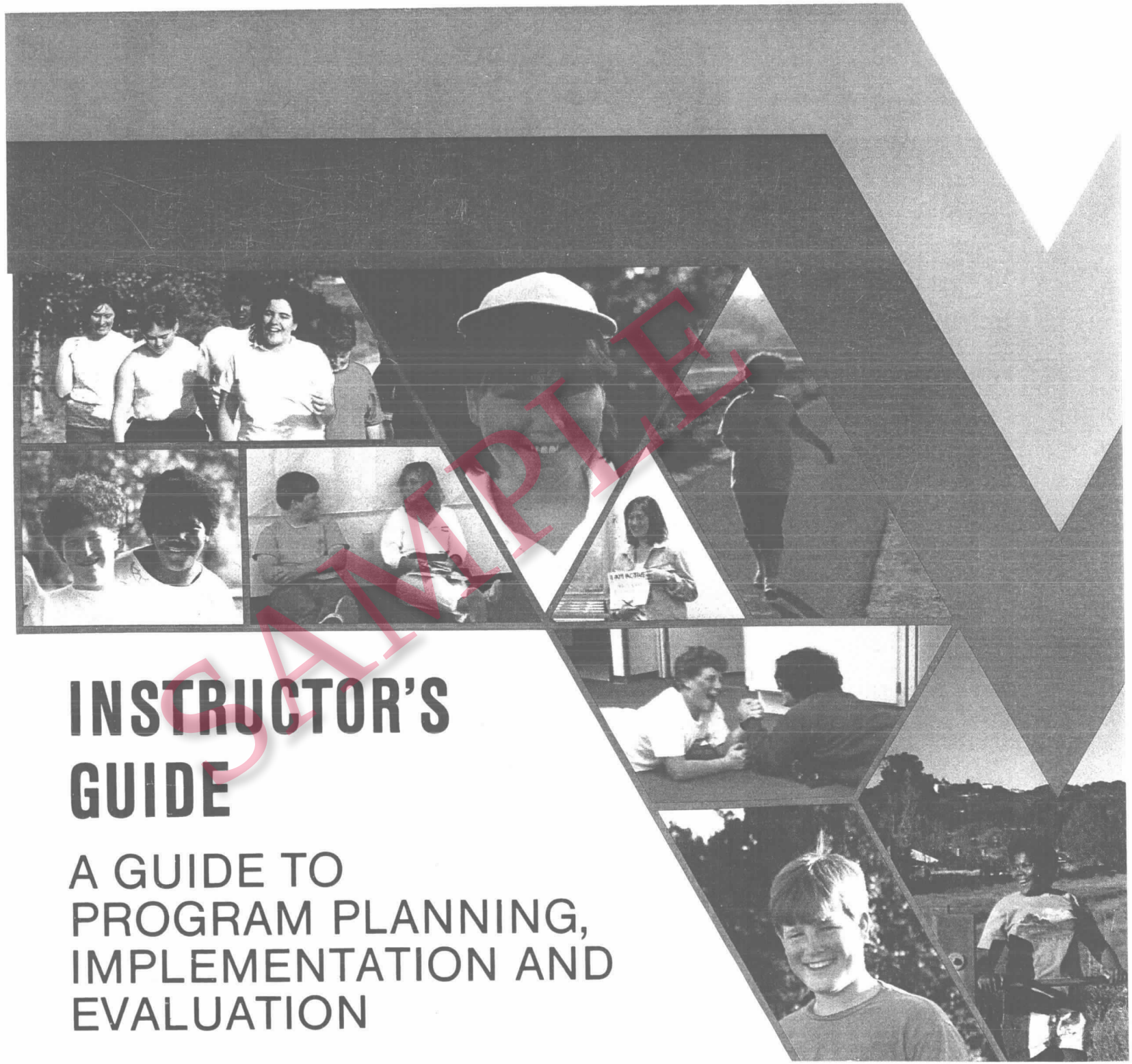

INSTRUCTOR'S GUIDE

A GUIDE TO PROGRAM PLANNING, IMPLEMENTATION AND EVALUATION

CONTENTS

I. ABOUT SHAPEDOWN

A. DEVELOPMENT AND PHILOSOPHY

1. Development

1977 to 1978 - The development of SHAPEDOWN begin in 1977 with a review of the obesity literature and resulting monograph identifying the methodologies shown through controlled clinical trials to be associated with weight loss. From the conclusion of this review a pilot program was developed that brought together an eclectic diet, exercise, behavior modification content with the underpinnings of an adolescent developmental perspective. This orientation toward adolescent health was the contribution of the Division of Adolescent Medicine, University of California, San Francisco, and the initial development of SHAPEDOWN was conducted with the support of the Division's interdisciplinary faculty with direct support from the Division of Maternal and Child Health, United States Department of Health and Human Services.

1978 to 1980 - The developmental testing of SHAPEDOWN continued between 1978 and 1980, during which time two editions of SHAPEDOWN were developed and tested. Throughout this developmental period we gave careful attention to the analysis of each adolescent's and family's experience during and after the intervention. We closely monitored all adolescents who dropped out or who relapsed and made modifications in program content and process accordingly. The most striking characteristic of this phase of the program's development was how often we were wrong. Many of the techniques and strategies we brought to the program, were clearly ineffective with obese teens. We continued to test new ideas, garnering a core of strategies that worked repeatedly.

1980 to 1983 - As modifications became less substantial, drop-out rate declined and predictable outcomes were achieved by participants, we published the adolescent workbook for limited use in various health centers across the country. Our research continued on the Habit Inventory, the program's psychobehavioral assessment instrument. We developed norms, reliabilities and validity data to support its utility. The experiences of each of the developmental testing sites were integrated to suggest programmatic changes and modifications in program delivery practices.

During this period a long-term, controlled clinical trial was conducted to validate the program's effectiveness. The results supported the short- and long-term effectiveness of SHAPEDOWN. In addition, it concluded that the program was beneficial to all segments studied, as for each variable examined the mean weight change was negative. It also suggested that a more comprehensive parent component may significantly improve weight change results. From these conclusions and in-depth interviews with validation site instructors, the third edition of SHAPEDOWN was developed. The program included cognitive restructuring, a leader's guide and a more adaptable format. The new format, composed of lessons rather than "weeks," supported instructors in adapting the program based on their own professional preferences and the needs of their clients. Our analysis of program instructor's needs led us to believe that most instructors preferred to develop their own programs. SHAPEDOWN could offer them the advantage of years of program development, name-recognition for promotional purposes

and scientific program validation, yet be flexible enough to make room for each instructor's preferences and orientations.

1983 to 1986 - SHAPEDOWN became widely disseminated during this period to a wide range of facilities, from health departments to major medical centers to private practices. During this period we recognized that not all programs were successful. Some were not receiving adequate support in giving the highest quality of care to obese adolescents and their families. From this realization we established two substantial program changes:

1. Criteria for acquiring SHAPEDOWN -

We developed criteria for acquiring SHAPEDOWN that supported providers' success and quality control. Because pediatric obesity is a biopsychosocial problem, almost any discipline can teach a pediatric obesity intervention. However no one discipline can best address all aspects of the problem in the most sophisticated manner. We established criteria for interdisciplinary involvement, including a physician, registered dietitian, and mental health professional in the roles of instructors or consultants. Later this would be expanded to include an exercise professional.

We also established staff development criteria. In 1983 we formed the Center for Adolescent Obesity (now the Center for Child and Adolescent Obesity), formerly known as the National Network of Adolescent Obesity Specialists, in response to the need for comprehensive training in adolescent obesity and to requests for literature updates. Between 1983 and 1986 more than 20 Intensive Courses in Pediatric Obesity were co-sponsored by the Center at various locations throughout the country. Co-sponsors included the American Dietetic Association, state health departments and medical schools. The courses were audio- and videotaped and became available through the Center. In 1985 the Center became affiliated with the Division of Family and Community Medicine, University of California, San Francisco and retained an affiliation with the University's Division of Adolescent Medicine through the presence of several of the Division's faculty members on the Center's Board of Advisors. The Advisory Board was further developed with the addition of nationally recognized authorities in adolescent obesity from a variety of disciplinary perspectives. The John Tung/American Cancer Society Clinical Nutrition Education Center provided interim support. Staff development criteria for acquiring SHAPEDOWN were identified as maintenance of a membership in the Center for Child and Adolescent Obesity and completion of the Intensive Course in Adolescent Obesity, either through attendance of a course or through viewing the videotaped course and submitting a case assessment to the Center.

2. Biopsychosocial assessment instrument -

A second major change during this period was the recognition that instructors needed a comprehensive biopsychosocial assessment instrument that would improve the sophistication of their care yet decrease assessment time and costs. Our Intensive Courses in Pediatric Obesity taught comprehensive assessment techniques. Yet providers reported that limited time and staffing were barriers to providing these assessments. In addition, these assessments lacked the consumer orientation and appealing presentation of the commercial weight establishment computer assessments. We began testing a biopsychosocial assessment instrument in