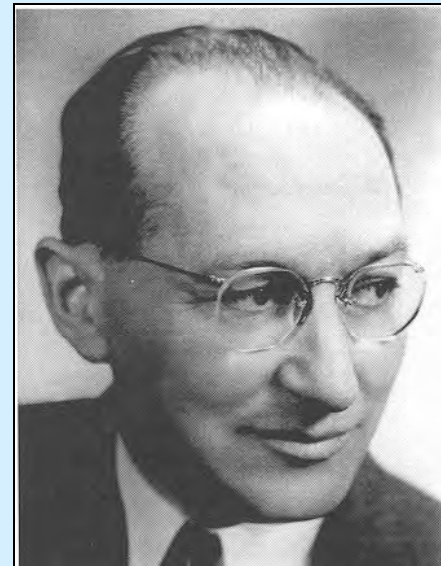


**“If you want to
truly understand something,
try to change it”**

- Kurt Lewin (1890-1947)

(no date/source, as quoted in)
APA Policy and Planning Board.
(2007). Who cares about APA
Policy and does it have an impact?
American Psychologist, 62, 491-503.



A Biopsychiatric Paradigm: Academy for Eating Disorders (AED) Position Paper

(Klump, Bulik, Kaye, Treasure, & Tyson, *IJED*, 2009)

“[state] unequivocally . . . that anorexia nervosa and bulimia nervosa, along with their variants, are **biologically based, serious mental illnesses (BBMI) that warrant the same level and breadth of health care coverage as conditions currently categorized in this way (e.g., schizophrenia, bipolar disorder, depression, obsessive-compulsive disorder)” (p. 97; **emphasis added**)**

An Evidence-Based **Sociocultural Approach to Eating Disorders Prevention in the Age of Neurobiology:**

10 Principles for a Bolder Model

Michael P. Levine, Ph.D., FAED

Emeritus, Department of Psychology, Kenyon College

- KEYNOTE -

CREDN Conference (2/17/2017)

**For Copies of Levine's Work on Prevention
and/or Mass Media
and/or To Join Levine Prevention List:**

Levine@kenyon.edu

DR. MICHAEL LEVINE, PH.D., FAED

1. Emeritus* Professor of Psychology, Kenyon College [BMI = 28.83 = overweight]
2. Ph.D. in Experimental Psychology [Daughter and wife shop at Victoria's Secret; sons play video games]
3. Age 68 [Really likes Pat Benatar]
4. No body image or eating issues at all

NOTE: Rare photo--Michael Levine at 1979 Faculty Orientation Picnic =>

* Latin Word Meaning "Medicare Eligible"





Principle 1:

Prevention Is a Primary Obligation, Not a Luxury

- “Detect It – Treat It” vs. History of medicine
- Prevalence, severity vs. person-power shortage
- Evidence: Sociocultural basis
- Multifaceted health promotion

Principle 2:

Know Your Concepts & Terms – Prevention is Primary

Focus	IOM* Terminology	Caplan (1964)	Examples
Large groups - healthy people	<i>Universal</i> prevention (public health prevention)	Primary	Laws regulating advertising of diets or supplements
Smaller groups - NS but HR**	<i>Selective</i> prevention	Primary	Programs (e.g., Piran's) for children entering elite ballet schools
Small groups - Very HR - clear precursors	<i>Indicated</i> or <i>Targeted</i> prevention	Secondary	DB*** programs for women with severe weight concerns

*IOM = Institute of Medicine, USA National Academy of Sciences

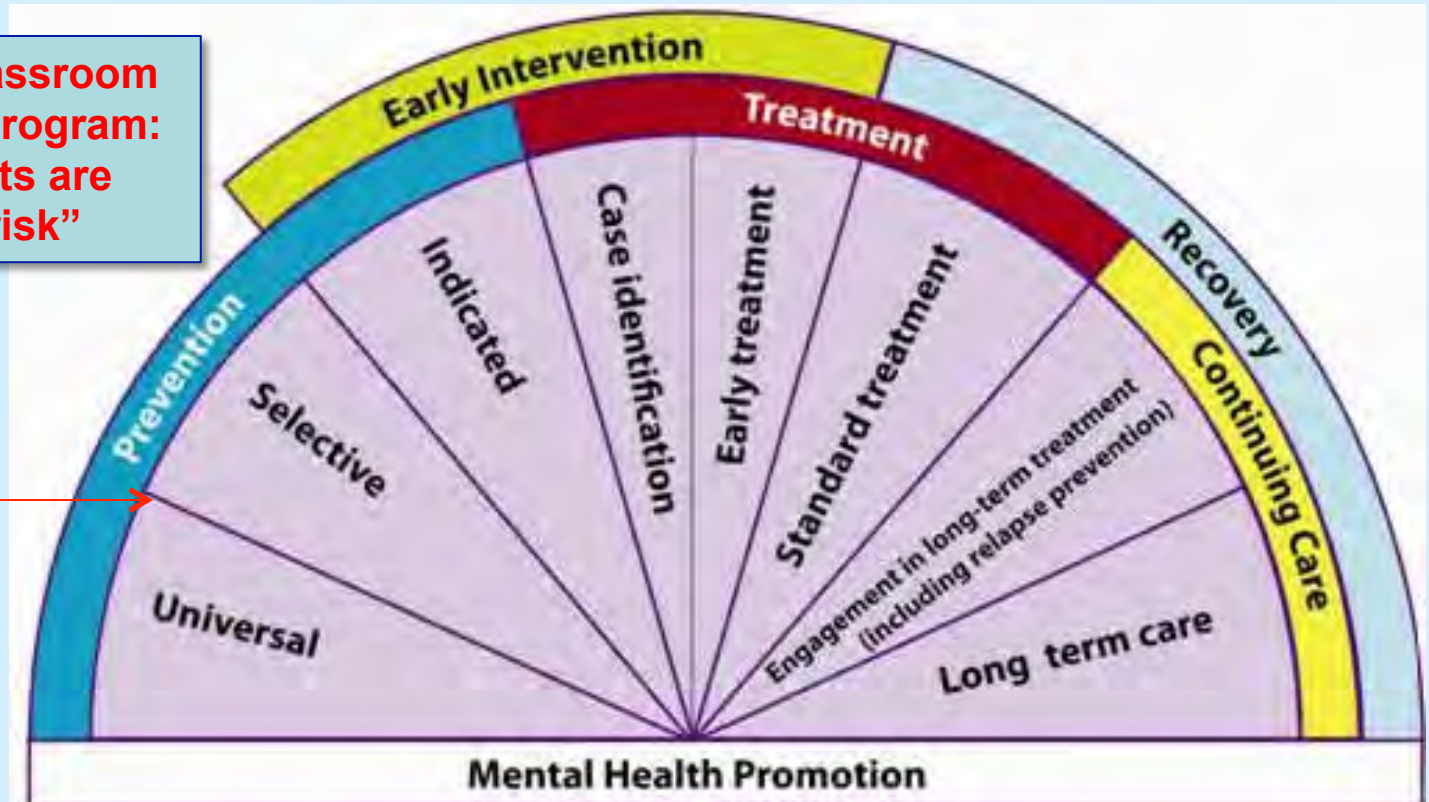
** NS = Non-Symptomatic; HR = High Risk

***DB = Dissonance-Based

Mental Health Intervention Spectrum

[Adapted from National Research Council and Institute of Medicine (2009, p. 67)]

Standard classroom
prevention program:
participants are
“mixed-risk”



Retrieved 4-18-15 from www.notredamecentre.org.uk

Cognition and Truth



Easily Extracted if Not Quite Clear Messages:
“Proof That Elephants Don’t Have a Union”



Abercrombie & Fitch

Principle 3: The issue for prevention is **us and our cultures, not “them” and “their eating disorders” or “their obesity.”**

We must think contextually and in terms of how each member of the community can contribute



Principle 3: The issue for prevention is us and our cultures →

**Prevention requires thinking about the
meanings of “Nervosa,”
not just “Anorexia” and “Bulimia”**



Source of image:

**[http://
connectomics.chalearn
.org/help/tutorial](http://connectomics.chalearn.org/help/tutorial)**

OK – I Don't Really Know Exactly “**Nervosa**” Means?

- Underlying **psychological** characteristics
Underlying **psycho** – **path** – ology
- **Shared Features – Psychological**
 - Undue influence of weight and shape, and control of same, on self-concept and identity
 - Irrational attitudes (beliefs, feelings, behaviors, resistance) in regard to “fat” and “fat people”
 - Glorification of and internalization of impossible ideals
 - Low and unstable self-esteem (sometimes accompanied by “musts” and “shoulds”)

Preventing What? And What Does “Nervosa” Mean, Anyway?

- Prevention will fail—and may be harmful—if it concentrates solely on the definition of clinical syndromes, the portrayal of fascinating “cases,” and the dangers of disordered eating.

The issue is the cost to individuals and society of set of issues, each of which (1) relates to negative body image and disordered eating; and (2) could be seen **spectrum or continuum**

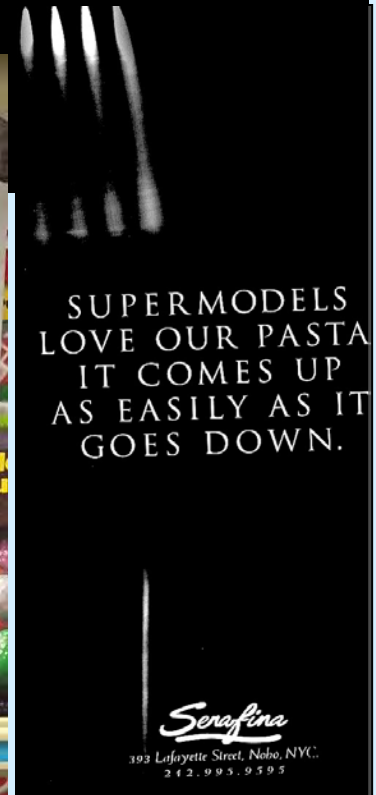
negative body image
self-objectification
fear of fat
shaky self-esteem +
compensatory
extremes (perfectionism)

internalization of impossible ideals
drive for thinness/leanness
unhealthy weight management
chaotic (including binge-) eating
extremes of activity/exercise

Principle 4: A Sociocultural Perspective, **Focusing on Specific and General Pathways,** **is Necessary and Evidence-Based**

Sociocultural variables refer to specific messages that reflect a culture's ideology and are conveyed by socialization agents.

-- (Levine & Smolak, 2014)



Principle 5: A Sociocultural Perspective, Focusing on General and Specific Pathways, is Necessary and Evidence-Based

Macro-Level Factors Within (e.g., Ethnicity) & Across Cultures

Sociocultural Factors or Pressures

Parents

Peers

Mass & Social Media

Other (School, Athletics)

- Negative body image
- Controlling wt/shape - priority in identity
- Weight concerns
- Thinness and/or muscularity/leanness schema

- Negative affect
- “Negative self-concept”

- Ego deficits
- Emotional instability
- History of overweight
- Impulsive/S-Seeking

- **Trauma**
- Insecure attachment(s)
- **Genetic vulnerabilities**
- Other vulnerabilities

Continuum of Clinically Significant Disordered Eating

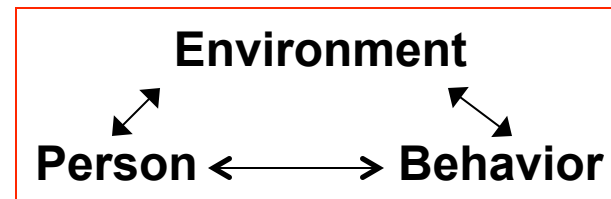
based on (e.g.):

Unhealthy weight management, **chaotic eating**, self-objectification, **ambivalence about power & control**

What A Sociocultural Perspective Is (Smolak, Levine, & Murnen, 2006)

- Focuses on **socially constructed + culturally endorsed variables**

- **A transactional approach**



- **Culture will determine what is ideal for whom *and* how to attain it (and/or reject it)**
- Culture will determine what is **normative** (*even if unhealthy*) and **pathological** (templates of deviance)
- **Within- and across-group differences** based on exposure to various sociocultural factors

A Sociocultural Perspective Does Not

- **Deny any role for genetics or neurobiology** as important – but not the *only* important – sources of individual differences in vulnerability
- **Minimize the seriousness of full-blown or partial syndrome eating disorders**, nor fail to make any distinctions between different types or levels of disordered eating
- **Expect that one model of risk will fit all** cultures or both genders or all ages

Sociocultural Models Do NOT

- **Oversimplify causal propositions**
- **Ignore heterogeneity and equifinality**
- **Focus on the “intuitively obvious” or variables with “face validity”** (cf. “the tyranny of face validity”)
- **Ignore the insularity or resistance to change (as disorders are ego- AND culturally syntonic)**

Sociocultural Models Do NOT

- **ignore distinctions between different types or levels of eating disorders**
- **In any way imply these disorders are caused by foolish choices about diet, fashion, or other frivolous matters**
- **(Repeat, subtly) Minimize the seriousness or self-defeating/self-perpetuating nature of full-blown eating disorders**

What About the Rarity of EDs?

Risk Factors & Probability (Hanson, 2004)

If there were **4 (relatively) independent risk factors for bulimia nervosa**, then to achieve a population frequency of .02 (the point prevalence), **each would have to occur at a frequency of .38 in the population**, because .38 to the 4th power ($.38^4$) = .0208.

“The factors that lead to schizophrenia, as Dr. Gottesman taught us, are multiple. **These factors must be quite common in the population and thus are not necessarily abnormal.** [We need to] get out of our mindset of searching for abnormal schizophrenia genes and **broaden our view to look at normal individual genetic variation in conjunction with exposure to common environmental agents**” (p. 214)

Sociocultural Perspective:
High Risk Families Are Important – BUT:
A Simplified Look at the Rose Paradox (Austin,
2001; Rose, 1995)

Number	Risk	% - Disorder	N
5,000	High	27.0	1350
95,000	Lower	3.0	2850
100,000 total	Low-mod?	4-5	4200

2850/4200 = 67.8% of cases
come from Low to Moderate Risk

Let Us Together Be Very Careful and Very Sensible

Consider the following imaginary example (From Lerner, 2002, p. 253):

A long-standing law dictates that only men can hold positions of leadership in a society. 10,000 people are chosen at random from the society. People could be classified into two groups: Those with absolutely no chance at being elected to a position of leadership and those with some meaningful chance. **All the difference in eligibility between the two groups can be summarized, i.e., accounted for, by genetic difference. The heritability of eligibility for elected office is thus 100%.**

Is the difference in eligibility “genetic in nature”?

AND

Will genes for eligibility eventually be found?

- High heritability does not mean that characteristics are fixed, unchangeable, or unresponsive to environmental change
- “Behavior genetics is concerned with the ‘what is’ rather than the ‘what could be’ or the ‘what should be’” – Richard Rende