrey, Butler, & Patton, 2001).

Schools are social communities with the potential to have vast influence on the lives of children and adolescents because they constitute such a large portion of a young person's world (Glover, Burns, Butler, & Patton, 1998). It is important that individuals in this community, namely, students, parents, and teachers, learn skills and develop understandings that enhance health and wellness. However, it is equally important to recognize that creating a school environment that supports wellness is fundamental to the sustainability of a healthy school community. More attention needs to be paid to providing resources for teachers and schools in an effort to build capacity and to create a healthy environment for students.

One area receiving attention in schools is eating disorder prevention. In a recent study (McVey, Tweed, & Blackmore, 2004) of girls aged 10-14, approximately 30% were dieting and 10% scored at risk for disordered eating. Weight loss behaviors, most common in girls, and muscle gaining behaviors, most common in boys, have been reported in children as young as 10 (McVey, Tweed, & Blackmore, 2005). Despite the mounting evidence creating concern and the amount of academic writing produced over the past decade on the prevention of eating disorders, few empirical research studies have been published (Austin, 2000). Evaluation of education programs in schools that specifically address eating disorder prevention through didactic teaching of signs and symptoms suggests minimal effectiveness in behavioral change. In fact education programs that emphasize disease prevention may do more harm than good by causing undue attention to pathology, with limited emphasis on promoting wellness, healthy attitudes, and behavior change (Mann & Burgard, 1998; Rosen & Neumark-Sztainer, 1998). To design effective wellness-based programs and prevent inadvertent escalation of those behaviors and attitudes targeted for prevention, programming must be developmentally appropriate, continually reinforced, and focus on healthy change (Piran, 1998). For example, youth must be consistently exposed to the ideas of self-acceptance and positive body image (Russell & Ryder, 2001a).

The current study uses focus groups to explore parents' and teachers' responses to interventions designed for grades 4-9 students and to capture experiences from the interventions designed to encourage parents and teachers as resources in the community. First, a summary is presented of previous

eating disorder prevention programs in schools. Next, focus group methodology is discussed. Then results from content and process analysis of focus group data are presented in the context of the current literature. Finally, recommendations are made for future studies to examine the process of change to create community capacity.

Previous Eating Disorder Prevention Programs in Schools

A brief discussion of the major empirical studies to date for elementary, middle, junior high, and high schools students follows. A review of this literature illustrates the gaps and provides the background that supports the importance of moving away from a focus on individual change toward building capacity in the school community.

Previous Studies with Elementary Students

A contemporary trend in eating disorder prevention is to focus efforts at the elementary school level as some evidence suggests that efforts with older children may be too late because the "cult of thinness" may already be internalized (Huon, Roncolato, Ritchie, & Braganza, 1997) and negative attitudes and behaviors already established (Smolak & Levine, 1994). Further, puberty is identified as a time of vulnerability because it is often associated with weight gain and a reduction in self-esteem for girls. Prevention with preadolescents may help guide children more smoothly through this life transition (Friedman, 1996; Huon et al.; Piran, 1997). Finally, Smolak, Levine, and Schermer (1998a) argue that targeting younger children with prevention efforts may be one solution to the modest findings of earlier research with adolescents that indicates only marginal influence on attitudes and behaviors.

A number of prevention programs have been evaluated with elementary schoolchildren. For example, Kater, Rohwer, and Levine (2000) describe some promising short-term preliminary data to a school-based curriculum model for grades 4-6 aimed at developing positive body image and preventing disordered eating. It is suggested that curriculum materials entitled "Teaching Kids to Eat and Love Their Bodies Too!" are successful at positively influencing attitudes because: identified risk factors are targeted, skill and competence-building is emphasized, identity-formation beyond appearance is encouraged, and the sociocultural context is addressed. Smolak, Levine, and Schermer (1998b) also tested a school-based curriculum entitled "Eating Smart, Eating for Me" with all grade 5 students in eight classrooms. The results of this program were more typical as it was relatively successful at imparting knowledge about nutrition, exercise, body fat, and dieting. Changes in attitudes and behaviors were less successful overall (as predicted), but the program did reduce negative attitudes about fat people.

Previous Studies with Middle School Students

Many studies talk about the overlap in terms of content goals (i.e., preparation for puberty) for elementary and junior high prevention programs (Smolak & Levine, 1994), and nowhere is this more apparent than in studies targeting middle school ages (generally grades 5-8). Predictably, results of prevention efforts are also similar to those for elementary-age prevention in that attitude and behavior change does not occur although an increase in knowledge might. For example, Killen et al. (1993) tested their intervention program on 900

grades 6 and 7 girls aimed at nutrition, physical activity, instruction about the harmful effects of unhealthy weight regulation, and the development of coping skills for resisting sociocultural influences. Similar to research with elementary school children, there was little effect other than an increase in knowledge.

Earlier Studies with Junior High Students
Advocates for prevention at the junior high level argue that the age of onset for eating disorders is during adolescence, and thus efforts at prevention should be targeted to this age group (Smolak & Levine, 1994). There is a general acknowledgment in the literature, however, that prevention programs at this level most probably need to aim at changing already existing unhealthy attitudes in addition to preventing new ones from developing (Smolak, 1999).

Studies targeted at this age also tend to indicate no differences in attitudes and behaviors between the intervention and control groups although an increase in knowledge is often indicated for the intervention group (Moreno & Thelen, 1993). Unfortunately, other studies indicate that this increase in knowledge about eating disorders may "do more harm than good" (Cohn & Maine, 1998; Piran, 1998). O'Dea and Abraham (2000) examined the effects of a self-esteem-based educational program on junior high school students' eating attitudes and behaviors and attitudes toward their bodies. The "Everybody's Different" program consists of nine weekly lessons of 50-80 minutes each. This is the first study in this age group to show significant findings above and beyond an increase in knowledge. This wellness-based intervention improved body satisfaction, physical appearance ratings, and current weight-losing behaviors of students. The authors suggest that the cooperative, interactive, student-centered approach that focused on producing positive changes in students' self-perceptions contributed to the outcome.

Summary
Eating disorder prevention outcome studies indicate that programs targeted at youth that avoid direct discussion of eating disorders are most effective in preventing unhealthy attitudes and behaviors, particularly for elementary through junior high school. Further, studies incorporating health promotion as well as addressing the limitations of the current eating disorder prevention programs (O'Dea & Abraham, 2000) have had the most significant results in terms of students' attitude and behavior change. Notably, the voice of teachers and parents as role models in the school community is absent in most eating disorder prevention studies.

The Current Study: Moving Forward With Community Capacity-Building as a Framework
There are legitimate concerns about the possibility that eating disorder prevention efforts could cause undue attention to pathology (Mann & Burgard, 1998). An alternate approach is a movement toward understanding factors that build resilience and protect youth from risk behaviors in general (Bond et al., 2001; Scales & Leffert, 1999). Capacity-building involves building on strengths in the individual, but also making use of available resources to strengthen the community. Eating disorder prevention programs have neither focused exclusively on wellness-based interventions nor captured the voices of parents and teachers in determining the efficacy of interventions to change students' attitudes

and behaviors. This study attempts to address both concerns by inviting the participation of teachers and parents as resources for healthy student development. First, the wellness-based interventions were designed with a focus on experiential and interactive approaches to facilitate learning. Also, as described in more detail in the next section, the student interventions focused exclusively on wellness and did not specifically address eating disorders. Second, teachers and parents were also included as targets of intervention with the purpose of creating a sense of community for student change and to capture the perspective of parents and teachers that is missing from earlier research.

Rationale for Intervention

The interventions in this research project respond to the need for quality health education. They are designed to empower students as active agents in maintaining healthy eating attitudes and behaviors. Targeting the school community inclusive of parents, teachers, and students potentially effects the development of a school culture that sustains healthy change. Educational wellness-based prevention messages need to be developmentally appropriate (Piran, 1998). For example, in an adult population, informing about the signs and symptoms of disordered eating is important for the potential secondary prevention gained. However, this same didactic information-giving approach has been proven ineffective in behavior change for younger audiences (Cohn & Maine, 1998; Piran, 1998; Russell & Ryder, 2001a).

Interventions

Studies have indicated that using puppetry with children can aid in building self-esteem, creative abilities, and problem-solving skills (Synovitz, 1999). A puppet play scripted and designed by Eating Disorder Awareness and Prevention (EDAP, 1996) entitled *It's What's Inside That Counts: Promoting Healthy Self-Esteem and Body Image* was the intervention used with elementary students. The goal of the play was to help children accept diverse body shapes and to reject messages that say they need to achieve a "perfect" body.

In collaboration with experts in the area of body image and eating disorders, youth representatives, and school board personnel, a play entitled *Heavenly Bodies* was scripted for the junior high intervention. It focused on healthy body image, self-esteem, self-acceptance, puberty changes, relationships, dangers of dieting, and the influences of Western culture. This play was loosely based on *Alice in Wonderland.*

Parents were involved in an in-service workshop entitled "Building Blocks to a Positive Body Image: A session for parents in the prevention of eating disorders." In this interactive session the relationship between body image, eating disorders, and a realistic sense of self was discussed. Parents also had an opportunity to discuss strategies that promote positive body image and to reflect on the multitude of factors that affect the development of body image in their children. A teachers' inservice workshop entitled "Building a Body-Positive Environment in Schools: A Session for Educators in the Awareness and Prevention of Eating Disorders" was the intervention for this target group. In this interactive session teachers were presented a continuum of disordered eating including the *whys* and *ways* that students may attempt to alter their bodies (Russell & Ryder, 2001b). A problem-solving discussion focused on how schools can create a more positive environment. As part of the parents' inser-

vice workshop, a series of handouts were gathered and developed to supplement and reinforce ideas presented in the sessions. Referral information was made available at the end of the handout package for parents who wanted further follow-up or treatment information. As a supplement to the teachers' inservice workshop and to encourage schools to expand on and reinforce the messages presented, follow-up classroom activities for teachers were researched and developed. Thus the wellness-based interventions involved separate developmentally appropriate approaches for elementary students, junior high students, parents, and teachers.

Focus Groups With Parents and Teachers

Focus groups are planned discussions on a specific and defined area of interest (Clark, Marsh, Davis, Igoe, & Stember, 1996) in an environment conducive to honest discussion and disclosure. They are used to capitalize on group interaction to elicit exploratory and descriptive data (Asbury, 1995). Focus groups are especially useful in exploring new research areas, examining complex clinical issues, or when a particular group's perspective is important (Asbury; Cote-Arsenault & Morrison-Beedy, 1999). The intent of the focus groups in this study was to understand how parents and teachers perceived the interventions (Krueger, 1994).

Focus groups were used to capture parents' and teachers' responses to the interventions and were co-facilitated by a project coordinator and the third author. Participants from the teacher and parent inservice workshops were invited to participate in separate focus groups following the interventions. Focus groups for teachers were conducted on a school day for 45 minutes during the lunch hour. Parents were invited through school communication to attend a 60-minute focus group at the school on a weeknight. A total of 50 parents and 52 teachers participated. Ten schools received the interventions, and the separate focus groups were designed to capture responses to the interventions. These focus groups aimed to answer five main questions to assess behavior change:

• What stood out for you in the intervention program?
• How did this program affect your child/student?
• How did this program affect your relationship with your child/student?
• How did the program affect you personally?
• What more could happen for parents, teachers, and students in this program?

Data Analysis

Focus groups were audiotaped and transcribed. The nature of coding focus group data is unique because there are two units of analysis: the individual and the group. Morgan (1997) suggests that analysis must seek a balance that acknowledges both. The individual influences the group and vice versa; therefore, both levels of analysis are important to consider. Analysis centers on the substantive content produced with consideration of the individuals, the group, and the interaction (Morgan). In this study, emerging content and process themes were identified according to the specific focus group questions and in keeping with the study goals of tracking individual student and school community health-promoting, wellness-based changes.

The focus group data reflect the content of discussion in the focus groups. The processes of interaction are also captured. Often focus group analysis attempts to surface content themes. However, the processes of interaction in relation to community capacity-building are also of value in this study. Morgan (1997) invites in-depth analysis of interaction and encourages researchers to take advantage of the complexity of group in the analysis. Recent authors echo this idea: "The participants in a focus group are not independent of each other, and the data collected from one participant cannot be considered separate from the social context in which it was collected" (Hollander, 2004, p. 602).

<div align="center">*Results*</div>

The following section highlights the pathways and barriers that emerged in the focus groups that inform our understanding of a school-based wellness intervention. Three components of the focus group are highlighted here: *emotional response to change, pathways and barriers to community capacity-building*, and *working as a community*. Excerpts from the focus group interviews exemplify the responses and interactions of parents and teachers to showcase both the content and process. Finally, each section highlights implications for learning and change.

<div align="center">*Emotional Response to Change*</div>

Content of Focus Groups

The interventions were the impetus for an emotional response, which seemed to center around a struggle for balance between common knowledge and the introduction of new ideas. This emotional reaction to new information for the teacher and parent groups seem to involve deciding what is best for the child/student and how this relates to one's own personal experience.

> The other thing, though I wonder if one of the main messages was, you now, be happy with the body you've got … and it sort of strikes me that there has to be some correlation between image and reality, and I don't, I almost don't think it's enough to say, "be happy with the body you've got." I think, you know, I mean if you're fat, you're fat and you're going, it's going to be a drag to try on clothes, it's going to be harder to work out and all that sort of thing and so the two sort of have to go hand in hand. But you can't have this "I'm fat and that's just who I am" sort of thing. I'm not sure that works. (Junior high teacher)
> But as an adult I sort of thought, you know, there's a bit of a conflict there in my mind, you, know, then how do you push the active living thing and at the same time do the body image thing. It's okay to be who you are, you know? How do you get around that? I have no answer. (Elementary teacher)

Frustration, confusion, conflict, and strong feelings characterize the content here. The introduction of new ideas seemed to be difficult to integrate with existing understandings, and groups seemed to do some juggling with the content.

Process of Interaction

At this point in the group process, tensions and conflict were evident. It was important that the facilitators stay with the tensions of the group and remain neutral, not defensive. It was also important that the facilitators encourage

discussion rather than give answers. The facilitator needed to be knowledge-able about questions and probes so that information could be obtained that would allow understanding on a deeper level (Nabors, Ramos, & Weist, 2001). The *emotional reaction* and *struggle for balance* that emerged through group interaction was one of the most important study findings in that an emotional response seems to precipitate significant learning experiences.

This study supports the idea that intervention needs to move beyond solely the delivery of information and include an affective component to experiential learning. This study reiterates the importance of moving away from didactic teaching to experiential learning (Piran, 1997). This was amplified in the parent group when parents were asked to reflect on their own experiences of body image through an experiential group exercise and then relate this experience to their children. It became evident that a personal connection to the material paved the way for deeper levels of understanding. This experiential learning across significant relationships had a notable effect on parents.

> I guess what struck me about the evening is that I thought it was more or less, like, how we could get information to help our children but what I took away from it was that this was information that was helping me. You know, in terms of my own sort of view of the world and view of myself and view of society, and actually I've been much more conscious about society's messages of weight bias and sort of what we look like and things that I see on TV or in print magazines, whatever, it infuriates me even more. (Elementary parent)

Pathways and Barriers to Community Capacity-Building

Content of Focus Groups

Both pathways and barriers to health-promoting change were identified throughout the focus group discussions. Polarized ideas emerged that seemed to be related to attempts to integrate new information. Pathways for health-promoting change centered around discussion of intrapersonal, interpersonal, and sociocultural experiences that facilitated awareness and action toward healthy change and capacity, whereas barriers centered around the blocks that challenged movement toward change. A select sample of content themes is presented to illustrate.

Role-modeling. Role-modeling can act as both a pathway and a barrier to awareness and action. Teachers and parents express their understanding that they have influence, positively and negatively, on the attitudes that students have about eating and body image.

> The relationship there and how we do mirror our attitudes, as subtle as they are, we pass them on to our children, and I think that they really pick up on that. (Junior high parent)
> I wonder what kind of messages we give to kids through modeling, which is, teachers all believe that's the best way to teach is through being, and I'm concerned and I'm as guilty as everybody else that eating on the run and not eating properly or stuffing, or even general discussions about food and the fact that we have a pop, two pop machines in the building bothers me greatly. (Junior high teacher)

Both parents and teachers talked about the importance of their own attitudes in relation to the attitudes students develop about eating and body image.

Investedness. Investedness is about the expressed need to be involved at some level and an acknowledgment of one's own role in the promotion of a healthy body image. Teachers in this section highlight going above and beyond the call of duty for what they consider an important topic.

> And that was even interesting to see that some classes had maybe one that didn't sign it [consent to research] and others maybe had one that did, and part of that is I know some teachers said, "you bring that in because that's homework. I want it signed whether/or, yes or no, but you bring it in—it's homework." And we did even try to, we did a pizza lunch for pete's sake. You'd think that would be enough to make them want to do it. (Junior high teacher)

In contrast, teachers also mentioned the limits to their responsibilities and sometimes feeling overwhelmed or burdened with the "extras."

> Well, I mean we're like students, you know, I get something extra on my plate. I'm ashamed to say that. I feel bad but still I mean this is the truth … Well, I would maybe structure it more to know wither the responsibility of the health teacher or religion like so people know exactly, ok, I've seen this, now it is my responsibility … to meet with the whole staff and then to meet specifically with whoever you feel that, which would be very difficult to do. Then it would become one of those, a thing being piled up on everybody to do, try to get to an extra meeting. (Junior high teacher)

Balancing the desire to make a difference with the existing pressures and duties is a difficult task for teachers.

Acceptance. Teachers and parents discussed the importance of accepting self and others regardless of appearance. It seems a difficult balance to be able to accept yourself despite external influences.

> I think the whole thing was a wonderful experience for my daughter. She's overweight and she's been struggling for several years on her weight and not accepting herself the way she is and know that it's not accepted by others, by her peers, and she's just come out of her shell. It's more accepting, it's fine, I'm overweight, I'm going to deal with it, she says, you know. She's trying to eat healthier, she's getting a different perspective on it and it's just totally wonderful. (Elementary parent)
>
> It's curious, I think, that you know, it's we sit here and say, okay, that you should all feel this way but we all feel our own inadequacies. We watch the play and we know how we should feel about ourselves too. (Elementary teacher)

Interconnectedness. Interconnectedness is evidenced when adults shift their focus from the child exclusively to discussing influences on their relationship. Interconnection is used to describe content that alludes to relational discourse. Interconnectedness between the child and parent and the student and teacher seemed to be experienced both as pathways and barriers. Parents reflected on choosing the battles with one's child wisely and seeing the larger value. Another parent commented on how parental expectation of their children could get in the way. Teachers also talked about their interconnectedness with students and how this affected their work in the school. Teachers talked about the difficulties in feeling as if their work made a difference. Interconnectedness, whether it is parent-child or teacher-student, can be experienced as a pathway

or a barrier. Either way, a reciprocal process is occurring where both people influence relationship.

> I mean there's a lot of other things that are a lot more important in life down the road that I may have to worry about, not if she's wearing a t-shirt everyday instead of a dress or something, you know, and so you sort of think of your priorities and what's important and. This time is where the kids start being more independent and wanting to buy their own clothes and go shopping with their friends and that kind of thing where before I always bought their stuff. (Junior high parent)

Prevention. Some teachers and parents talked about the value of the prevention of eating disorders, whereas others did not think it was necessary to spend time and resources when no problem currently existed.

> It should be mandatory. And it should address the k-3 level. And address the k-3, the younger grades because I think just as you had said, that basically it's there just as well as it is in grade 8 or 9, but we don't usually address it because we think, oh, they're only little kids but that's when the attitude develops and that's where it begins and that's where it fosters and grows. (Elementary teacher)
> And it, it was a very hopeful experience as far as I'm concerned, you know, that's, it's what people come out of these things, you know, A lot of the kids will come out of it, okay, this is fine, you know. I'm not talking about the kids with severe problems but, you know, for the general population, it was hopefulness. (Junior high parent)
> But I don't think in our school we should give, there are some kids that struggle with weight and issues and that's in grade 7 but I don't think you see it as much in terms of anorexia or bulimia until we hit towards the end of grade 8.… It's more when you get to grade 9 and grade 10 that you hear the comments that "I didn't eat today" or "so and so said this." (Junior high teacher)

It seems that prevention is an elusive concept because it is easy to dismiss something when there is no crisis or nothing to draw immediate attention to the need. However, many teachers and parents seemed to recognize the value of intervention before there is a problem and alluded to the importance of promoting health for all, even the youngest students.

Summary. Both pathways and barriers to change were identified, and it seemed as if parents and teachers were doing a balancing act to try to make sense of all these influences. There was evidence in the discussion of attempts to work it out, to make sense of it in their lives, and their students'/children's lives. The content suggests that both parents and teachers were affected by the intervention and that involving adults in the school community has potential to influence the effectiveness of wellness-based interventions.

Process of Interaction

At one point in the focus group process, the discussion centered about polarized ideas or ways of thinking. Themes were around pathways and barriers to change and revolved around discussion of intrapersonal, interpersonal, and sociocultural experiences that facilitate or block movement toward change. This discussion highlights the context of the interventions in that any intervention program has to assume outside influences because programs do not take

place in a vacuum. Franko and Orosan-Weine (1998) suggest that earlier prevention programs failed to create behavioral change because of the gap between the power of cultural forces and the limited scope of didactic presentations. They suggest that cultural influences are powerful and that countering such influences requires a comprehensive effort. Further, any intervention must also assume that change is a complex process and that people struggle to incorporate new information into existing knowledge. The larger societal culture plays a role in the school culture, and in turn the school culture plays a role in the focus of group interactions. It is important to recognize that outside influences interact with any program designed to create change.

Analysis of data suggests that the change process in relation to the wellness-based interventions and creating health promoting change included four levels of dissonance: affective (personal), cognitive (knowledge), relational (parent-child; teacher-student), and social (norms). First, affective dissonance was noted and was expressed in the group through tension and conflict about what constituted barriers and pathways. Second, cognitive dissonance required a shift in thinking in relation to what was important and useful for student health and wellness. For example, many teachers had spent years teaching about the signs and symptoms of eating disorders, and the knowledge that this could potentially be harmful was not only new, but contradictory to their current understanding. Third, relational dissonance resulted when it became clear that the rules for self were different than the rules for their child/student. For example, many parents or teachers will interact with each other with a focus on weight. "Wow, you look great; have you lost weight?" However, this type of focus and interaction is the very thing we are trying to discourage in children. Fourth, social dissonance results when cultural norms are violated. It is a challenge to go against acceptable standards or understandings of the culture. For example, exercise in our Westernized cultures is seen as such a virtuous activity that is difficult for people to imagine that when taken to extremes it could be unhealthy.

Earlier prevention literature (Franko & Orosan-Weine, 1998; Stice, Mazotti, Weibel, & Agras, 2000) suggests that one of the most important conceptual issues is that of increasing knowledge versus producing attitude and behavior change. Knowledge can be taught, but it rarely results in any meaningful changes in attitudes or behaviors. "It has been shown unmistakably that mere possession of information does not affect attitudes and behavior related to health" (Latzer & Shatz, 1999, p. 29). This disparity is one of the challenges that faces wellness interventions. This study suggests that exploring dissonance as an avenue for attitude and behavior change is a promising area for further study.

Working as a Community

Content of Focus Groups

The theme *working as a community* emerged early and is characterized by the expressed need for developing relationships between parents, teachers, and other individuals and organizations in the community. Working as a community arose out a need to change the environment to have the child feel accepted. There seems to be evidence of a clear shift from individual change to environmental change. Working as a Community does not absolve one from

responsibility; rather it includes engaging children and families for the purpose of developing community.

> I think it should be something that really connects home and school. (Elementary teacher)
> And I think that would be really good for teachers, administration, and parents to know what kid of tools are available for us to deal with those types of emotions of how they see themselves. Tools for parents and teacher and then the kids as well. (Elementary parent)
> So if you have the same kinds of key words that you're using with the children at school, at the school and at home and in the community. (Elementary parent)

Working as a community involves partnerships among the stakeholders in the child's life. Promoting a caring, healthy school environment, according to teachers and parents, requires the participation of the entire school community.

Process of Interaction

At this point in the group process, focus groups had to work through the dissonance and figure out how to incorporate new learnings. This new awareness was brought about through the negotiating of tensions. It became clear that group members were beginning to become more committed to the issues and more flexible in their positions. This negotiating and increased awareness led to a change in perspective where there was a shift in responsibility from the individual (or another individual) to locating responsibility as an interactive working together. For example, teachers' focus groups stopped suggesting what parents could do more or less of, and parents' groups stopped questioning the efforts of teachers and rather focused on a discussion that centered around accountability and responsibility as a community.

Emphasizing systematic change in the school culture that addresses varied aspects of the school environment (parents, teachers, and students) increases the likelihood that that new, healthy behaviors will be sustainable (Piran, 1999). The participatory model allows for health promotion ideas to develop through a process of dialogue (Fetterman, 2001; Patton, 1997) and to address the concerns of students, teachers, and parents in a specific school. This was a discussion focusing on action. Action was an acknowledgment of what had been done, what could be done, and what parents and teachers planned to do. The central premise was *working as a community* and really asked the question, "How can we continue to work together for change?" Parents and teachers had a plethora of strategies and ideas for action.

Interventions need to extend beyond a singular event to build capacity in a community. Fetterman (2001) talks about the importance of the "personal factor," which involves finding interested, passionate, committed people for the purpose of sustaining the momentum developed by an evaluation. In this study the personal factor was found in the parents' and teachers' groups. Particular parents and teachers enthusiastically embraced health promotion in the school community, and many creative ideas were generated that fitted the particular needs of the school. Wellness interventions should be the responsibility of everyone, and interventions should not be left exclusively to health professionals in acute-care settings. Community capacity-building allows communities (school, health, families, psychology, nursing, students, etc.) to be involved in the planning implementation and evaluation of interventions and

allows ongoing change to occur. "The passion, knowledge and skills of experts must be blended with participatory approaches that nurture reflection, dialogue, critical analysis and activism by students, parents, and other community members" (Levine & Piran, 2001, p. 248).

This study shows that meaningful learning experiences are participatory and facilitative to create an atmosphere that is rich in dialogue, self-reflection, and critical enquiry. The traditional teaching paradigm as information transfer is being replaced by contemporary experiential learning perspectives where learning involves hands-on, flexible, stimulating, and purposeful activities (Ruben, 1999). Finn and Voelkel (1993) propose two components to engagement for the purpose of learning: participation and identification. Participation is a behavioral component and is the extent to which the student is involved in activities. Identification is an emotional component and is the degree to which the student feels a sense of belonging in the school. This study finds support for the importance of both participation and identification for promoting learning and change in attitudes and behaviors.

Summary

The excerpts illustrate that student intervention needs to be combined with community capacity-building models to increase the commitment of all stakeholders and change the attitudes and behaviors of parents, teachers, and other role models regarding body image, self-esteem, and attitudes to eating. A longer-term, multi-method participatory research project with a capacity-building focus that investigates how change occurs for individuals, groups, and the school community would fill in some the gaps in this project. Future research could involve baseline, process, and outcome evaluation strategies to determine if emotional reaction, barriers and pathways, and working as community are potential indicators of healthy change in relation to community capacity-building.

This is one of the only studies to explore a wellness approach to eating and body image change that also considers the influence of parents and teachers in the intervention. This collaborative approach to education and prevention enhanced personal change in attitudes and behaviors, as well as social change at the level of the larger school community: changes that sustain wellness in the school community as a whole. This study provided evidence of the effect of parent and teacher involvement on student change. This information holds implications for what constitutes effective teacher preparation, as well as parent education. In addition, information from this study will further understanding of curriculum development relevant to wellness-based interventions. Finally, this study values the strengthening of the school community through collaborative systems of planning and delivering health education services to children and their families. Through collaborative partnering, this research is one more step toward the development of effective health-promotion strategies that meet children's mental health needs.

Conclusion

Placing the entire responsibility for change at the individual level while ignoring the unhealthy environment violates a major assumption of mental health promotion. Mental health promotion aims to foster resilient individuals *and* supportive environments. As Austin (2000) points out, focusing change in the

individual reflects a continuing individualist orientation and/or disease orientation toward the conceptualization of health promotion and illness prevention research. Sociocultural and environmental factors are fundamental to health and support the goals of mental health promotion. Similarly, the focus on both the content and process of focus group interaction assists researchers to understand the paradigm shift from individual change to social and environmental change. Both the method and results of this study support a multilevel intervention strategy for health-promoting community capacity-building.

References

Asbury, J. (1995). Overview of focus group research. *Qualitative Health Research, 5*, 414-420.

Austin, S.B. (2000). Prevention research in eating disorders: Theory and new directions. *Psychological Medicine, 30*, 1249-1262.

Bond, L., Glover, S., Godfrey, C., Butler, H., & Patton, G.C. (2001). Building capacity for system-level change in schools: Lessons from the Gatehouse Project. *Health Education and Behavior, 28*, 368-383.

Clark, L., Marsh, G.W., Davis, M., Igoe, J., & Stember, M. (1996). Adolescent health promotion in a low-income, urban environment. *Family Community Heath, 19*(1), 1-13.

Cohn, L., & Maine, M. (1998). The last word: More harm than good. *Eating Disorders, 6*, 93-95.

Cote-Arsenault, D., & Morrison-Beedy, D. (1999). Practical advice for planning and conducting focus groups. *Nursing Research, 48*, 280-283.

Eating Disorder Awareness and Prevention (EDAP). (1996). *It's what's inside that counts: Promoting healthy self-esteem and body image*. Next door neighbors/EDAP puppet program. Seattle, OR: Author.

Fetterman, D.M. (2001). *Foundations of empowerment evaluation*. Thousand Oaks, CA: Sage.

Finn, J.D., & Voelkl, K.E. (1993). School characteristics related to student engagement. *Journal of Negro Education, 62*, 249-268.

Franko, D.L., & Orosan-Weine, P. (1998). The prevention of eating disorders: Empirical, methodological and conceptual considerations. *Clinical Psychology: Science and Practice, 5*, 459-477.

Friedman, S.S. (1996). Girls in the '90s. *Eating Disorders, 4*, 238-244.

Glover, S., Burns, J., Butler, H., & Patton, G. (1998). Social environments and the emotional wellbeing of young people. *Family Matters, 49*, 11-16.

Hawe, P., King, L., Noort, M., Jordens, C., & Lloyd, B. (2000). *Indicators to help with capacity building in health promotion*. Australian Centre for Health Promotion. NSW Health Department. Available: www.health.nsw.gov.au

Hollander, J.A. (2004). The social context of focus groups. *Journal of Contemporary Ethnography, 33*, 602-637.

Huon, G., Roncolato, W., Ritchie, J.E., & Braganza, C. (1997). Prevention of diet-induced disorders: Findings and implications of a pilot study. *Eating Disorders, 5*, 280-293.

Kater, K.J., Rohwer, J., & Levine, M.P. (2000). An elementary school project for developing healthy body image and reducing risk factors for unhealthy and disordered eating. *Eating Disorders, 8*, 3-16.

Killen, J.D., Taylor, C.B., Hammer, L.D., Litt, I., Wilson, D.M., Rich, T., Hayward, C., Simmonds, B., Kraemer, H., & Varady, A. (1993). An attempt to modify unhealthful eating attitudes and weight regulation practices of young adolescent girls. *International Journal of Eating Disorders, 13*, 369-384.

Krueger, R.A. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage.

Latzer, Y., & Shatz, S. (1999). Comprehensive community prevention of disturbed attitudes to weight control: A three-level intervention program. *Eating Disorders, 7*, 3-31.

Levine, M.P., & Piran, N. (2001). The prevention of eating disorders: Toward a participatory ecology of knowledge, action, and advocacy. In R.H. Striegel-Moore & L. Smolak (Eds.),

Eating disorders: Innovative directions in research and practice (pp. 233-253). Washington, DC: American Psychological Association.

Mann, T., & Burgard, D. (1998). Eating disorder prevention programs: What we don't know can hurt us. *Eating Disorders, 6*, 101-103.

McVey, G., Tweed, S., & Blackmore, E. (2004). Dieting among preadolescent and young adolescent females. *Canadian Medical Association Journal, 170*(10), 1559-1561.

McVey, G., Tweed, S., & Blackmore, E. (2005). Correlates of weight loss and muscle-gaining behavior in 10-to-14 year old males and females. *Preventive Medicine, 40*, 1-9.

Moreno, A.B., & Thelen, M.H. (1993). A preliminary prevention program for eating disorders in a junior high school population. *Journal of Youth and Adolescence, 22*(2), 109-124.

Morgan, D.L. (1997). *Focus groups as qualitative research* (2nd ed.). Vol. 16. Qualitative Research Methods Series. Newbury Park, CA: Sage.

Nabors, L.A., Ramos, V., & Weist, M.D. (2001). Use of focus groups as a tool for evaluating programs for children and families. *Journal of Educational and Psychological Consultation, 12*, 243-256.

O'Dea, J., & Abraham S. (2000). Improving the body image, eating attitudes and behaviors of young male and female adolescents: A new educational approach that focuses on self-esteem. *International Journal of Eating Disorders, 28*(1), 43-57.

Patton, M.Q. (1997). *Utilization-focused evaluation: The new century text* (3rd ed.). Thousand Oaks, CA: Sage.

Piran, N. (1997). Prevention of eating disorders: Directions for future research. *Psychopharmacology Bulletin, 33*, 419-423.

Piran, N. (1998). The last word: Prevention of eating disorders: The struggle to chart new territories. *Eating Disorders, 6*, 365-371.

Piran, N. (1999). Eating disorders: A trial of prevention in a high risk school setting. *Journal of Primary Prevention, 20*(1), 75-90.

Rosen, D.S., & Neumark-Sztainer, D. (1998). Review of options for primary prevention of eating disturbances among adolescents. *Journal of Adolescent Health, 23*, 354-363.

Ruben, B.D. (1999). Simulations, games and experience-based learning: The quest for a new paradigm for teaching and learning. *Simulation and Gaming, 30*, 498-505.

Russell, S., & Ryder. S. (2001a). BRIDGE: Building the relationship between body image and disordered eating graph and explanation: A tool for parents and professionals. *Eating Disorders: The Journal of Treatment and Prevention, 9*(1), 1-14

Russell, S., & Ryder, S. (2001b). BRIDGE 2: Building the relationship between body image and disordered eating graph and explanation: Interventions and transitions. *Eating Disorders: The Journal of Treatment and Prevention, 9*(1), 15-27.

Scales, P.C., & Leffert, N. (1999). *Developmental assets: A synthesis of the scientific research on adolescent development*. Minneapolis, MN: Search Institute.

Smolak, L. (1999). Elementary school curricula for the primary prevention of eating problems. In N. Piran, M.P. Levine, & C. Steiner-Adair (Eds.), *Preventing eating disorders: A handbook of interventions and special challenges* (pp. 85-104). Philadelphia, PA: Brunner/Mazel.

Smolak, L., & Levine, M.P. (1994). Toward an empirical basis for primary prevention of eating problems with elementary school children. *Eating Disorders, 2*, 293-307.

Smolak, L., Levine, M.P., & Schermer, F. (1998a). A controlled evaluation of an elementary school primary prevention program for eating problems. *Journal of Psychosomatic Research, 44*(3/4), 339-353.

Smolak, L., Levine, M.P., & Schermer, F. (1998b). Lessons from lessons: An evaluation of an elementary school prevention program. In W. Vandereycken & G. Noordenbos (Eds.), *The prevention of eating disorders* (pp. 137-172). New York: New York University Press.

Stice, E., Mazotti, L., Weibel, D., & Agras, W.S. (2000). Dissonance prevention program decreases thin-ideal internalization, body dissatisfaction, dieting, negative affect and bulimic symptoms: A preliminary experiment. *International Journal of Eating Disorders, 27*, 206-217.

Synovitz, L.B. (1999). Using puppetry in a coordinated school health program. *Journal of School Health, 69*(4), 145-147.