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An effectiveness trial of a new enhanced dissonance eating disorder prevention program among female college students

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ABSTRACT

Objective: Efficacy trials indicate that a dissonance-based prevention program in which female high school and college students with body image concerns critique the thin-ideal reduced risk factors, eating disorder symptoms, and future eating disorder onset, but weaker effects emerged from an effectiveness trial wherein high school clinicians recruited students and delivered the program under real-world conditions. The present effectiveness trial tested whether a new enhanced dissonance version of this program produced larger effects when college clinicians recruited students and delivered the intervention using improved procedures to select, train, and supervise clinicians.
Method: Young women recruited from seven universities across the US (N = 408, M age = 21.6, SD = 5.64) were randomized to the dissonance intervention or an educational brochure control condition.
Results: Dissonance participants showed significantly greater decreases in risk factors (thin-ideal internalization, body dissatisfaction, dieting, negative affect) and eating disorder symptoms versus controls at posttest and 1-year follow-up, resulting in medium average effect size (d = .60). Dissonance participants also reported significant improvements in psychosocial functioning, but not reduced health care utilization or unhealthy weight gain.
Conclusions: This novel multisite effectiveness trial with college clinicians found that the enhanced dissonance version of this program and the improved facilitator selection/training procedures produced average effects that were 83% larger than effects observed in the high school effectiveness trial.
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Approximately 10–13% of young women meet DSM-IV (Hudson, Hiripi, Pope, & Kessler, 2007; Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006) or DSM-5 criteria for eating disorders (Stice, Marti, & Rohde, 2013). Eating disorders are marked by chronicity, relapse, distress, functional impairment, and risk for future obesity, depression, suicide attempts, anxiety disorders, substance abuse, and mortality (Arcelus, Mitchell, Wales, & Nielsen, 2011; Crow et al., 2009; Stice et al., 2013; Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011; Wilson, Becker, & Heffernan, 2003). Thus, it is vital to develop and disseminate effective eating disorder prevention programs.

Several prevention programs have produced significant reductions in eating disorder symptoms that persist through at least 6-month follow-up in single trials (Jones et al., 2008; McVey, Tweed, & Blackmore, 2007; Neumark-Sztainer, Butler, & Palti, 1995; Stewart, Carter, Drinkwater, Hainsworth, & Fairburn, 2001). Yet more support has emerged from several independent labs for a selective dissonance-based eating disorder prevention program (the *Body Project*), in which young women with body image concerns voluntarily critique the thin ideal in verbal, written, and behavioral exercises in session and in home exercises (Stice, Mazotti, Weibel, & Agras, 2000). Criticizing the thin ideal publically in this group-based program theoretically reduces thin-ideal internalization because humans seek to maintain consistency between their behaviors and attitudes. This reduced subscription to the thin ideal putatively decreases body dissatisfaction, unhealthy weight control behaviors, negative affect, eating disorder symptoms, and future eating disorder onset. This intervention targets young women with body dissatisfaction because it is an established risk factor for future eating pathology (e.g., Johnson & Wardle, 2005; Killen et al., 1996).

Efficacy trials have shown that the *Body Project* produces greater reductions in eating disorder risk factors (thin-ideal internalization, body dissatisfaction, dieting, and negative affect), eating disorder

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symptoms, functional impairment, mental health service utilization, and eating disorder onset over a 3-year follow-up relative to assessment-only control conditions and three alternative interventions (e.g., Stice, Marti, Spoor, Presnell, & Shaw, 2008; Stice et al., 2000; Stice, Rohde, Durant, & Shaw, 2012; Stice, Shaw, Burton, & Wade, 2006). Efficacy trials conducted by independent teams have also found that dissonance-based eating disorder prevention programs produce greater reductions in risk factors and eating disorder symptoms than assessment-only control conditions (Halliwell & Diedrichs, 2013; Matusek, Wendt, & Wiseman, 2004; Mitchell, Mazzeo, Rausch, & Cooke, 2007) and alternative interventions (Becker, Smith, & Ciao, 2005). It appears to be the only eating disorder prevention program that has produced intervention effects that have independently replicated and has significantly outperformed alternative interventions.

In support of the theory for this program, reductions in thin-ideal internalization appear to mediate the effects of the *Body Project* on change in the other outcomes (Seidel, Presnell, & Rosenfield, 2009; Stice, Presnell, Gau, & Shaw, 2007). In line with the thesis that dissonance induction contributes to intervention effects, participants assigned to high-versus low-dissonance versions of this program showed significantly greater reductions in eating disorder symptoms (Green, Scott, Diyankova, Gasser, & Pederson, 2005; McMillan, Stice, & Rohde, 2011), though intervention content and non-specific factors clearly contribute to intervention effects.

Given the empirical support for the *Body Project* from efficacy trials, the next step is to conduct effectiveness trials of this prevention program. Efficacy trials test whether preventive interventions produce effects under carefully controlled experimental conditions, in which the research clinicians are thoroughly trained and supervised, the intervention is delivered in adequately staffed settings, and the participants are homogenous. In contrast, effectiveness trials test whether interventions produce effects when delivered by endogenous clinicians (e.g., school counselors) who receive less supervision under real world conditions in natural service provision settings with heterogeneous populations (Flay, 1986). Scholars have stressed the importance of confirming whether interventions that are efficacious in tightly controlled trials affect outcomes in effectiveness trials involving endogenous clinicians working in real-world settings (Clarke, 1995; Hoagwood & Olin, 2002; Weisz, Donenberg, Han, & Kauneckis, 1995). Effectiveness trials can also provide information concerning the degree of training and supervision necessary to achieve intervention effects and reveal problems that must be resolved before the prevention program can be successfully disseminated.

To date, only one[1] effectiveness trial has evaluated the *Body Project* when endogenous clinicians recruit participants and deliver the intervention in traditional service settings (Stice, Rohde, Gau, & Shaw, 2009; Stice, Rohde, Shaw, & Gau, 2011). It focused on clinicians in high schools because mid-adolescence is a period in which eating disordered symptoms emerge (Lewinsohn, Striegel-Moore, & Seeley, 2000; Stice et al., 2013) and school-based prevention programs are an effective way to reach adolescents (Newton, Conrod, Teesson, & Faggiano, 2012). The *Body Project* produced significant reductions in eating disorder risk factors and symptoms relative to an educational brochure control condition when high school clinicians recruited female students with body image concerns and delivered the intervention under ecologically valid conditions in schools, including significant reductions in eating disorder symptoms that persisted through 3-year follow-up (Stice et al., 2009, 2011). However, the average effect size was 32% smaller than observed in our large efficacy trial (Stice et al., 2006, 2008) and unlike the efficacy trial, the *Body Project* did not significantly reduce health care utilization and eating disorder onset over 3-year follow-up relative to controls.

Although the high school effectiveness trial represents an important step in this research program, there are several reasons why it is crucial to conduct effectiveness trials of eating disorder prevention programs in colleges. First, eating disorders typically emerge during this time (Hudson et al., 2007; Stice et al., 2013). Second, colleges represent a large population that can be reached with eating disorder prevention programs because there are over 10 million female college students (U.S. Department of Education, 2008). Third, our first effectiveness trial revealed that high schools have a limited infrastructure to support delivery of mental health prevention programs, which may have constrained the intervention effects in that setting. In contrast, college health and counseling clinics typically have an established and well-functioning infrastructure that is much more conducive to delivering prevention programs (Foster et al., 2005; Gallagher & Taylor, 2011). Whereas high schools generally lack staff with adequate training in delivery of group-based prevention programs and time to deliver these programs, colleges typically have student health or counseling centers with clinicians who have experience delivering group interventions and an explicit mandate to offer services that addresses student health and mental health problems. Fourth, it is vital to conduct effectiveness trials with both high schools and colleges, because the original efficacy trials involved both types of schools and the nature of the providers, institutions, and students are quite different in these two settings.

Our experience with the high school effectiveness trial suggested several opportunities for improving effect sizes when endogenous clinicians deliver this prevention program under real world conditions. First, we used an enhanced training wherein facilitators performed more extended role-plays of the intervention and received feedback on how to improve their delivery, in contrast to the more didactic training used in the high school effectiveness trial. Second, we improved the supervision in two ways; we reviewed videotapes of the first group conducted by facilitators and rated sessions for intervention fidelity and therapeutic competence, which was used to provide more detailed supervision. In the high school effectiveness trial, supervision was based on reviews of audiotaped sessions (which provide no visual information or the session or participants) and not on fidelity and competence ratings. Third, we used a new enhanced dissonance version of the *Body Project* designed to increase the voluntary nature of participation, the level of required effort, and accountability for taking an anti-thin-ideal perspective, as these factors increase dissonance induction (Green et al., 2005).

Accordingly, we initiated the first effectiveness trial to evaluate the *Body Project* when college clinicians recruit young women at risk for eating pathology and deliver the intervention under ecologically valid conditions at universities. To maximize effects, we worked with clinicians from universities who had more clinical experience, improved the selection, training, and supervision of the

[1] Becker and associates have conducted several trials that have compared the effects of a version of the *Body Project* that was adwapted for sorority members to the effects of another eating disorder prevention program when both group-based interventions were delivered by peer leaders (Becker, Bull, Schaumberg, Cauble, & Franco, 2008; Becker, Smith, & Ciao, 2006; Becker et al., 2010). These trials have features of effectiveness research, such as the fact that the interventions were delivered by non-research staff, and have established that peer-leaders can be used to broadly disseminate this prevention program. However, these trials differ from typical effectiveness trials in that they (a) did not evaluate the effects of interventions when delivered by endogenous clinicians under real world service provision settings, (b) recruited from a narrow/targeted segment of population (they focused solely on sorority members rather than college students more broadly), and (c) did not involve any type of usual care control condition that is typically used in colleges (e.g., an educational brochure control condition).

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