THERAPY VIDEOTAPE PRESENTATION FOR EATING DISORDER CLIENTS:

DEVELOPMENT AND EVALUATION

by

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Eating disorder clients show low motivation, poor follow-through, and inordinate premature dropout rates in treatment. Earlier studies support the use of pretherapy training to help clients understand the tasks and challenges of therapy. However, a pretherapy intervention, such as showing prospective clients a video that outlines recovery issues and themes, had not yet been developed specifically for the prevalent, recalcitrant problem of eating disorders. Thus, of particular interest to clinicians who treat eating disorders may be the development of a theoretically sound, pretherapy videotape that outlines recovery issues.

One of the purposes of this study was to review prior investigations of the effects of pretherapy films/videos on therapy outcomes. However, the central focus of this dissertation was to develop a pretherapy video for use with eating disorder clients, and using quantitative methods, assess the quality and likely therapeutic utility of the
pretherapy video. The video was developed to be theoretically consistent with Bandura's modeling paradigm, social learning theory.

Eating disorder clients, a comparison group of college women, and professional clinicians who are experienced at treating women with eating disorders were asked to view and evaluate the video (developed to orient prospective clients to recovery issues during treatment for eating disorders). All three groups reportedly found the recovering women portrayed in the video credible, believable, and persuasive. All groups of observers indicated that the video presented an understandable and hopeful message possessing emotional impact, and they avowed that the video created expectations for improvement.

Also, the viewers believed the pretherapy video would likely increase knowledge of eating disorder recovery, and that future eating disorder clients viewing the video would likely learn new information that would facilitate their recovery. Additionally, the three groups indicated the video seemed to be of general relevance and therapeutic utility to women with eating disorders.
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CONTENTS

ABSTRACT ........................................ iii
ACKNOWLEDGMENTS ................................ iv
LIST OF TABLES ................................ xi
LIST OF FIGURES ................................. xii
CHAPTER
I. INTRODUCTION ................................. 1
II. REVIEW OF PUBLISHED LITERATURE ............ 8
   Definition of Pretherapy Training .................. 8
   Definition of Therapeutic Outcome Variables ....... 8
   Definition of Therapeutic Process Variables ...... 9
   Results ........................................ 14
   Discussion .................................... 21
III. METHODS OF THE PROPOSED STUDY ............ 26
   Subjects ....................................... 26
   Instrumentation ................................ 29
   Development of Pretherapy Video ................. 36
   Procedures .................................... 40
   Data Analysis .................................. 41
IV. RESULTS .................................... 45
   Demographic Data ............................... 45
   POMS Data .................................... 45
   VAQ Data ..................................... 48
   VAQ II Expert Data ............................. 50
   VAQE Section III Expert Qualitative Data ....... 52
   Strengths of the Video .......................... 52
   Weaknesses of the Video ......................... 54
   Summary of Results: Answers to Research Questions ... 55
V. DISCUSSION ................................................................. 58

Mood Change/Affective Involvement with the Video .................. 58
Expert Endorsement of the Video ........................................ 60
Consistency with Bandura's Social Learning Theory ................. 63
Limitations and Recommendations for Future Research .............. 64

REFERENCES ................................................................. 66

APPENDIXES ........................................................................ 72
Appendix A: Definition of Recovery Criteria for Participation in Anorexia and Bulimia Nervosa Recovery Interviews (Quakenbush & Stein, 1996) .............................................................. 73
Appendix B: College Student Recruitment Speech ....................... 75
Appendix C: Eating Disorder Clients' Recruitment Speech .......... 77
Appendix D: Advertisement Requesting Participants for Eating Disorder Treatment Video ........................................ 79
Appendix E: Anorexia and Bulimia Nervosa Treatment Research .............................................................. 81
Appendix F: Clinician's DSM-IV Interview Rating Form .............. 83
Appendix G: Professional Recruitment Letter ........................... 85
Appendix H: Permission Statement for Dissertation Research Study .............................................................. 87
Appendix I: Permission Statement for Thesis Research Study ....... 89
Appendix J: Utah State University Psychology Department Release Form .............................................................. 91
Appendix K: IRB Human Subjects Research Approval: Masters Research Study .............................................................. 93
Appendix L: IRB Human Subjects Research Approval: Dissertation Research Study .............................................................. 96
Appendix M: Demographic Fact Sheet for College Student Subjects .............................................................. 98
Appendix N: Demographic Fact Sheet for Eating Disorder Subjects .............................................................. 101
Appendix O: Video Appraisal Questionnaire (VAQ) ................... 104
Appendix P: VAQ Subscale Key ............................................. 108
Appendix Q: Eating Disorder Recovery Themes ......................... 111
Appendix R: EDL—Video Outline ........................................... 113
Appendix T: Final Video EDL Worksheets ................................ 120
Appendix U: Instructions for Video Study ................................ 127
Appendix V: VAQ III Clinicians Comments ............................. 129

VITA ................................................................................. 142
**LIST OF TABLES**

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Effect Size for Quality of Study (Across All Studies)</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>Study Characteristics and Effect Sizes</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>Mean Effect Size for Dependent Variables Across Studies</td>
<td>17</td>
</tr>
<tr>
<td>4</td>
<td>Demographic Data ($n = 116$): CS and ED Subjects</td>
<td>46</td>
</tr>
<tr>
<td>5</td>
<td>POMS Pretest Values for CS and ED Subjects</td>
<td>47</td>
</tr>
<tr>
<td>6</td>
<td>Pre- to Post-POMS Values for CS and ED Subjects</td>
<td>49</td>
</tr>
<tr>
<td>7</td>
<td>VAQ Values for CS, ED, and Expert Subjects</td>
<td>49</td>
</tr>
<tr>
<td>8</td>
<td>VAQE Section II Expert Data</td>
<td>51</td>
</tr>
<tr>
<td>Figure</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1</td>
<td>Procedures across groups</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>Eating disorder recovery themes</td>
<td>112</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Researchers report that most women with eating disorders are reluctant to receive treatment. In general, they tend to show low motivation, poor follow-through, and high drop-out rates (Barth & Wurman, 1986; Hall, 1985; Lee & Rush, 1986; Merrill, Mines, & Starkey, 1987; Riebel, 1990). Several attempts have been made to manage low motivation and the problem of premature termination in various client populations. Garfield (1986) stated that one strategy is to more carefully screen clients before they are assigned to a therapist or type of psychotherapy. With this strategy, the emphasis is placed largely on the client, who is viewed as being suitable or unsuitable for particular forms of psychotherapy. Unfortunately, this approach may not be advantageous to the less educated, less intelligent, and nonpsychologically minded client. A second approach to improving client motivation and attendance is to prepare the therapist to deal with anticipated problems (Garfield, 1986). Additionally, some experts favor the use of pretherapy training to help clients understand the tasks and challenges of therapy (Heitler, 1976; Hoehn-Saric et al., 1964). To date, pretherapy preparation of clients has been used with a variety of clinical problems. However, a pretherapy intervention, such as showing prospective clients a video that outlines recovery issues and themes, has not yet been developed specifically for the prevalent, recalcitrant problem of eating disorders.

Three basic approaches have generally been used to systematically prepare clients for psychotherapy: the role induction interview, vicarious training, and
therapeutic reading. The role induction interview (Hoehn-Saric et al., 1964) involves direct learning and group experience. Vicarious pretherapy training (Truax, 1963) is based on imitation learning and modeling procedures, and most often utilizes videotaped modeling. Finally, therapeutic reading (Wolberg, 1967) uses the principles of indirect learning and rational understanding.

Although no research has been conducted on the use of pretherapy training with eating disorder clients per se, data from four general reviews of the psychotherapy literature support the suggestion that pretherapy training may be a beneficial approach (i.e., Bednar, Weet, Evensen, Lanier, & Melnick, 1974; Kaul & Bednar, 1986; LaTorre, 1977; Piper, Debbane, Garant, & Bienvenu, 1979). These reviews show that clients who participated in pretherapy training responded more appropriately in therapy and achieved more favorable outcomes than did control clients.

Thus, of particular interest to clinicians who treat eating disorders may be the development of a theoretically sound, pretherapy videotape that outlines recovery issues. As a prelude to developing such a pretherapy training video for eating disorder clients, an attempt should be made to identify the most effective video pretherapy methods used to date. Therefore, one of the purposes of this study was to review prior investigations of the effects of pretherapy films/videos on therapy outcomes. However, the central focus of the present dissertation was to develop a pretherapy video for use with eating disorder clients and, using quantitative methods, to assess its likely utility (e.g., positive affective changes in subjects associated with seeing the video).

The videotape developed and evaluated in the present study was based on the
recovery issues and factors identified in a recent study by Quakenbush and Stein (1996). The goal of developing the videotape was to help educate prospective clients about the process of recovery and increase their understanding, hope, and motivation about pursuing treatment. Quakenbush and Stein (1996) videotaped semi-structured interviews of 30 women recovering from eating disorders (see Appendix A for definition of recovery used by Quakenbush and Stein, 1996). Through a structured analysis of the interviews, the researchers identified some of the critical factors that women with eating disorders believed were crucial in prompting and facilitating their recovery. Specifically, the personal, interpersonal, and environmental factors believed by anorexic and bulimic subjects to increase their motivation to recover were documented. Also, factors that subjects believed hindered their recovery progress were identified. In this study, subjects reported that social support was a critical factor across all three stages of recovery (beginning recovery, maintaining recovery, and coping with relapse). Being “tired” of the symptoms and maladaptive behaviors associated with the disorder, and receiving therapy were frequently cited as relevant to beginning recovery. Improved self-esteem was deemed significant in helping subjects both maintain recovery and cope with the threat of relapse. Establishing healthy eating habits and attitudes was often deemed to be a necessary factor required in maintaining recovery. Subjects avowed that developing healthy ways to deal with emotions enabled them to deal successfully with the threat of relapse.

Anorexic subjects reported that (a) perceived excessive expectations from others and society, (b) fear of becoming fat, (c) avoidance of emotions, and (d) poor eating
habits and attitudes impeded their recovery. Bulimic subjects indicated that (a) excessive people and societal expectations, (b) avoidance of emotions, (c) lack of understanding from other people, and (d) poor eating habits and attitudes hindered their recovery.

Summarizing women’s recovery stories in a video is important because prospective clients may be able to better understand the multifaceted nature of their own eating disorder, and the recovery process. Also, observing other women successfully recover may inspire them to persist in the recovery process.

Given the extreme, logistical difficulty of identifying adequate numbers of eating disorder subjects, a direct assessment of a pretherapy video product on eating disorder treatment outcomes was not a goal of this study. However, three research samples provided data relevant to other evaluation objectives: (a) women who were currently in treatment for anorexia and/or bulimia nervosa (ED); (b) female college student samples (psychology, physical education, and nutrition science students who represent a normal, “at risk group” [CS]); and (c) professional clinicians experienced in treating eating disorders (“Experts”). These three groups of subjects provided parallel, but somewhat different sources of information regarding the quality and potential usefulness of the proposed pretherapy video. Further, the “at-risk group” of college women was also deemed to be a useful reference group with regard to content validity assessment. If differences were found between an “at-risk group” and the ED group on viewer evaluation indices, it could be assumed that the contents of the video were differentially meaningful to these groups of women or that it impacted them in
different ways. Also, the use of a comparison group helped control for history and maturation threats to internal validity of this study.

The present author speculated that eating disordered (ED) subjects would evidence a number of emotional reactions to the video, compared to college women. Such reactions by this group would reflect potentially greater, therapeutic impact on women with eating disorders. For example, if eating disorder themes in the video were emotionally salient, subjects with eating disorders would likely attribute a greater mood impact to the video, relative to college student subjects. They would also be expected to avow a higher degree of similarity to videotaped interviewees’ experiences and a higher level of general emotional impact, and would rate the video’s potential helpfulness higher than college women.

The professional clinician subject group ("Experts") was included in the present study to provide content validity data on the video. It was important to assess whether the Experts generally believed that the video contained most of the recovery issues and problems that are important to women recovering from an eating disorder. Establishing content validity involves judging the degree to which the subject matter covered by each item matches the topic initially specified for the corresponding objective (Worthen, Borg, & White, 1993). The extent to which items are congruent with the objective they are intended to assess helps determine their content validity.

Questions addressed in this study were:

1. Do both women with eating disorders and a reference group of college women evaluate the pretherapy video as credible, realistic, and believable? This
question was addressed by examining group differences on Video Appraisal Questions (VAQ) designed to measure content and face validity, specifically, the credibility of the video.

2. Does viewing the video correlate with a positive change in mood (pre- to post) in subjects? This question was addressed by comparing subjects' mood state before and after viewing the video using the Profile of Mood States (POMS).

3. After viewing the videotape, do subjects with an eating disorder produce higher ratings of inspirational impact than referent college women? This question was addressed by comparing these two groups on VAQ items designed to measure if the video provided subjects with an understandable and hopeful message.

4. After viewing the videotape, do eating disorder subjects report that the video elicited stronger avowals of identification with video models, than the college women? This question was addressed by VAQ items designed to measure one's personal similarity with the recovered women interviewed in the video.

5. Do the eating disorder subjects and college women avow that women can likely learn some keys to recovery, or that recovery knowledge can be gained from watching the video? This question was addressed by the VAQ items designed to measure content and face validity: specifically, the adequacy of knowledge provided about eating disorder recovery.

6. After viewing the videotape, do eating disorder subjects report that the video elicited stronger avowals of affective impact, than the college women? This question
was addressed by VAQ items designed to measure one’s belief that the content of the video is emotionally compelling.

7. Do women with eating disorders believe that the video would likely increase clients’ expectations for improvement? This question was addressed by the VAQ items designed to measure increased expectations, and the awareness that recovery efforts produced incentives.

8. Do eating disordered subjects, college women subjects, and professional clinicians who treat women with eating disorders evaluate the pretherapy video as having general utility? This question was addressed by VAQ items designed to measure the utility of the video. Additionally, this question was addressed through four VAQ questions addressing the practical therapeutic utility of the video (completed by expert clinicians only).
CHAPTER II

REVIEW OF PUBLISHED LITERATURE

The section that follows will define terms important to understanding the pretherapy training literature. Also, past reviews of the pretherapy literature will be summarized and general outcome trends outlined. Additionally, individual outcome studies examining the utility of videotape pretherapy methods will be reviewed. Criteria used to select the studies will also be presented. Finally, the concept of vicarious motivation, a key feature of Bandura's (1986) social learning theory will be outlined to provide a theoretical framework for understanding why vicarious, pretherapy training methods might be useful to clients.

Definition of Pretherapy Training

In both the individual and group therapy literature (Bednar et al, 1974; LaTorre, 1977; Piper et al., 1979, pretherapy training has usually been defined in terms of: (a) clarifying client and therapist role expectations; (b) clarifying the therapeutic process; (c) providing a rational basis for clients to accept psychotherapy as a means of helping them deal with their problems; and (d) providing interviews, structured exercises, or audio/video tape models of desirable client behavior.

Definition of Therapeutic Outcome Variables

It is important to know if therapeutic interventions are alleviating clients' target
symptoms. One way to assess therapy effectiveness is to measure therapeutic outcomes. Outcome can be assessed by client posttherapy ratings of satisfaction, therapist posttherapy ratings of improvement, and posttherapy ratings by others (e.g., family, parents, peers). Also, psychological test data can be used to assess outcome effectiveness.

Definition of Therapeutic Process Variables

Therapeutic process variables refer to a client's behavior during therapy. For example, expression of feelings and thoughts, interaction with group members, and completion of homework assignments are therapy behaviors believed to facilitate the therapy process; ostensibly, these should correlate with a client's improvement.

Review of Published Reviews of Pretherapy Training

This section will begin by examining reviews that have been published to date regarding the efficacy of pretherapy methods. The reviewers' conclusions tend to support the position that, in general, pretherapy training is effective. Bednar et al. (1974) summarized the results of seven individual and group therapy studies that assessed the effects of varied methods of pretherapy training on process and outcome measures. The results indicated that clients with pretherapy training responded more positively in therapy and achieved more favorable outcomes than did controls. Additionally, the group therapy studies showed positive and consistent results. Accelerated group development (e.g., group cohesion; openness and interaction among
members) and client improvement were related to pretherapy training in the form of verbal instructions clarifying group process and role expectations, and as vicarious learning in which models demonstrate effective client behavior. Pretherapy training was effective with four different populations on several different criterion measures. The authors reported vicarious learning (i.e., videotaped modeling) is a particularly influential kind of pretherapy training, affecting both outcome and process measures.

Piper et al. (1979) reviewed six group therapy studies examining the effects of pretherapy training. The studies differed with regard to the types of pretraining methods used, the type of patients studied, the time periods examined, and the type of measures used. Five of the six studies looked at therapy process variables. Of these five, three reported data favoring pretraining. Three of the six studies looked at outcome variables. All three reported data favoring pretrained patients. One of the studies reported on the attendance rate (only nonsignificant differences were found). Only two studies reported patient dropout rates. Of these, one study found nonsignificant differences, while the other found a trend favoring pretraining. Overall, there was some positive process and outcome data favoring pretraining; however, limited data are available regarding impact on attendance and dropout rates.

LaTorre’s (1977) review of pretherapy role induction studies (through 1977) found that pretherapy disclosure of appropriate therapist and client roles improved process and outcome variables. The effects were especially noteworthy with minimally or moderately disturbed psychiatric outpatients who had little education and therapy experience.
Kaul and Bednar (1986) summarized the results of six studies examining the effects of pretherapy training in group treatments. The results suggested that pretherapy training was effective. However, role expectations (expectations of client and/or therapist’s behavior) may have been confounded with prognostic expectations (one’s early expectations regarding success or failure in therapy). There was insufficient information to determine whether role or prognostic expectations, or both, were influenced by the experimental treatments.

In summary, the aforementioned reviews examined all of the evaluations of pretherapy training published to date. While vicarious pretherapy training in particular was found to benefit therapy process and outcome, only two studies specifically examined the usefulness of videotaped modeling as a pretherapy orientation strategy. Thus, the present dissertation will contribute to the modest fund of knowledge currently available about the use of pretherapy videotapes.

Meta-Analysis of Individual Studies of Pretherapy Training

The purpose of this meta-analysis was to assess available outcome studies examining the effectiveness of using vicarious pretherapy training methods. Ideally, such a review would provide information on the quality of the studies, the methods utilized, and summarize the results. Tables 2 and 3 (shown later) provide summaries of the findings of the meta-analysis (reported below). Primary outcome studies derived from the literature search will be reviewed. Of the five articles used in this integrative review, two compare the effects of video pretraining with other methods of pretraining
(e.g., Role-Induction Interview; Therapeutic Readings), and with a control group; two compared the effects of video pretraining with a control group only; and one study compared the video pretraining outcomes with a comparison video. Effect sizes were calculated for the results of each of the five studies.

Four outcome variables are focused upon in this analysis: attendance rates, drop-out rates, therapy outcome variables, and therapy process variables. Therapy outcome variables included both client sources of outcome (e.g., post-therapy ratings of satisfaction, psychological test data), and assessments by independent judges (e.g., therapists, peers, and parents). Process outcome variables refer to the client’s behavior in therapy (e.g., expressiveness, readiness, group interaction).

Selection criteria. Selection of studies was limited to research examining the effects of pretherapy training utilizing videos/films on therapeutic process, outcome, attendance, and drop-out variables. Also, this review only included studies that used both experimental and control/comparison groups.

Search methods. The search method used in this review involved widely available computer data bases including PsychLit and ERIC. The following key words (and their combinations) were used: pretherapy, therapy, training, continuation, process, outcome, role expectations, video, orientation, psychoeducational. Also, ancestry and descendency approaches were used. This involves consulting the reference lists attached to each review article or outcome study article to find relevant materials. The search did not extend to unpublished papers, theses, or dissertations. Together, five primary outcome studies and four review papers were located.
Rating of studies. Once selected, outcome studies were rated on a 3-point scale (1 = good, 2 = fair, 3 = poor) according to the quality of the experiment. The method used to rate the studies in this analysis was modeled after a rating method presented in a published dissertation (Zhang, 1993/1994), and used as an example in a doctoral research methods class. An article rated “good” should clearly explain the design. Major threats to internal validity should be controlled. Second, a “good” article should use appropriate statistical methods and report the results clearly. An article rated “fair” will have several minor threats to validity, or one moderate threat to validity; or, statistical results will not be as clear or thoroughly reported. “Poor” studies will have many minor threats to validity or one major threat to validity that could explain most or all of the observed treatment results. Also, statistical methods and results are inappropriately applied and reported in “poor” studies.

Quality of studies. The quality of studies was reviewed to ascertain whether better studies showed different effect sizes than poorer studies (see Table 1). Only one study, that of Strupp and Bloxom (1973), could be rated as “good.” Only effect sizes for therapy outcome measures were available in this study. A large effect size suggested that the use of the pretherapy video improved therapy outcomes significantly. Studies rated as “fair” tended to produce large therapy outcome effects, and very large weaker effects existed for attendance and dropout rates. The lone “poor” study (Sauber, 1974) offered very little information. In this investigation, the construct of therapy readiness was evaluated for a pretherapy video group versus a group that was administered a role induction interview. The video was reported to be much more
Table 1

**Effect Size for Quality of Study (Across All Studies)**

<table>
<thead>
<tr>
<th>Quality of Study</th>
<th>Outcome</th>
<th>Process</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>0.95 (3)</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Fair</td>
<td>0.63 (4)</td>
<td>1.41 (2)</td>
<td>0.25 (3)</td>
</tr>
<tr>
<td>Poor</td>
<td>0.00</td>
<td>1.03 (1)</td>
<td>0.00</td>
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*Note.* Numbers in parentheses indicate the number of effect sizes.

effective than the interview in improving therapy readiness. Both the good and fair studies strongly suggested that the use of a pretherapy video was beneficial to both the process and outcome of therapy.

**Results**

**Therapy Outcome Variables**

Table 2 presents therapy outcomes associated with two “sources” (client or objective judge). The “ES” column of Table 2 presents effect sizes associated with (a) client self-reported satisfaction and outcome measures and (b) objective judges’ evaluations of clients. A positive effect size indicates that clients who participated in the video pretherapy training were relatively more improved than clients in the control condition. Table 3 presents the mean effect sizes across the studies.

Strupp and Bloxom (1973) compared the effects of a pretherapy film, role-induction interview, and control video group. Effect sizes involved the video
### Table 2

**Study Characteristics and Effect Sizes**

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment type; (#/sessions)</th>
<th>Setting, client type, (n)</th>
<th>Therapist, contrast</th>
<th>Pretraining method; length</th>
<th>Dependent measure</th>
<th>ES</th>
<th>Quality of study</th>
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<tr>
<td>Coleman &amp; Kaplan 1990</td>
<td>Individual (#=4)</td>
<td>Mental health center, children (n=49)</td>
<td>Psy PhD, MSW, and doctoral students</td>
<td>1) Video only, 13 min 2) Lecture on history of agency</td>
<td>Knowledge gains of treatment process and structure</td>
<td>2.03</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Parents rating of child improvement</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Drop-out</td>
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</tr>
<tr>
<td>Craigie &amp; Ross 1980</td>
<td>Individual (#=3)</td>
<td>VA inpatient detox, alcoholics (n=31)</td>
<td>Experimenter</td>
<td>1) Video plus discussion, 103 min 2) Comparison video</td>
<td>Treatment referral and contract</td>
<td>0.75</td>
<td>Fair</td>
</tr>
<tr>
<td>Hilkey 1982</td>
<td>Group (#=8)</td>
<td>Federal prison, inmates (n=90)</td>
<td>Psy PhD, and Psy doctoral students</td>
<td>1) Video and guided performance, 30 min 2) Control</td>
<td>Therapist ratings of improvement</td>
<td>0.94</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Peer ratings of improvement</td>
<td>0.72</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Client ratings of improvement</td>
<td>0.18</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Group interaction</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Attendance</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Sauber 1974</td>
<td>Individual (#=1)</td>
<td>University marriage counseling clinic, female students (n=36)</td>
<td>Not stated</td>
<td>1) Video only, 45 min 2) Role Induction (R-I) interview 3) Therapeutic reading</td>
<td>Therapy readiness (video vs RII)</td>
<td>1.03</td>
<td>Poor</td>
</tr>
</tbody>
</table>

*(table continues)*
<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment type; (#/sessions)</th>
<th>Setting, client type, (n)</th>
<th>Therapist, contrast</th>
<th>Pretraining method; length</th>
<th>Dependent measure</th>
<th>ES</th>
<th>Quality of study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strupp &amp; Bloxom (1973)</td>
<td>Group (#=12)</td>
<td>12 community agencies, low SES (n=122)</td>
<td>Psy PhD, psychiatric nurse</td>
<td>1) Video only, 32 min 2) R-I interview 3) Control video</td>
<td>- Attendance (video vs control) = - Pt ratings of improvement (video vs control) = - Pt satisfaction with treatment (video vs control) = - Thpt rating of improvement (video vs control) =</td>
<td>0.00</td>
<td>Good</td>
</tr>
</tbody>
</table>
Table 3

Mean Effect Size for Dependent Variables Across Studies

<table>
<thead>
<tr>
<th>Client satisfaction and outcome measures</th>
<th>Mean ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent judges</td>
<td>0.59 (4)</td>
</tr>
<tr>
<td>Process measures</td>
<td>1.28 (3)</td>
</tr>
<tr>
<td>Dropout or attendance</td>
<td>0.19 (4)</td>
</tr>
</tbody>
</table>

Note. Numbers in parentheses indicate the number of effect sizes.

group and the control group. An effect size of 1.78 ($p < .03$) was associated with patients' satisfaction with the treatment program. Patients viewed any role induction as more helpful than none, and the video was considered more helpful than the interview.

Self-ratings of perceived progress in therapy (Strupp & Bloxom, 1973) showed that the video-induction reported the greatest satisfaction; the interview group occupied an intermediate level, and the neutral group ranked third (between video group and control, $ES = 1.06, p < .001$). Patients who had participated in the video and interview groups showed a significant increase in satisfaction with their interpersonal relations, while patients in the neutral condition remained relatively unchanged. This increase in satisfaction appeared early in the therapy program among patients receiving the video induction, but later in the program for those in the interview group.

In contrast, the presentation of videotape pretraining and guided performance procedures did not yield differential self-reports between experimental and control groups ($ES = .18$) in a prison population (Hilkey, 1982). Both experimental and
control groups reported moderate progress toward their goals. However, findings indicated that persons assigned to pretherapy training groups observed greater peer changes (perceived progress of other clients' goals) than persons in control groups (ES = .72, p < .01). This study also found that the combination of videotape pretraining and guided performance appeared to be an effective method of fostering progress toward clients' therapy goals, as perceived by their group therapists (ES = .94, p < .001).

The effects of a pretherapy videotape preparation on child therapy outcomes were assessed by Coleman and Kaplan (1990). Prepared mothers rated their children as having fewer problematic behaviors than did nonprepared mothers over the course of four therapy sessions (ES = .68, p < .05). In contrast, Strupp and Bloxom (1973) did not find significant differences among the pretherapy training conditions and control groups when rating post-therapy improvement by the therapists. As mentioned earlier, there were significant group differences in the patient ratings, indicating that greater improvement was reported by patients than by therapists.

**Process Variables**

Table 2 also displays effects associated with three therapy process variables. All three variables involve the clients’ state of “preparedness” to begin therapy. These variables include knowledge gains of therapy process and structure, initial group interaction, and therapy readiness. The mean effect size across three studies was 1.28 (SD = .54). All three effect sizes were large and supported the use of video
pretherapy training. Two studies were rated "fair," and the third was rated "poor."

Hilkey (1982) compared the experimental and control groups on the first, third, fifth, and eighth sessions to see if any differences between groups existed in quality of interaction. Hilkey found that a significant difference was evident in the first sessions, suggesting that groups receiving training prior to group psychotherapy elicited more positive social-emotional responses than did groups not exposed to training. There was no significant difference for subsequent sessions.

Coleman and Kaplan (1990) found that mothers and children who received videotaped pretherapy information demonstrated significantly more knowledge about the structure and the process of child psychotherapy than did children and mothers who did not receive training ($ES = 2.03$, $p < .001$). Sauber (1974) reported that pretraining therapy consisting of viewing a video tape of several patients was the most effective method among three experimental (and one control) conditions in facilitating a state of "readiness" in clients ($ES = 1.03$, $p < .025$).

**Attendance and Drop-Out**

Three studies examining attendance or drop-out outcomes did not show any differences between groups as a function of pretherapy training. However, in a fourth study, Craigie and Ross (1980) did find that pretherapy training using a video facilitated follow-through on treatment referral and contact after alcoholics were discharged from a VA hospital detox center. In addition, experimental subjects who made treatment contact tended to remain longer and/or complete treatment more than
comparison subjects who only made treatment contact. Initial treatment contact and follow-through are analogous to attendance variables.

As mentioned above, the sample of available studies is small, so the mean effect sizes can be misleading and conclusions should be tentative. Just as the pretherapy training literature was once sparse and fragmented, pretherapy video training studies are still limited in both number and scope. However, examining how study characteristics covary with treatment outcomes provided useful information to the present researcher (as the proposed study was being designed).

Summary of Studies

Although it cannot be realistically expected that a 1-hour, pretraining procedure would enhance outcome behaviors among prison inmates in such a brief period of time, the benefits of pretraining early in therapy appeared significant in the study by Hilkey (1982). Further, pretraining results with alcoholics were consistent with the prediction that therapeutic involvement would facilitate the modeling of relevant behaviors, and help describe the nature and expected benefits of treatment (Craigie & Ross, 1980). Part of the effectiveness of Craigie and Ross’ procedure may have been due to the fact that pretherapy training helped subjects become convinced of the multifaceted nature of their problems and the specific ways in which multimodal treatment could help.

Videotaped preparation was an effective way of educating children and parents about child psychotherapy (Coleman & Kaplan, 1990). Therapy preparation also had a significant effect on mothers’ evaluation of children’s progress over the course of four
therapy sessions. Increased understanding, greater involvement, and higher expectations for improvement by parents may be factors contributing to this finding.

Strupp and Bloxom (1973) found evidence that a role induction interview and a role induction video facilitated both process and outcome therapy measures. When compared to the role induction interview, the video was superior over a wider range of measures. Helping clients understand the appropriate role behavior as a therapy collaborator may be very useful.

Discussion

Overall, available studies indicate that pretherapy training videos facilitate the therapy experience of prison inmates, alcoholics, children, married university students, and low-income clients. A large treatment effect size is associated with a number of therapy outcome and process variables. These results are consistent across studies regardless of study characteristics (e.g., sample size, therapist training, quality of study). However, it is necessary to consider the methods utilized and study quality before interpreting the large effect sizes as indicating a powerful treatment effect. For example, direct comparisons of a group of five video studies is difficult because each study varied considerably in terms of the therapy population methods, and the specific content of the video, interview, discussion, or guided performance. Two of the five studies supplemented pretraining with additional material. This confounded the effects of the video per se and made it more difficult to discern what effects the video versus other factors had on therapy outcome and process measures.
Furthermore, differences in the literature were evident with regard to patients' levels of sophistication, therapist experience, therapy setting, the quality of study, and the fact that studies use diverse measures. Additionally, only one of the five studies was of "good" quality; three were "fair," and one was of "poor" quality. Considering the general methodological weaknesses of available studies, a cautious acceptance and interpretation of the large effects present in the literature are warranted.

**Pretherapy Studies for Eating Disorders**

No studies to date examining the impact of pretherapy programs on eating disorder clients have been published. Given the apparent superiority of videotape versus interview and other methods of pretherapy training, it was useful to examine outcomes from studies using videotape approaches to pretherapy training to guide decisions about the utility of this approach for an eating disorder population.

**Theoretical Framework for Explaining Pretherapy: Vicarious Motivators**

A major, theoretical model for understanding how vicarious pretherapy training methods may influence individuals who observe persons similar to themselves is provided by social learning theory. Many researchers have studied vicarious learning, which is also referred to as "observational learning" and "social modeling." The most comprehensive and useful theoretical framework explaining the process of vicarious learning has been provided by Bandura (1986) through his social learning theory. Bandura maintains that people, as social beings, observe the behavior of others and
attend to the occasions on which others are rewarded, punished, or ignored. In doing so, people benefit from the successes and mistakes of others, as well as from their own direct experiences. Generally, research has focused on the idea that seeing successful outcomes among others' behavior increases one's tendency to behave in a similar manner. On the other hand, observing punished behavior decreases the likelihood that an observer will behave as the model did.

According to Bandura, imitative behavior will occur if the observer is attentive to the modeled behavior. Attention is more likely if the modeled behavior is easily observable, emotionally engaging, relatively simple, exhibited frequently, and if it is important in the life of the observer. Also, imitative behavior is more likely to occur when the observer has the expectation that the behavior should be imitated, understands the meaning of the modeled behavior, is emotionally aroused by the model, and if the model is rewarded.

Retention, production, and motivational processes indicate that observational learning is more likely to occur when the modeled behavior is retained through (cognitive) coding and organization, and behavioral rehearsal. It is also likely to occur when production of the modeled behavior is facilitated by understanding, comparison, feedback, and if one is physically capable of emitting the behavior. Finally, as has been noted, modeling is more likely to occur when associated with external and internal incentives (Bandura, 1986; Hallenbeck & Kauffman, 1995).

More importantly, Bandura (1986) asserted that observed outcomes can affect a subject's level of motivation. This process occurs through two cognitive mechanisms. First, vicarious outcomes create outcome expectations that may serve as positive or
negative incentives for behavior. However, motivation is mediated by self-beliefs of efficacy, the second mechanism. Knowing what outcomes result from a given behavior is unlikely to inspire others to take similar action if they doubt they can be successful.

Bandura (1986) has suggested that perseverance at a task or behavior is affected by how much, as well as by how often, others are rewarded. Vicarious outcomes foster the most perseverance when one observes that a tenacious effort produces infrequent, but sizable rewards. The motivation of individuals who aspire to achievement in athletic, business, scientific, and professional enterprises is partly sustained when their own labor brings intermittent rewards, and when they observe others gaining recognition and success through sustained effort.

Social learning theory (Bandura, 1986; Hallenbeck & Kauffman, 1995) avows that the transition from observing modeled events to actually emulating a similar pattern of behavior involves attentional processes (e.g., salience; affective valence; complexity), retention processes (e.g., cognitive organization and rehearsal; symbolic coding), production processes (e.g., observation of enactments; feedback information), and motivational processes (external incentives; self-incentives). These four processes are not only influenced by the modeled behavior, but also by attributes of the observer.

What are the implications of social learning theory for designing and evaluating a pretherapy video for women with eating disorders? Imitative behavior would be more likely among observers of a pretherapy video if the models were highly similar to them. The fact that the interviewees in the Quakenbush and Stein (1996) video sequences were all women who experienced eating and dieting symptoms, emotional experiences, conflicts, and so forth, makes them most similar to those women who may
wish to enter treatment for eating disorders (i.e., the intended audience of the pretherapy videotape). The video includes theme reiteration, which should enhance vicarious rehearsal for observers (e.g., the social relationship examples described by the video models). Also, reiteration of themes should enhance modeling effects for observers if they are affectively compelling, and highly salient to observers. Further, the stories the recovered women model in the videotape may serve as vicarious reinforcers for observers (e.g., increased self-efficacy, increased enjoyment of one’s social network, and enhanced ability to deal with emotions appropriately). Thus, many factors in a pretherapy video may enhance modeling effects and observational learning among viewers who themselves have an eating disorder.

To date, too few studies are available to identify which particular types of videotape formats or video contents may be superior in terms of promoting therapy outcomes. In general, exposing prospective clients to others’ life experiences or therapy behaviors seem to provide a powerful modeling influence. Exposing women with eating disorders to models of successful recovery may help them identify some of the steps needed to recover. Also, as has been noted, such models will likely offer vicarious reinforcement to eating disorder observers, because of similarities in their eating and emotional experiences. In summary, modeling influences from an eating disorder recovery video will be most effective if observers with eating disorders attend to the model, have a strong, positive affective response toward the model, see the model reinforced, see themselves as similar to the model, and have their expectations for improvement increased.
CHAPTER III

METHODS OF THE PROPOSED STUDY

This study examined the impact of a motivational pretherapy video for eating disorder clients on three relevant groups of subjects: (a) a normative or "at risk" group of college females; (b) a group of women with eating disorders; and (c) a group of experts who regularly treat women with eating disorders. An overview of procedures of the study is presented in Figure 1, and the procedures are detailed in the sections that follow. Figure 1 shows that college student subjects viewed the pretherapy videotape and completed the same evaluation procedures as the subjects with eating disorders; however, eating disorder subjects also participated in a telephone screening interview prior to inclusion in the study to verify their diagnosis. The professional clinician group was not asked to complete the consent form, demographic fact sheet, or the Profile of Mood States (POMS).

Subjects

College Student Subjects

Women attending universities are known to be at higher risk for developing eating disorders, relative to other women. Female Utah State University Psychology 101 students were recruited as subjects for the reference ("at risk") group (see Appendix B, Recruitment Speech). The students were awarded extra credit for their
College Student Subjects

Recruitment from Psy 101 Physical Education, and Nutrition and Food Science classes

Consent Form
Demographic Face Sheet
Profile of Mood States (Pre)
Profile of Mood States (Post)
Exposure to Video
Video Appraisal Questionnaire

Eating Disorder Subjects

Recruitment from USU Counseling Center, USU Psychology Community Clinic, USU general campus, Cache Valley area

Diagnostic Screening Interview
Consent Form
Demographic Face Sheet
Profile of Mood States (Pre)
Profile of Mood States (Post)
Exposure to Video
Video Appraisal
Questionnaire

Professional Clinicians

Recruitment from clinical referral lists of local and regional clinicians who treat eating disorders

Exposure to Video
Video Appraisal
Questionnaire

Figure 1. Procedures across groups.

participation, based on their instructor’s policy regarding the awarding of course credit.

A majority of the students in Psychology 101 classes are typically between 18 and 19 years of age. This is approximately the peak age of onset for certain eating disorders in females, especially bulimia nervosa (American Psychiatric Association, 1994). Over 50% of the students in Psychology 101 are female.

Additionally, USU nutrition and food science, and physical education students were recruited. The physical education students were awarded extra credit for their participation, based on their instructor’s policy regarding the awarding of course credit. The nutrition and food science students were not awarded extra credit. They participated in the study as a required class activity.

Eating Disorder Subjects

Eating disorder subjects were recruited from USU Psychology Community

Clinic and USU Counseling Center clientele (see Appendix C, Recruitment Speech). Also, subjects were recruited from university campus and from the local city. Advertisements were placed on community, school, and the university bulletin boards (see Appendices D and E).

All procedures were the same for both eating disorder (ED) subjects and college students (CS), with the exception that the ED subjects were asked to complete an initial telephone screening interview at the onset of the study. It was necessary to verify that eating disorder subjects did indeed have a diagnosable eating disorder. The women with eating disorders who were receiving treatment were asked questions regarding the history of their bulimia nervosa, anorexia nervosa, or binge eating disorder. Subclinical subjects were not included in the study. A checklist of DSM-IV criteria for anorexia and bulimia nervosa, and binge eating disorder (Appendix F) was used to guide the diagnostic interview for these subjects.

Professional Clinicians

Professional clinicians were recruited from clinician referral lists of local and regional clinicians who are known to regularly treat eating disorders. They were contacted via mail, then followed-up by telephone and asked to participate in the evaluation of the pretherapy video (see Appendix G, Professional Recruitment Letter).
Consent Forms

A consent form (see Appendix H) advised college student and eating disorder subjects that (a) participation in the study would take about 1 hour; (b) they would be asked to complete a short demographic fact sheet, Profile of Mood States (pre and post), the Video Appraisal Questionnaire, and watch a video; (c) completed forms and questionnaires would contain no identifying information and would be kept in a secure place; (d) results of the study would report only group data and would be used for research purposes only; (e) there were no known risks; (f) participation was voluntary—subjects were free to withdraw their consent at any time; (g) subjects were invited to inquire about study procedures at any time; and (h) the results of the study would be available to them in about 6 months. Experts were not asked to complete a consent form.

The women who completed the eating disorder recovery interviews (used to produce the recovery videotape) had given consent to be videotaped prior to participating in the Quakenbush and Stein (1996) study (see Appendix I). They waived confidentiality and allowed their videotaped interview to be included in the pretherapy recovery video. Further, they signed a Utah State University Psychology Department Release Form for the Eating Disorders Recovery Video (see Appendix J). This release (a) assigns all rights to the videotape to the Psychology Department, Utah State University and (b) authorizes the broadcast, exhibition, copyright, reproduction,
distribution, and/or sale of the videotape without limitations.

The Utah State University Institutional Review Board (IRB) approved both phases of the video development project as ethical and suitable for use with human subjects (see Appendices K and L).

**Demographic Form**

College student subjects and eating disorder subjects were requested to complete a demographic fact sheet (see Appendices M and N). This sheet contained various information, such as subjects’ age, ethnicity, religious affiliation, marital status, and number of children. The form was slightly different for the college student and the eating disorder subjects. The eating disorder form asked for information regarding age of onset of the eating disorder, and eating disorder treatment history. The college student form asked the question, “Do you have higher-than-average concerns about your eating habits and/or body shape and weight?”

This information was gathered for descriptive purposes and so that other researchers could more easily replicate this study. There was no theoretical basis for assuming that any demographic variables would be associated with video evaluation outcomes.

**Profile of Mood States**

The Profile of Mood States (McNair, Lorr, & Droppleman, 1971; POMS) is a factor analytically-derived inventory that measures six identifiable mood or affective states: Tension-Anxiety; Depression-Dejection; Anger-Hostility; Vigor-Activity;
Fatigue-Inertia; and Confusion-Bewilderment. The POMS scales have been shown empirically to be useful descriptive mood measures for assessing psychiatric outpatients' mood responses to various treatment interventions. Also, the POMS scales have been shown to sensitively measure the effects of various experimental manipulations on the mood of normal subjects and other nonpsychiatric populations (Haskell, Pugatch, & McNair, 1969; Lorr, Daston, & Smith, 1967; Lorr, McNair, & Weinstein, 1964; Lorr, McNair, Weinstein, Michauz, & Raskin, 1961; McNair, Goldstein, Lorr, Cibelli, & Roth, 1965; Pillard, Atkinson, & Fisher, 1967).

The POMS consists of 65, five-point adjective rating items, which represent the refinement of a total of 100 different adjectives (through factor analyses). Generally, individuals with a seventh-grade education can understand the items of the POMS with little or no difficulty. The wording used on the usual form of the POMS is:

Below is a list of words that describe feelings people have. Please read each one carefully. Then fill in ONE space under the answer to the right which best describes HOW YOU HAVE BEEN FEELING RIGHT NOW. The numbers refer to the following descriptive phrases: 0 = Not at all, 1 = A little, 2 = Moderately, 3 = Quite a bit, 4 = Extremely.

Two Profile Sheets are available for plotting POMS results: an Outpatient Form (OP) and a College Form (C). The outpatient form was used in the current study. The Outpatient Form is based on norms collected for 350 male and 650 female psychiatric outpatients who completed the POMS on their first visit to an eastern U.S. university medical center psychiatry clinic between 1966 and 1969. Exclusion criteria included illiterates, alcoholics, extreme psychotics, emergency admissions, and non-English-
speaking patients. When raw scores are plotted they can be converted to T scores. The mean standard score for each scale is 50 with a standard deviation of 10. The POMS, College Form is based on a sample of 516 women and 340 men college undergraduate students at a large eastern university in the United States.

The POMS is recommended primarily as a measure of mood states in psychiatric outpatients, and as a method of assessing changes in these patients. Also, the POMS is recommended for similar purposes, but only on a research basis for normal subjects, age 18 and over, who have had at least some high school education. The validity and reliability of the POMS has not been sufficiently demonstrated with psychiatric inpatients. Further, few data are available on normal or disturbed adolescents; however, it is likely that the POMS would be useful in research involving adolescent subjects.

The POMS is typically self-administered and can be used in an individual or group format. Most subjects will complete the POMS in 3 to 5 minutes. To obtain a score for each mood factor, the sum of the responses is obtained for the adjectives defining one particular mood factor. A Total Mood Disturbance Score may be obtained by summing the scores on the six primary mood factors (vigor items are negatively weighted). Internal consistency values are highly satisfactory: All of the indices of the extent to which the individual items within the six mood scales measure the same factor are near .90 or above (McNair & Lorr, 1964). The internal consistency reliabilities of the POMS are as follows: Anxiety subscale, \( r = .92 \); Depression subscale, \( r = .95 \); Anger subscale, \( r = .92 \); Vigor subscale, \( r = .89 \);
Fatigue subscale, \( r = .94 \); and Confusion subscale, \( r = .87 \).

The six-factor analytic replications used to develop the POMS may be taken as evidence of the factorial validity of the POMS’s six mood factors. Additionally, four areas of research have provided evidence for the construct and predictive validity of this instrument. These four areas are (a) brief psychotherapy, (b) controlled outpatient drug trials, (c) studies of response to emotion-inducing conditions, and (d) studies of concurrent validity coefficients (Haskell et al., 1969; Lorr et al., 1961, 1964, 1967; McNair et al., 1965; Pillard et al., 1967).

Lorr et al. (1961) compared a sample of 180 VA outpatients with a control group of 45 normals over an 8-week treatment period, with the total sample of VA outpatients showed highly significant \( p < .001 \) improvement on the Anxiety, Depression, Anger, and Fatigue subscales. No significant changes were found for the control group of normals who were retested after a similar 8-week interval. Also, Haskell et al. (1969) found the POMS to be sensitive to a reduction in depression in a group of 43 outpatients.

To assess concurrent validity, the patients in the normative samples also completed a modified version of the Hopkins System Distress Scales (Parloff, Kelman, & Frank, 1954). The Distress Scales consist of three scores: somatization, anxiety, and depression. The three scores, especially anxiety and depression, have been found to be highly correlated with the POMS subscales. The correlation between the mood factors and the symptom distress measures for the anxiety score ranged from .52 to .77. The correlations for the Depression score range from .58 to .86. Nearly all the
POMS factors are moderately to highly correlated with the three symptom distress measures.

**Video Appraisal Questionnaire**

The Video Appraisal Questionnaire (VAQ; Appendix O) was developed by the present author to assess the utility and content quality of the recovery videotape. Of particular interest was whether individuals evaluating the video would find it credible, inspiring, and informative. Also, whether viewers could identify with the experiences of the women in the videotape was of interest, as was whether the video promoted expectations for improvement. Items were developed to ascertain whether the videotape contained many of the critical themes viewers believed were pertinent to recovering from anorexia and bulimia nervosa, and whether certain modeling influences were likely present.

The first 37 items on the VAQ were subjected to a principal component analysis. The analysis revealed that the items formed subscales which paralleled research questions pertinent to assessing subjective appraisal of the quality of the video. Also, these questions were designed to document whether features of the video were theoretically consistent with Bandura's modeling theory (e.g., subject perception of personal similarity to model; promotion of affective involvement; credibility to the viewer; evidence of reinforcement of the model; and improvement expectancies).

The VAQ Subscale Key (Appendix P) summarizes how items were grouped via a principal component analysis. Mean scores on these subscales could range from 0 -
4. Mean scores of “3” or higher reflected high quality ratings. On reversed-scored items, a mean score of “2” or lower indicated high quality.

The VAQ subscales are (a) Credibility (viewer agreement that the models portrayed in the video were believable, had real problems, etc.); (b) Inspirational (viewers perceive that the video would likely promote feelings of hopefulness among viewers that persons with eating disorders can successfully recover); (c) Similarity (viewer agreement that opinions, beliefs, avowed problems, etc. of women portrayed in the video were similar to their own); (d) Knowledge gain (viewer agreement that video content provided them with new, helpful information about eating disorders and recovery issues; (e) Expectancies (affirmation that the video may create positive expectations of improvement among viewers with eating disorders; (f) Affect (subject belief that the video is emotionally compelling to viewers); (g) Utility (avowal that the video might be generally useful and relevant to persons with eating disorders; and (h) Global (a total VAQ score, likely reflecting global liking or positive evaluation of the video).

Internal consistency for VAQ subscales was evaluated, and Item-to-Total correlation and split-half reliability coefficients were produced. Coefficient alpha (internal consistency) values for each of the VAQ subscales are as follows: Credibility subscale, \( r = .67 \); Inspiration subscale, \( r = .83 \); Similarity subscale, \( r = .89 \); Knowledge subscale, \( r = .63 \); Expectancies subscale, \( r = .61 \); Affect subscale, \( r = .70 \); and Utility subscale, \( r = .63 \).

Content validity was established by Expert evaluation (measured by VAQ) that
the video content contained the critical themes associated with eating disorder recovery. Also, the original format that guided the semistructured interviews of the models portrayed in the current pretherapy video was based on themes past researchers have identified as important to recovery from eating disorders. Five judges independently confirmed that the VAQ items were face valid characterizations of these earlier documented themes.

A slightly expanded version of the VAQ was used for Experts (i.e., the VAQE). This expanded version included additional items that asked Experts to rate (on a scale from “-4 to +4”) the perceived therapeutic utility of the video (see VAQ Section II). Prior to the collection of any data, it was decided that mean scores of “2” or higher on these items would be interpreted as reflecting Expert judgment of adequate to high utility. Also, the VAQE asked subjects to spontaneously report any critical themes they believed were absent from the video, and list any strengths or weaknesses of the video (see VAQE, Section III). Information from Section III of the VAQE was expected to help the researcher revise and improve the video in the future.

Development of Pretherapy Video

The videotape was constructed from edited excerpts taken from the Quakenbush and Stein (1996) eating disorder recovery research videotape interviews. These interviews queried subjects about themes that many past researchers have identified as likely being important for women to talk about and/or resolve if they are to recover from an eating disorder (Quakenbush & Stein, 1996). Additionally, some recovery
themes were derived post-hoc: Subgroups of the women who completed the recovery interviews occasionally reported similar recovery issues not documented by past researchers, nor subsumed under topics typically identified as important by other experts. These themes were discovered by a group of trained judges who recorded and coded all videotapes.

Thus, the present video as derived from these themes, is presumed to have a high degree of content validity. In part, expert opinion helped determine the content of the interview questions, as did (structured) interview data obtained from 30 recovering women. These themes and the research relevant to developing the video are outlined in Appendix Q.

The general design of the video involved a sequence of short interview clips to emphasize each recovery theme. At the beginning of the video, professional clinicians introduce the objectives of the video and provide a quick overview of the recovery themes. Next, actual case vignettes are used to illustrate each recovery theme in more detail.

Interview vignettes illustrated what motivated the women in the videotape to: (a) begin recovery, (b) maintain recovery, and (c) cope with the threat of relapse. Additionally, the difficulties these women experienced and overcame while recovering from their eating disorder were emphasized.

Admittedly, these stages have been oversimplified to make the concepts easily understandable to the intended audience of the video. Although this stage model refers to relapse as a separate and definitive stage, the researcher acknowledges that relapse
occurrences can take place at any point in the recovery process. For example, dealing with relapse issues is often confronted during the maintenance phase of recovery.

First, the video showed women discussing their early recovery process, including themes of "giving up control," "taking new risks," and "cultivating hope." Second, women described their process of becoming "tired of the disorder" or "hitting a personal low point." Third, they gave examples of how psychotherapy, group and individual, aided recovery from their eating disorder. Fourth, the models described how they maintained their recovery gains. Topics included "making critical choices," "replacing eating disorder behavior with healthy behaviors," and "challenging rigid thinking." Fifth, issues of self-esteem were outlined by several different recovering women, including self-acceptance and reducing emphasis of physical attractiveness. The sixth major theme highlighted by the women was development of healthy eating habits and attitudes. Nutrition, restructuring eating patterns, use of time delays, and cognitive restructuring (e.g., food as nutrition vs. the enemy) were discussed.

Next, the women offered suggestions about coping with relapse and setbacks. For example, they advised other bulimic and anorexic individuals to associate with other recovering women, and to accept temporary setbacks as part of the recovery process. The eighth major theme dealt with the concept of developing emotional management skills. Issues highlighted included: (a) dealing with guilt and responsibility, (b) identification of feeling states, (c) dealing with conflict, (d) finding new ways to deal with negative feelings, and (e) developing assertiveness skills.

The last major themes portrayed were spirituality and social support. Summary
statements highlighted and clarified the most important points of the recovery process and each major recovery theme. The video closed with a motivational section in which several of the recovering women discussed the value of struggling with the recovery process, and that recovery from eating disorder symptoms was possible and worth the effort.

To be selected for use in the pretherapy video, an individual vignette from the Quakenbush and Stein recovery interviews (1996) was viewed independently by the researcher and two research assistants. Vignettes were nominated by each, and a full consensus of all three viewers determined the final selection of video segments.

The technical process called “edit decision list” (EDL; Appendices R, S, T), began by completing a needs assessment and then developing an outline for the video. The overall raw video footage was logged (viewed), and then reduced. All the excerpts had location numbers that identified where they were on the tape. The logged footage was then transferred to a broadcast Beta SP format tape for editing. The footage was timed and logged with time code numbers. Rights to the music included in the video had been previously bought by Utah State University’s Multi-Media Center, so the copyright was waived. Once the master tape was completed, S-VHS, VHS, and PAL (International) copies were made from the master tape.
Instructions to Subjects to Watch and Rate Video

College and eating disorder subjects were told that the goal of the study was to evaluate men’s and women’s reactions to a training video about eating disorders, which was currently under development at Utah State University. Professional clinicians (Expert) were also told that the goal of the study was to evaluate a pretherapy eating disorder video. All subjects were told that they would watch a 36-minute video and complete some evaluation materials regarding the video.

Video Observation and Rating Procedures

The college and the eating disorder subjects completed the consent form, demographic fact sheet, and the POMS Questionnaire (pretest). Subjects then watched the video, completed the POMS again (posttest), and filled out the VAQ. The expert subjects merely watched the video and completed the VAQ. Experts were also asked to provide information regarding how many eating disorder clients they have been responsible for treating, their degree, and their current job role and setting.

All data collection for the Psychology 101 college women group and the eating disorder subjects took place at the USU Psychology Community Clinic, Psychology Department. Subjects watched the video in small groups of 6 to 10 and adhered to written instructions read aloud by research assistants to ensure systematic procedures (Appendix U). First, assistants passed out packets of all inventories; next, subjects
read and signed the consent form. Subjects then completed the demographic fact sheet, and the POMS (pre), marking answers on a 5-option Scantron form. Then subjects viewed the recovery video and completed the posttest POMS and then the VAQ. Research assistants monitored each group to prevent conversation and discussion; they also answered questions posed by participants and clarified instructions. Data collection for those college women enrolled in the physical education and nutrition courses occurred during a normal class period.

Data Analysis

The POMS and the VAQ provided data that are continuously scaled (i.e., sum of items rated on a 5-point Likert scale for individual Subscale total scores and a Global Total score; sum of items rated on a scale ranging from “-4” through “+4”). Item subscale data from the POMS and VAQ were summarized in frequency distribution tables.

ANCOVA was used to evaluate whether posttest means of POMS test scores were significantly different for the college group versus the eating disorder group. Subjects’ posttest scores served as the dependent variable, and pretest scores as the covariate. This analysis pertained to Research Question #2 regarding mood state changes associated with watching the pretherapy videotape.

Separate $t$-tests were used to compare the group means (CS and ED groups) on the VAQ subscales. A Total score on the VAQ will represent global appraisal. These analyses addressed Research Questions (RQ) Numbers 1, 3, 4, 5, 6, 7, and 8,
regarding the pretherapy video’s: RQ 1) credibility; RQ 3) inspirational impact; RQ 4) similarity; RQ 5) ability to increase knowledge of eating disorder recovery; RQ 6) affective impact; RQ 7) ability to increase expectations for improvement; and RQ 8) overall therapeutic utility.

Research Question #1 asked, “Do both women with eating disorders and a reference group of college women evaluate the pretherapy video as credible, realistic, and believable?” Frequency counts and mean (SD) scores were reported for VAQ items 1, 3, 7, 15, 21, and 35 (Credibility subscale). A mean score of “3” or higher on the VAQ Credibility subscale was interpreted to mean general group avowal of the credibility of the video.

Research Question #2 asked, “Does viewing the video correlate with an increase in positive change in mood (pre-to-post) in all these groups of women (mood state change)?” To assess whether positive mood change occurred pre-to-post in all women, and whether group means were different, a one-way ANCOVA was conducted using pretest POMS scores as the covariate and posttest POMS scores as the dependent variable. Effect sizes were reported for each group (pre-to-post). Also, subjects’ beliefs about whether the video was emotionally compelling were assessed by the VAQ Affect subscale.

Research Question #3 asked, “After viewing the videotape, do eating disorder subjects produce higher ratings of inspirational impact than college women (VAQ Inspirational subscale)?” Separate t tests involving the VAQ Inspirational subscale were computed and effect sizes were calculated.
Research Question #4 asked, “After viewing the videotape, do eating disorder subjects report that the video elicited stronger avowals of identification and empathy than the college women?” To assess possible differential avowal of identification (college versus eating disorder subjects), separate $t$ tests involving the VAQ Similarity subscale were calculated. Effect sizes were calculated.

Research Question #5 asked, “Do the eating disorder subjects and college women avow that women can likely learn some keys to recovery, or that recovery knowledge can be gained from watching the video?” Separate $t$ tests involving the Knowledge Gained subscale were computed. Effect sizes were calculated.

Research Question #6 asked, “After viewing the videotape, do eating disorder subjects report that the video elicited stronger avowals of affective impact, than the college women?” A mean score of “3” or higher on the VAQ Affective Impact subscale was interpreted to mean general group avowal that the content of the video is emotionally compelling.

Research Question #7 asked, “Do women with eating disorders assess the video as being likely to increase clients’ expectations for improvement?” A mean score of “3” or higher on the VAQ Expectancies subscale was interpreted as indicating that the eating disorder group avowed that the video would likely increase clients’ expectations of improvement.

Research Question #8 asked, “Do eating disordered subjects, college women subjects, and professional clinicians who treat eating disorder clients evaluate the pretherapy video as having therapeutic utility in the treatment of eating disorders?”
mean score of "3" or higher on the VAQ Utility subscale was interpreted as indicating that the subjects avowed that the video had overall utility in treating individuals with eating disorders. Effect sizes and t tests were computed.

For the Expert group only, frequency counts and mean (SD) scores were reported for VAQ II items 1, 2, 3, and 4, as well as an average for the sum of items. The average for the sum of items represented a global utility score. A mean score of "2" or higher on these items was interpreted to mean that the Expert group endorses the therapeutic utility of the video.

Research question #9 asked, "Do Experts who treat eating disordered clients believe that the pretherapy video contain most of the critical themes that are pertinent to recovery from anorexia and bulimia nervosa?" This question was addressed by the VAQE Section II item #4, and the VAQE Section III item #1 (designed to elicit qualitative responses).
CHAPTER IV

RESULTS

Demographic Data

One hundred twenty-six subjects participated in the study. The 95 CS subjects and the 21 ED subjects completed demographics questionnaires. The 10 Experts were not asked to fill out the demographic fact sheet. The mean age of the CS and ED subjects was 21.42 years (SD = 3.96). The youngest subject was 15, and the oldest was 45. Of these 116 subjects, 69% were single and 23% were married (see Table 4).

A majority (85%) of the subjects did not have children. One hundred twelve (97%) of the 116 subjects were Caucasian. Thirty-one subjects were freshman, 29 were sophomores, 31 were juniors, and 19 were seniors. Seventy-one subjects lived with a roommate and 24 lived with their spouse. In terms of religious orientation, 96 (83%) of the women were affiliated with The Church of Jesus Christ of Latter-day Saints (LDS).

POMS Data

POMS Pretest

Table 5 presents the POMS pretest mean values, standard deviations, and effect sizes for the ED group and the CS group. ANOVA was used to evaluate whether group means on POMS pretest scores were statistically significantly different for the college group versus the eating disorder group for POMS subscale variables.
Table 4

Demographic Data (n = 116): CS and ED Subjects

<table>
<thead>
<tr>
<th>Demographic variables</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status:</strong></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>69.0</td>
</tr>
<tr>
<td>Married</td>
<td>23.3</td>
</tr>
<tr>
<td>Divorced</td>
<td>1.7</td>
</tr>
<tr>
<td>Separated</td>
<td>.9</td>
</tr>
<tr>
<td>Engaged</td>
<td>4.3</td>
</tr>
<tr>
<td>Homosexual partnership</td>
<td>.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Number of children:</strong></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>85.3</td>
</tr>
<tr>
<td>1-2</td>
<td>8.6</td>
</tr>
<tr>
<td>3-5</td>
<td>4.3</td>
</tr>
<tr>
<td>6-8</td>
<td>.9</td>
</tr>
<tr>
<td>More than 8</td>
<td>.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>96.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>.9</td>
</tr>
<tr>
<td>Asian American</td>
<td>1.7</td>
</tr>
<tr>
<td>International student</td>
<td>.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Student Status:</strong></td>
<td></td>
</tr>
<tr>
<td>Freshman</td>
<td>26.7</td>
</tr>
<tr>
<td>Sophomore</td>
<td>25.0</td>
</tr>
<tr>
<td>Junior</td>
<td>26.7</td>
</tr>
<tr>
<td>Senior</td>
<td>16.4</td>
</tr>
<tr>
<td>Graduate</td>
<td>1.7</td>
</tr>
<tr>
<td>Nonstudent</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Housing:</strong></td>
<td></td>
</tr>
<tr>
<td>Parents or family</td>
<td>12.9</td>
</tr>
<tr>
<td>Alone</td>
<td>.9</td>
</tr>
<tr>
<td>Roommates</td>
<td>61.2</td>
</tr>
<tr>
<td>Spouse</td>
<td>20.7</td>
</tr>
<tr>
<td>Children only</td>
<td>.9</td>
</tr>
<tr>
<td>Other</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 5

POMS Pretest Values for CS and ED Subjects

<table>
<thead>
<tr>
<th>Pre-POMS</th>
<th>CS group</th>
<th></th>
<th>ED group</th>
<th></th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Confused</td>
<td>6.83</td>
<td>3.75</td>
<td>94</td>
<td>10.10</td>
<td>5.64</td>
</tr>
<tr>
<td>Fatigue</td>
<td>8.17</td>
<td>5.94</td>
<td>93</td>
<td>10.00</td>
<td>7.07</td>
</tr>
<tr>
<td>Vigor</td>
<td>14.60</td>
<td>6.61</td>
<td>94</td>
<td>12.05</td>
<td>7.65</td>
</tr>
<tr>
<td>Anger</td>
<td>4.39</td>
<td>5.4</td>
<td>95</td>
<td>9.10</td>
<td>9.29</td>
</tr>
<tr>
<td>Depression</td>
<td>7.36</td>
<td>7.45</td>
<td>94</td>
<td>17.09</td>
<td>15.81</td>
</tr>
<tr>
<td>Anxiety</td>
<td>6.95</td>
<td>4.22</td>
<td>95</td>
<td>11.90</td>
<td>7.58</td>
</tr>
<tr>
<td>Total</td>
<td>19.00</td>
<td>24.72</td>
<td>93</td>
<td>46.14</td>
<td>47.38</td>
</tr>
</tbody>
</table>

Statistically significant differences were found on five out of the seven variables. The ED group evidenced far more initial dysphoria or negative affect than the CS group.

Given the significant pretest group differences on the POMS, ANCOVA was used to evaluate whether group means on POMS posttest scores (pre-to-post) for the college group versus the eating disorder group were significantly different for the seven POMS subscale variables. Nonsignificant statistical differences were found between groups on the following POMS subscales: Total subscale variables, $F(1, 108) = .303$, $p > .10$; Confused subscale variables, $F(1, 108) = .603$, $p > .10$; Fatigue subscale variables, $F(1, 109) = .404$, $p > .10$; Vigor subscale variables, $F(1, 109) = .775$, $p > .10$; Depression subscale variables, $F(1, 109) = .424$, $p > 1.0$; and the Anxiety
subscale variables, $F(1, 110) = 1.703, p > .10$. A slight trend toward statistical difference was found for the Anger subscale variables (increase in anger), $F(1, 110) = 2.97, p < .10$.

**POMS Data Summary**

The ED group entered the video viewing situation with substantially more dysphoria or negative mood than control women. Table 6 shows the POMS posttest mean values, standard deviations, and the pre-post change effect sizes for each group. The effect sizes show that the POMS detected no meaningful mood changes associated with the video.

**VAQ Data**

Table 7 reports the mean values and standard deviation scores for the VAQ subscales. ED and CS subjects' mean scores, standard deviations, and effect sizes were computed for all subscales. Means and standard deviations were not computed for Experts for the Similar and Global Total subscales. Mean scores on these subscales can range from "0" to "4." Mean scores of "3" or higher reflected high quality ratings.

ANOVA tests and effect sizes were used to evaluate whether group means on VAQ individual subscales were significantly different for the college group versus the eating disorder group. Statistically significant differences were found on three of the eight variables. A large, statistically significant difference was found between the two
Table 6

Pre- to Post-POMS Values for CS and ED Subjects

<table>
<thead>
<tr>
<th>POMS subscale</th>
<th>CS group</th>
<th></th>
<th></th>
<th>ED group</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
<td>ES</td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Anxiety</td>
<td>6.49</td>
<td>3.89</td>
<td>93</td>
<td>-.10</td>
<td>10.68</td>
<td>7.59</td>
<td>19</td>
</tr>
<tr>
<td>Depression</td>
<td>7.98</td>
<td>9.41</td>
<td>93</td>
<td>.07</td>
<td>17.26</td>
<td>15.21</td>
<td>19</td>
</tr>
<tr>
<td>Anger</td>
<td>4.25</td>
<td>6.32</td>
<td>93</td>
<td>.01</td>
<td>10.26</td>
<td>11.52</td>
<td>19</td>
</tr>
<tr>
<td>Vigor</td>
<td>11.89</td>
<td>6.88</td>
<td>93</td>
<td>-.35</td>
<td>11.21</td>
<td>8.44</td>
<td>19</td>
</tr>
<tr>
<td>Fatigue</td>
<td>9.11</td>
<td>6.47</td>
<td>93</td>
<td>.14</td>
<td>9.84</td>
<td>7.32</td>
<td>19</td>
</tr>
<tr>
<td>Confused</td>
<td>5.96</td>
<td>3.60</td>
<td>92</td>
<td>.15</td>
<td>9.05</td>
<td>5.45</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>21.99</td>
<td>26.44</td>
<td>92</td>
<td>.12</td>
<td>45.89</td>
<td>47.06</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 7

VAQ Values for CS, ED, and Expert Subjects

<table>
<thead>
<tr>
<th>VAQ variable</th>
<th>CS group</th>
<th></th>
<th></th>
<th>ED group</th>
<th></th>
<th></th>
<th>ED/CS</th>
<th>Expert group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
<td>ES</td>
<td>Mean</td>
</tr>
<tr>
<td>Credibility</td>
<td>3.60</td>
<td>.43</td>
<td>95</td>
<td>3.65</td>
<td>.46</td>
<td>21</td>
<td>0.11</td>
<td>3.67</td>
</tr>
<tr>
<td>Inspirational</td>
<td>2.87</td>
<td>.58</td>
<td>95</td>
<td>2.91</td>
<td>.55</td>
<td>21</td>
<td>0.07</td>
<td>3.03</td>
</tr>
<tr>
<td>Similarity</td>
<td>1.82</td>
<td>.68</td>
<td>94</td>
<td>3.40</td>
<td>.44</td>
<td>21</td>
<td>2.47</td>
<td>NA</td>
</tr>
<tr>
<td>Knowledge gain</td>
<td>3.01</td>
<td>.62</td>
<td>95</td>
<td>3.21</td>
<td>.70</td>
<td>21</td>
<td>0.30</td>
<td>3.20</td>
</tr>
<tr>
<td>Affective impact</td>
<td>2.47</td>
<td>.50</td>
<td>95</td>
<td>2.89</td>
<td>.42</td>
<td>21</td>
<td>.85</td>
<td>2.87</td>
</tr>
<tr>
<td>Expectations</td>
<td>3.03</td>
<td>.68</td>
<td>95</td>
<td>3.22</td>
<td>.75</td>
<td>21</td>
<td>0.28</td>
<td>3.47</td>
</tr>
<tr>
<td>Utility</td>
<td>3.23</td>
<td>.63</td>
<td>95</td>
<td>3.08</td>
<td>.80</td>
<td>21</td>
<td>-0.23</td>
<td>3.20</td>
</tr>
<tr>
<td>Global (Total)</td>
<td>2.71</td>
<td>.40</td>
<td>95</td>
<td>3.23</td>
<td>.38</td>
<td>21</td>
<td>1.30</td>
<td>NA</td>
</tr>
</tbody>
</table>
groups on the Similarity variable, $F (1, 113) = 102.67, p < .0001$. A very large effect size was found, 2.47. The Affect subscale also suggested that, relative to other viewers, ED subjects believed the video would have an especially strong impact on viewers, $F (1, 113) = 12.41, p < .001$; ES = .85. Also, the subscale reflecting global appraisal showed that the eating disorder group evaluated the video much more positively overall than the college women group, $F (1, 114) = 28.29, p < .001$; ES = 1.30.

Nonsignificant differences were found between the two groups on the remaining subscales: Credible subscale, $F (1, 113) = .196, p > .10$ (ES = .11); Inspire subscale, $F (1, 113) = .165, p > .10$ (ES = .07); Knowledge subscale, $F (1, 113) = 1.205, p > .10$ (ES = .30); Expectations subscale, $F (1, 114) = 1.71, p > 1.0$ (ES = .28); and the Utility subscale, $F (1, 114) = .855, p > .10$ (ES = -.23).

**VAQ II Expert Data**

Item subscale data for the four VAQE Section II Professional Clinician questions are summarized in a frequency distribution table (see Table 8). Frequency counts and mean (sd) scores are reported for VAQE items, 1, 2, 3, and 4, as well an average for the sum of items. The average for the sum of items represented a global utility score. Values ranged from “-4” through “4,” with a mean value of “2” or higher indicating the Expert group endorsed the therapeutic utility of the video. The value of “2” was selected arbitrarily by the researcher based on common Likert scales.
Table 8

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std dev</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1: Therapeutic</td>
<td>2.50</td>
<td>.76</td>
</tr>
<tr>
<td>Item 2: Show to client</td>
<td>2.88</td>
<td>.99</td>
</tr>
<tr>
<td>Item 3: Increase verbal expression</td>
<td>2.63</td>
<td>1.06</td>
</tr>
<tr>
<td>Item 4: Contains critical issues</td>
<td>3.00</td>
<td>.76</td>
</tr>
<tr>
<td>Total of Items: Overall Utility</td>
<td>2.75</td>
<td>.61</td>
</tr>
</tbody>
</table>

Eight experts completed the four VAQ (addendum) items. Item #1 asked the experts to rate the therapeutic value of the video. The mean value for Item #1 was 2.5 (SD = .76). Item #2 asked the clinicians to rate the likelihood of showing the video to their clients. The mean value for Item #2 was 2.88 (SD = .99). Item #3 asked them to rate the critical issues associated with recovery in eating disorders. The mean value for Item #4 was 3.0 (SD = .76). Finally, the mean value for the sum of items was 2.75 (SD = .61).

The above results indicate that the experts endorsed the video as adequately covering the critical issues associated with recovery in eating disorders. Experts also avowed that they would likely show the video to their clients. Additionally, they believed the video would be therapeutic, and that its use would aid clients’ ability to express themselves more clearly. The Total mean value (2.75, SD = .76) suggested
VAQE Section III Expert Qualitative Data

Nine expert subjects completed section III of the VAQ (see Appendix V for original clinician comments). Item #1 asked professional clinicians to report any critical themes they believed were absent from the film. There was not any one particular theme identified by a majority of Experts as “missing” from the video. Nonetheless, some of the Experts made individual comments regarding absent themes, which included the following: (a) sexuality, (b) individuation from the family system and other family issues; (c) forgiveness of self, (d) feminist or sociological perspective on societal pressure for women to be thin, (e) sexual abuse, (f) anger management, (g) dealing with shame and embarrassment, (h) length of time to recover, (i) compulsive overeating, (j) overexercise and laxative abuse, and (k) difficulty of recovery.

The Experts also suggested that the video might profitably emphasize and expand on the following themes: (a) spirituality, (b) facing fears and avoidance patterns, (c) resolution of abuse and traumatic events, (d) dealing with body image issues, and (e) nutrition.

Strengths of the Video

The professional clinicians were asked to list the strengths of the video in Item #2. Some of the general comments were as follows: (a) “Excellent video--real stories
give hope to other women”; (b) “Realistic--especially about recovery and relapse”; (c) “Overall good job”; (d) “Nice, simple recovery model and concepts”; (e) “In general: Excellent and useful, thank you”; (f) “The tape was very good at addressing critical issues”; (g) “Great job! Looks like a wonderful and creative dissertation project”; and (h) “I’d like to have a copy of tape when you are done to see how useful this would be for my group.”

More specific comments on the strengths of the video included: (a) “Both presenters had a nice, calm professional demeanor. They appeared to be knowledgeable and caring”; (b) “Video had a nice balance of appearing professionally done, but not so professionally done that it appeared slick. The nice casual approach allowed you to relate to the women as real people”; (c) “Good variety of women shown on film. I think clients can find someone to relate to”; (d) “Qualitative information is so powerful”; (e) “The women came from several different cultural backgrounds”; (f) “Attention was paid to the issue of perfectionism”; and (g) “Large number of clients used, will help increase hope in video viewers.”

Additional specific feedback included such comments as: (a) “I liked the question about ‘why should one recover?’”; (b) “I especially liked the section about the process of recovery--it was the most interesting to me”; (c) “I liked the way you organized the subject matter into the phases of treatment--it was very understandable, and your comments/points were relevant but short enough to remember”; and (d) “I liked the mix of summary points on screen that breaks up the women’s comments into segments.”
Weaknesses of the Video

Additionally, the professional clinicians were requested to identify and list weakness of the video and areas that needed improvement. The experts gave the following suggestions regarding the content of the video: (a) “Example of healthy eating given by one woman (no meat or dairy) may be misinterpreted”; (b) “No conclusion. I felt left hanging at the end”; (c) “Understanding of clients not too deep—no glimpses of their true emotional story, background, and personal eating disorder etiology”; and (d) “How closely is the issue of spirituality tied to cultural issues. Utah has a more religious focus than other areas.”

One expert provided a detailed comment regarding the socialization of women to accept a cultural definition of beauty. She stated,

The women appeared to still be so attached to traditional standards of beauty (i.e., heavily made up; hair made up). They appeared to still buy into the concept that they have to change their body drastically in order to be beautiful or acceptable. I wonder if this would have a negative impact on clients, or if clients further along in their healing would feel that they couldn’t relate. It would have been nice to see some women that were further along in recovery speak directly on the issue of releasing themselves from societies’ nonrealistic and oppressive views of women’s bodies.

The professional clinicians also made suggestions to improve the technical aspects of the video, including: (a) “Emotional Management graphic bullets need grammatical consistency”; (b) “Voices were sometimes hard to hear, especially with the street noise in the interview outside”; (c) "Benita, when you look on screen, look into the camera as if it was the most important person in that audience”; (d) “If you
reshoot, change the camera angle to have more direct eye contact to help engage the viewer more with each participant”; (e) “Maybe show the interviewer from the side or back occasionally, so it is not just an off-screen voice”; (f) “For clinical usage, a length of 8-12 minutes would be more helpful and may hold interest better”; and (g) “The female narrator seemed ill at ease--head was held in awkward position--lack of connection with problem and audience.”

Summary of Results: Answers to Research Questions

This section organizes the results data within the context of the original research questions of this study.

1. Do both women with eating disorders and a reference group of college women evaluate the pretherapy video as credible, realistic, and believable? This question was addressed by examining group differences on the Video Appraisal Credible Subscale designed to measure content and face validity.

Both groups found the women portrayed in the video credible, believable, and persuasive.

2. Does viewing the video correlate with a positive change in mood (pre-to-post) in subjects? This question was addressed by comparing subjects’ mood state before and after viewing the video using the Profile of Mood States (POMS).

The POMS detected no meaningful mood changes associated with viewing the video.

3. After viewing the videotape, do eating disorder subjects produce higher
ratings of inspirational impact than college women? This question was addressed by comparing these two groups on the VAQ Inspirational subscale designed to measure if the video provided subjects with a understandable and hopeful message.

Both groups endorsed the video as having an understandable and hopeful message.

4. After viewing the videotape, do eating disorder subjects report that the video elicited stronger avowals of identification and empathy, than the college women? This question was addressed by the VAQ Similarity subscale designed to measure one's personal similarity, and affective involvement with the recovered women interviewed in the video.

Eating disorder subjects reported much higher ratings of similarity to the video models than the college students reported.

5. Do the eating disorder subjects and college women avow that women can likely learn some keys to recovery, or that recovery knowledge can be gained from watching the video? This question was addressed by the VAQ Knowledge Gain subscale designed to measure content and face validity: specifically, the adequacy of knowledge provided about eating disorder recovery.

Both groups avowed viewing the video would likely increase knowledge of eating disorders and recovery issues.

6. After viewing the videotape, do eating disorder subjects report that the video elicited stronger avowals of affective impact, than the college women? This question was addressed by the VAQ Affective Impact subscale designed to measure the affective
impact of the video content.

The eating disorder subjects reportedly found the video more affectively compelling than did college student subjects.

7. Do women with eating disorders believe that the video would likely increase clients' expectations for improvement? This question was addressed by the VAQ Expectations subscale designed to measure increased expectations, and the awareness that recovery efforts produced.

The eating disordered subjects avowed that the video created expectations for improvement.

8. Do eating disordered subjects, college women subjects, and professional clinicians who treat women with eating disorders evaluate the pretherapy video as having general use or utility? This question was addressed by the VAQ Utility subscale designed to measure the utility of the video. Additionally, this question was addressed through four VAQ questions addressing the practical therapeutic utility of the video (completed by expert clinicians only).

All three groups indicated the video seemed to be of general relevance and utility to women with eating disorders.

9. Do Experts who treat eating disordered clients evaluate the pretherapy video as containing most of the critical themes believed to be pertinent to recovery from anorexia and bulimia nervosa? This question was addressed by the VAQ Section II item #4, and the VAQ III item #1 (designed to elicit qualitative responses).

The Experts affirmed that the video contained most of the critical themes associated with recovery from eating disorders.
CHAPTER V
DISCUSSION

Eating disorder clients, a comparison group of college women, and professional clinicians who are experienced at treating women with eating disorders were asked to view and evaluate a video (developed to orient prospective clients to recovery issues during treatment for eating disorders.) All three groups reportedly found the recovering women portrayed in the video credible, believable, and persuasive. All groups of observers indicated that the video presented an understandable and hopeful message possessing emotional impact, and they avowed that the video created expectations for improvement.

Also, the viewers believed the pretherapy video would likely increase knowledge of eating disorder recovery, and that future eating disorder clients viewing it would likely learn new information that would facilitate their recovery. Additionally, the three groups indicated the video seemed to be of general relevance and utility to women with eating disorders.

Mood Change/Affective Involvement with the Video

Relative to college women controls, the eating disorder subjects showed large, practically meaningful avowals that they felt very similar to the women presented in the video. They also rated the video as having a stronger positive affective impact than controls. Further, they were significantly more likely to affirm the overall value and
quality of the video. These findings suggest that the eating disorder subjects did indeed
evidence a high level of identification, empathy, and affective involvement with the
women (models) shown in the video. Also, the results indicate the eating disorder
subjects attended to the women's stories and found the content of the video meaningful
and highly salient.

On the other hand, the researcher expected to see a change in positive mood
before versus after viewing the video, especially in the eating disorder subjects.
Certainly, the ED group showed dramatically poorer mood (more depression, anger,
anxiety, confusion, and total mood disturbance) than controls prior to viewing the
video, as assessed by the POMS. However, neither group showed a significant shift in
mood after watching the video according to a general mood inventory (POMS), though
they reported (post hoc) on another questionnaire that the video was affectively
compelling.

One reason the pre-post POMS results did not mirror stronger, immediate mood
states of the ED and CS subjects may be that the POMS might require a more dramatic
and distinctive change in mood states (as assessed by classic mood states questions).
On the other hand, the VAQ questions tap both feelings and attitudes, and ask mood-
related questions directly tied to the video. In other words, the VAQ mood items are
situation-specific and solicit subjects' perceptions of how the video impacts one's
feelings and attitudes.

The VAQ was designed to be consistent with Bandura's modeling theory (e.g.,
assess if the video was affectively compelling). Positive avowal of affective impact
may be correlated with the overall liking and approval, and whether the video was emotionally engaging. Emotional involvement with the video (measured by the VAQ) does not necessarily mean that an individual will have a sudden shift in formal mood states (measured by the POMS).

A second point to consider is that the ED subjects' ratings of negative mood were so high on the POMS (pre) that ceiling effects prevented detection of an increase in dysphoria. However, this point does not explain why there were no meaningful differences pre-post on the POMS for the CS subjects.

It is possible that EQ subjects experienced ambivalent feelings while viewing the video (e.g., angry at themselves for still being where they are in the treatment process; hopeful and happy that they, too, can be successful). Ambivalent responses may have led to off-setting scores, resulting in pre-to-post changes. On the other hand, the CS subjects were less emotionally engaged and interested (as evidenced by scores on the VAQ), and it would be unlikely to detect a shift in mood.

**Expert Endorsement of the Video**

The professional clinicians supplied in-depth information regarding the video's utility. These Experts endorsed the video as adequately covering the critical issues associated with recovery in eating disorders, and they believed it was likely to increase clients' ability to verbally discuss recovery issues. Also, the Experts believed that they would likely show the video to their clients. Overall, they perceived the video to be a potentially useful therapeutic aid in the treatment of eating disorders.
Nonetheless, the professional clinician's qualitative comments identified minor weaknesses in the video, and offered suggestions for improvement. The relevance of professionals' comments must be viewed in light of the overall goals associated with developing the video, as well as the needs of the intended audience (new clients or clients early in the recovery process). First, the present author maintains that it was important to develop a video consistent with Bandura's social learning model to help ensure that the video content was theoretically sound. For example, it was a goal of the researchers to keep the modeled behavior easily observable, relatively simple, and somewhat redundant. Therefore, there were realistic limitations placed on the video to assure that these goals were obtained, and that the final product would be theoretically sound. For that reason, discussion of in-depth background and eating disorder etiology information was considered beyond the scope of this project.

Although some of the comments were valid, the researchers felt they were more appropriate for women who were further along in the recovery process. One clinician asserted that societal pressures to be thin could have been more prominently highlighted, and discussed from a feminist or sociological perspective. There was concern that women in the video portrayed an emphasis on physical beauty, and that women further along in recovery might not be able to relate to them. There was also some apprehension that one model's description of purported "healthy eating" (i.e., "no red meat" or "dairy") might not be in women's best health interest.

As mentioned earlier, the video was developed as a potential treatment aid for those early in the treatment process. If the models are too dissimilar to the intended
audience of the video, modeling effects will be less likely to occur. In fact, spontaneous verbal comments from some eating disorder subjects after viewing the video revealed that their strongest identification occurred with one particular anorexic model who was just 3 months into recovery, and still struggling with symptoms.

Presenting a variety of women in different stages of recovery should increase the likelihood that viewers can find someone with whom they could identify. Indeed, the video models were in recovery for varying lengths of time. Some women were dressed in fashionable attire (e.g., hair, clothes, make-up), but others were dressed in casual wear, with their hair hanging in their face. Several of the women were not unusually thin, and they emphasized at length that successful recovery for them included being able to accept the fact that they were a bit overweight.

Other suggestions by Experts appeared to be more pertinent to the purposes of this pretherapy video. First, it was suggested that closing comments by the narrators might be offered to give a sense of cohesion and completion to the various video sections. Improvements in audio recording and mixing techniques (use of more sophisticated equipment) could help prevent and/or reduce sound distortion, especially in the interviews conducted in outdoors scenes. Camera angles should allow the models to make more direct eye contact with the audience, and the narrator could improve her presentation by looking directly into the camera and appearing relaxed and confident.

Overall, the quantitative rating of the Experts suggest that the adequacy of critical issues and themes was evaluated as very positive. Qualitative comments also
indicated that the tape was successful in addressing most critical themes. The clinicians suggested several themes that could be included or expanded to cover the full breadth of eating disorder recovery issues. Most of their ideas were well-founded, and their inclusion in future video vignettes will certainly be considered. However, time restrictions on the length of the video make it unfeasible to cover every theme. To do so would reduce the utility of the video.

Consistency with Bandura’s Social Learning Theory

The overall positive evaluation of the video suggests that the video adhered to the principles of social learning theory. The eating disorder subjects appeared to attend to the models (women in the video), saw themselves as highly similar to the models, and had an affective response toward the models. Viewing the video also seemed to increase their expectations for improvement.

Attention to the women in the video was possibly facilitated by attempts to keep the modeled behavior easily observable, emotionally engaging, relatively simple, and salient to eating disordered individuals. The video included theme reiteration (i.e., more than one model commented on each theme), which should have enhanced vicarious rehearsal for the eating disorder clients. Also, the positive ratings on the VAQ Inspirational subscale (understandable and hopeful message or themes) indicated that the eating disorder subjects understood the meaning of the modeled behavior and had the expectation that the behavior should be imitated. According to social learning theory, imitative behavior is more likely to occur if these conditions are met. Thus,
these factors in the pretherapy video should (theoretically) enhance modeling effects and observational learning among persons with eating disorders.

In general, exposing prospective clients to others' life experiences or therapy behaviors provides a powerful modeling influence. The results of the video evaluation imply that exposing women with eating disorders to models of successful recovery should help them identify some of the steps needed to recover. Also, because of similarities in their eating and emotional experiences, the models in the video appear to have been a source of vicarious reinforcement to eating disorder subjects. It seems feasible that use of this pretherapy treatment video as an adjunct treatment tool with eating disorder clients holds promise for increasing client motivation for treatment.

Limitations and Recommendations for Future Research

One way to address content limitations of the video would be to develop a series of therapy videos. A video series could include a pretherapy video such as the one developed, plus additional videos that expand on eating disorder themes in more depth (e.g., etiology, family issues, relapse prevention), or that are more appropriate for clients in more advanced phases of recovery (e.g., feminist perspectives). However, research efforts are first needed to confirm the clinical effectiveness of the pretherapy video. Once the current video has been revised, future research should be directed toward conducting outcome studies with eating disorder clients. For example, does viewing such a pretherapy video reduce therapy drop-out rates? If outcome studies support the use of a pretherapy video with eating disorder clients, the development of a
comprehensive series of eating disorder treatment videos becomes a meaningful aspiration.

Future research might seek to identify which particular video models and specific points outlined by models accounted for the bulk of subjects' favorable evaluation of the video. The present study was not designed to identify which discussions of recovery themes seemed to be the most compelling or educational to the women. Also, an item analysis of POMS (post) needs to be conducted to assess whether offsetting scores are resulting in flat results for eating disordered subjects.
REFERENCES


APPENDIXES
Appendix A:

Definition of Recovery Criteria for Participation in Anorexia and Bulimia Nervosa Recovery Interviews
Definition of Recovery

Subjects for the study had to demonstrate that they met the following defining conditions for recovery:

1) Previously met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, 1994) diagnostic criteria for anorexia nervosa or bulimia nervosa for at least a three month period.

2) Currently, maintenance of body weight was no less than 10% of optimal weight for longevity based on Metropolitan Life Insurance Tables (1983), for at least three months.

3) Currently, no more than monthly binge eating episodes (consumption of 2000 calories or more with a sense of loss of control, for at least three months).

4) Presently, no more than monthly use of one or more of the following extreme methods for the purpose of losing weight:
   a) self-induced vomiting
   b) use of laxatives or diuretics for purpose of losing weight
   c) loss of 10% body weight coupled with more than 1 hour per day of high aerobic exercise.

All subjects had been recovering for at least three months.
Appendix B:

College Student Recruitment Speech
You are invited to participate in a study. The goal of the present study is to evaluate men’s and women’s reactions to a training video about eating disorders under development at Utah State University. Participation will involve approximately 1 hour. You will receive extra credit according to the policy of your instructor, please check with him/her. You will be asked to watch a 36-minute video, and complete some evaluation materials and questionnaires. Thank you for your participating in this study. I believe you will find the study interesting.
Appendix C:

Eating Disorder Clients’ Recruitment Speech
You are invited to participate in a study. One of the goals of the present study is to evaluate eating disorder clients’ reactions to a training video about eating disorder recovery. The video was developed at Utah State University. Participation will involve 1 hour. You will be asked to watch a 36-minute video, and complete some evaluation materials and questionnaires. If you are interested, please contact Benita Quakenbush at 753-8509 or 797-1012. I will be able to explain the study to interested persons, and answer any questions that they may have. If the person is wanting to volunteer after understanding the purpose and methods of the study, a very brief phone interview will occur. Then an appointment will be set to view the video. Thank you for your participating in this study if you decide to do so. I believe you will find the study interesting.
Appendix D:

Advertisement Requesting Participants for

Eating Disorder Treatment Video
If you are in treatment from anorexia or bulimia nervosa, or recovering without professional help, we invite you to evaluate a eating disorder treatment video that has been developed by a Utah State University research team. Please call (801) 753-8509 or send your name, phone number, and address to:

Benita Quakenbush, M.S. and David M. Stein, Ph.D.
Psychology Department - UMC 2810
Utah State University
Logan, UT 84322-2810
Appendix E:

Anorexia and Bulimia Nervosa Treatment Research
A Utah State University team is conducting a research study to evaluate a recently developed eating disorder treatment video.

You can help others in their struggle to recover from an eating disorder. If you are being treated professionally for an eating disorder or recovering on your own, and would like to participate in this study, please call (801) 753-8509 or send your name, phone number and address to:

Benita Quakenbush, M.S. and David M. Stein, Ph.D.
Psychology Department - UMC 2810
Utah State University
Logan, UT 84322-2810
Appendix F:

Clinician's DSM-IV Interview Rating Form
In rating the severity or frequency of each symptom below, rely on your subjective experience, using as your frame of reference, a typical patient in this treatment program who apparently has the same disorder (e.g., bulimia, or anorexia). The typical or usual patient should be assigned a rating of "3" on a symptom. Leave an item blank if it does not apply to the patient because of age or gender. When a symptom is not present, rate it a "1". The system of rating is as follows:

1 = Severity or frequency of symptom is extremely low; or symptom is not present
2 = Severity or frequency of symptom is below the norm for treatment group
3 = Severity or frequency of symptom is typical of patients with this disorder, in this program
4 = Severity or frequency of symptom is somewhat above the norm for the treatment program
5 = Severity or frequency of symptom is extreme or unusually high for treatment program

Rating

A. Intense fear of gaining weight or becoming fat, even though underweight

B. Disturbance in the way in which one's body weight or shape is experienced
Or denial of seriousness of current low body weight
Or undue influence of body weight or shape on self-esteem

C. Refusal to maintain body weight over a minimal normal weight for age and height

D. Weight loss leading to maintenance of body weight 15% below expected

E. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or sec. amenorrhea). List the number missed in past 6 months. (Rating: 0 missed = 1; 1 missed = 2; 2-3 missed = 3; 4-5 missed = 4; 6 missed = 5)

F. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours). List the average number of binges during the past month. (Rating: 0-2 episodes = 1; 3-5 episodes = 2; 6-8 episodes = 3; 9-12 episodes = 4; > 12 episodes = 5)

G. During the eating binges there is a feeling of lack of control over the eating behavior.

H. In order to counteract the effects of binge eating, the individual regularly engages in;

I. Self-induced vomiting; List the average number in last month (Rating: less than monthly or never = 1; 1-4/month = 2; 5-9/month = 3; 10-15/month = 4; > 15/month = 5)

J. Use of laxatives or diuretics, diet pills, enemas, or other medications. Rate highest frequency in last month of any one item (Rating: less than monthly or never = 1; 1-4/month = 2; 5-9/month = 3; 10-15/month = 4; > 15/month = 5)

K. Rigorous dieting or fasting. Rate frequency of 12 to 24 hour fasts in last month (Rating: less than monthly or never = 1; 1-4/month = 2; 5-9/month = 3; 10-15/month = 4; > 15/month = 5)

L. Rate frequency of vigorous exercise during past month. Rate frequency in last month (Rating: less than monthly or never = 1; 1-4/month = 2; 5-9/month = 3; 10-15/month = 4; > 24/month = 5)

Please fill in patient's current weight ________   Height ________   Body fat composition ________
Appendix G:

Professional Recruitment Letter
Dear:

Thank you for your willingness to view and evaluate my eating disorder video. As a dissertation project, the video was developed as a therapy aid to primarily motivate clients to remain in treatment and persist with their recovery efforts. Also, the video is intended to educate eating disorder clients about the recovery process. The video showcases 15 bulimic and anorexic women telling their recovery experiences. They emphasize critical factors or themes that prompted them to begin recovery, maintain recovery, and cope with the threat of relapse.

Professional clinician opinion and feedback is desired to assist myself and Dr. David Stein with any future edits. Enclosed with the video is a Video Appraisal Questionnaire (VAQ) with an accompanying scantron answer sheet. After viewing the 36-minute video, please respond to the questions on the VAQ (please mark your answers to Section I of the VAQ on the provided scantron sheet). The first and second sections consists of Likert response questions. The third section prompts for open-ended answers.

A self-addressed stamped envelope is enclosed to facilitate returning the materials to me. I am leaving for an internship in New Zealand the first of March, and am trying to collect and analyze the evaluation data before I go. If you could view, evaluate, and return the video to me as soon as conveniently possible, I would appreciate your efforts. I know you are busy, and thank you again for taking the time to help me with this research. I think that you will find the video interesting.

Sincerely,

Benita Quakenbush
Appendix H:

Permission Statement for

Dissertation Research Study
As a participant in the study being conducted by Benita Quakenbush, M.S., and David M. Stein, Ph.D. of Utah State University, I understand that:

The purpose of the study is to help individuals with eating disorders and their therapists better understand how successful recovery may be facilitated. Specifically, the study seeks to develop a pretherapy video to be used in treatment of eating disorders, and evaluate its likely utility.

I understand that participation will take about 1 hour and will include completing a demographic fact sheet, three questionnaires, and viewing a 36 minute videotape.

I understand the results from questionnaires will report only group data and will be used for research purposes only.

I understand that I will not now, nor in the future expect to receive any financial compensation for my participation in the study.

Further, I understand there are no known risks associated with participating in the study, and that my involvement is voluntary. I understand that codes will be used in place of identifying information (e.g., name) to label all forms and questionnaires to protect my confidentiality. Additionally, I understand that all research materials will be kept locked in a safe place to further ensure my confidentiality. Subjects are free to withdraw their consent any time during the study period without consequence.

I understand that subjects are invited to inquire about study procedures at any time, and that results of the study will be available in about 6 months from Dr. Stein, Utah State University.

______________________________
Name

______________________________
Signature

______________________________
Date

Any questions or concerns, please contact
Benita Quakenbush, M.S. at 753-8509 or 797-1012
David M. Stein, Ph.D. at 797-3274
Appendix I

Permission Statement for

Thesis Research Study
As a participant in the study being conducted by Benita Quakenbush and David M. Stein, Ph.D. of Utah State University, I understand that:

The purpose of the study is to help individuals with eating disorders and their therapists better understand how successful recovery may occur. Specifically, the study seeks to identify important recovery themes in the lives of women who have experienced eating disorders.

I understand that participation will take about 1 1/2 hours - 2 1/2 hours and will include completing a demographic fact sheet, a 75-item questionnaire, and a videotaped interview.

I understand the results from questionnaires will report only group data and will be used for research purposes only. Additionally, I understand that with my additional written permission in the future, segments of the videotape interview may be used to develop a pretreatment orientation therapy film. This film is expected to be used in future research at Utah State University (designed to better understand and facilitate client recovery. For example, future research efforts may result in the production of video or audio segments that use part of my interview as a motivational aide to clients. I understand that I would be contacted before the film is developed and give my written permission for any segment of my video to be used in anyway.

I understand that I will not now, nor in the future expect to receive any financial compensation for my participation in the study, or if segments of my videotape are eventually used in the development of a commercial treatment orientation video, or other research training or treatment materials.

Further, I understand there are no known risks associated with participating in the study, and that my involvement is voluntary. In fact, some subjects find that talking about their recovery is a helpful or therapeutic experience. I understand that codes will be used in place of identifying information (e.g., name) to label all forms, questionnaires, and video tapes to protect my confidentiality. Additionally, I understand that all research materials will be kept locked in a safe place to further ensure my confidentiality. Subjects are free to withdraw their consent any time during the study period without consequence.

I understand that subjects are invited to inquire about study procedures at any time, and that results of the study will be available in about 6 months from Dr. Stein, Utah State University.

______________________________
Name

______________________________
Signature

______________________________
Date

Any questions or concerns, please contact
Benita Quakenbush at 752-3398 or 797-1012
David M. Stein, Ph.D. at 797-3274
Appendix J:

Utah State University Psychology Department

Release Form
RELEASE FORM

Project or Program Title: EATING DISORDERS RECOVERY VIDEO

Producers: Benita J. Quakenbush
            David M. Stein, Ph.D.

I hereby assign all rights to the videotape and/or audio tape made of me on this date, ________, by the Psychology Department, Utah State University, Logan, Utah 84322.

I hereby authorize the broadcast, exhibition, copyright, reproduction, distribution, and/or sale of said videotape and/or audio tape without limitation.

NAME: ____________________________  (Please Print)

SIGNATURE: ____________________________

DATE: ____________________________

If performer is under 18 years of age, parent or guardian must sign release.

NAME: ____________________________  (Please Print)

SIGNATURE: ____________________________

DATE: ____________________________
Appendix K:

IRB Human Subjects Research Approval:

Thesis Research Study
October 11, 1995

TO:    David M. Stein - PI
       Benita J. Quakenbush - Student Researcher

FROM:  True Rubal, IRB Secretary

SUBJECT: Proposal Titled, "Anorexia Nervosa and Bulimia Nervosa: The Patients' Perspective"

The above-referenced proposal has been reviewed by this office and is exempt from further review by the Institutional Review Board. The IRB appreciates researchers who recognize the importance of ethical research conduct. While your research project does not require a signed informed consent, you should consider (a) offering a general introduction to your research goals, and (b) informing, in writing or through oral presentation, each participant as to the rights of the subject to confidentiality, privacy or withdrawal at any time from the research activities.

The research activities listed below are exempt from IRB review based on the Department of Health and Human Services (DHHS) regulations for the protection of human research subjects, 45 CFR Part 46, as amended to include provisions of the Federal Policy for the Protection of Human Subjects, June 18, 1991.

1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (a) research on regular and special education instructional strategies, or (b) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (a) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (b) any disclosure of the human subjects' responses outside the research could
reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

3. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (2)(b) of this section, if: (a) the human subjects are elected or appointed public officials or candidates for public office; or (b) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

4. Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

5. Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (a) public benefit or service programs; (b) procedures for obtaining benefits or services under those programs; (c) possible changes in or alternatives to those programs or procedures; or (d) possible changes in methods or levels of payment or benefits or services under those programs.

6. Taste and food quality evaluation and consumer acceptance studies, (a) if wholesome foods without additives are consumed, or (b) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

Your research is exempt from further review based on exemption number 2. Please keep the committee advised of any changes, adverse reactions or termination of the study. A yearly review is required of all proposals submitted to the IRB. We request that you advise us when this project is completed, otherwise we will contact you in October of 1996.
Appendix L:

IRB Human Subjects Research Approval:

Dissertation Research Study
MEMORANDUM

TO: Dave Stein
    Benita Quakenbush

FROM: True Rubal, Secretary to the IRB

SUBJECT: Pretherapy Videotape Presentation for Eating Disorder Clients: Development and Evaluation

The above-referenced proposal has been reviewed by this office and is exempt from further review by the Institutional Review Board. The IRB appreciates researchers who recognize the importance of ethical research conduct. While your research project does not require a signed informed consent, you should consider (a) offering a general introduction to your research goals, and (b) informing, in writing or through oral presentation, each participant as to the rights of the subject to confidentiality, privacy or withdrawal at any time from the research activities.

The research activities listed below are exempt from IRB review based on the Department of Health and Human Services (DHHS) regulations for the protection of human research subjects, 45 CFR Part 46, as amended to include provisions of the Federal Policy for the Protection of Human Subjects, June 18, 1991.

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (a) information obtained is recorded in such a manner that human subjects can be identified, directly or through the identifiers linked to the subjects: and (b) any disclosure of human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your research is exempt from further review based on exemption number 2. Please keep the committee advised of any changes, adverse reactions or termination of the study. A yearly review is required of all proposals submitted to the IRB. We request that you advise us when this project is completed, otherwise we will contact you in one year from the date of this letter.
Appendix M:

Demographic Fact Sheet for College Student Subjects
**DO NOT PUT YOUR NAME ON THIS FORM**  

Student ID# ____

---

**Age:** ____

**Marital Status:**
- [ ] Never Married
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Engaged
- [ ] Homosexual Partnership
- [ ] Widowed

**Housing:**
- I Live with:
  - [ ] parents or family
  - [ ] alone
  - [ ] roommates (#) ____
  - [ ] my spouse
  - [ ] children only
  - [ ] other ____________

**Number of Children:**
- [ ] 0
- [ ] 1-2
- [ ] 3-5
- [ ] 6-8
- [ ] more than 8

**Ethnic Origin:**
- [ ] Caucasian/White
- [ ] African American
- [ ] Native American
- [ ] Hispanic
- [ ] Asian American
- [ ] Internat’l Student

(Country: ____________)

**Student Status**
- [ ] Freshmen
- [ ] Sophomore
- [ ] Junior
- [ ] Senior
- [ ] Graduate
- [ ] Spouse
- [ ] NA

**Religious Affiliation:**
- [ ] N/A
- [ ] LDS
- [ ] Catholic
- [ ] Lutheran
- [ ] Episcopalian
- [ ] Baptist
- [ ] Unitarian
- [ ] Jewish
- [ ] Methodist
- [ ] Presbyterian
- [ ] Seventh Day Evangelist
- [ ] Church of God
- [ ] Buddhist
- [ ] Hindu
- [ ] Muslim
- [ ] Nondenominational
- [ ] Other ______________

**Previous Psychological Counseling** (specify below, check all that apply)
- [ ] Psychologist/Therapist
- [ ] Psychiatrist
- [ ] University Counseling
- [ ] Mental Health Center
- [ ] Other ______________
- [ ] Minister
- [ ] Marriage & Family Therapist
- [ ] Hospital Outpatient
- [ ] Hospital Inpatient
- [ ] None
Please briefly describe any problem(s), if any, you have sought services for (e.g., depression, anxiety, phobia, eating disorder).

________________________________________________________________________

________________________________________________________________________

Do you have higher than average concerns about your eating habits and/or body shape and weight? _____ Yes   _____ No
Appendix N:

Demographic Fact Sheet for Eating Disorder Subjects
**DO NOT PUT YOUR NAME ON THIS FORM**  **Student ID# _____:**

**Age:** ___

**Marital Status:**
- Never Married
- Married
- Divorced
- Separated
- Engaged
- Homosexual Partnership
- Widowed

**Number of Children:**
- 0
- 1-2
- 3-5
- 6-8
- more than 8

**Housing:**
- I Live with:
  - parents or family
  - alone
  - roommates (#) ___
  - my spouse
  - children only
  - other ___________

**Ethnic Origin:**
- Caucasian/White
- African American
- Native American
- Hispanic
- Asian American
- Internat’l Student

(Country: __________)

**Student Status:**
- Freshman
- Sophomore
- Junior
- Senior
- Graduate
- Spouse
- NA

**Religious Affiliation:**
- N/A
- LDS
- Catholic
- Lutheran
- Episcopalian
- Baptist
- Unitarian
- Jewish
- Methodist
- Presbyterian
- Seventh Day Evangelist
- Church of God
- Buddhist
- Hindu
- Muslim
- Nondenominational
- Other _________________________

**Estimate of Age at Onset of Bulimia or Anorexia:** __________

**Have you ever received treatment for Anorexia:**
- Yes ___  No ___

**Bulimia**
- Yes ___  No ___

**Length of Treatment** __________
**Previous Psychological Counseling:** (specify below, check all that apply)

___ Psychologist/Therapist  ___ Minister  
___ Psychiatrist  ___ Marriage & Family Therapist  
___ University Counseling  ___ Hospital Outpatient  
___ Mental Health Center  ___ Hospital Inpatient  
___ Other ________________  ___ None

Please briefly describe any additional problem(s), if any, you have sought services for (e.g., depression, anxiety, phobia)

________________________________________________________________________

________________________________________________________________________
Appendix O:

Video Appraisal Questionnaire (VAQ)
I. Please answer the following questions/statements using the following rating scale:

1 = I never thought, felt, or reacted this way at all.
2 = I rarely thought, felt, or reacted this way.
3 = I sometimes thought, felt, or reacted this way.
4 = I usually thought, felt, or reacted this way.
5 = I most definitely thought, felt, or reacted this way.

*** DO NOT MARK ON THIS FORM. PLEASE MARK ALL ANSWERS ON THE BLUE SCANTRON FORM ONLY. ***

1. I don’t think the women in the video are typical of most women with eating disorders. ___
2. I found the video exciting. ___
3. I believe most of these women were actors. ___
4. The video maintained my attention. ___
5. This video would not help most people understand eating disorders. ___
6. The eating problems described in the video are similar to my own experiences. ___
7. I felt respect for women in the video. ___
8. I had difficulty relating to problems described by the women in the video. ___
9. The video made me feel it is possible to overcome difficult problems. ___
10. The video depressed my mood. ___
11. The issues involved in recovering from an eating disorder are simple and straightforward. ___
12. It is unlikely that the video would increase an eating disorder client’s expectations for improvement. ___
13. I understood how women in the video felt. ___
14. I found the video interesting. ___
15. The stories or descriptions of most women in the video were not believable. ___
16. I could relate to the problems portrayed in the video. ___
17. I think the video will not be useful to women with eating disorders. ___
18. The video was uplifting. ___
19. I could not really understand why these women had such difficulties with eating. ___
20. The women with eating disorders demonstrated that one can get control of their symptoms.

21. The women in the video convinced me their problems and solutions were real.

22. I felt I had things in common with these women.

23. I felt there were many important themes about eating disorder recovery absent from the video.

24. Women with eating disorders who view the video would likely feel hopeful that they can get better.

25. The difficulties women with eating disorders experience are more complex than I realized (before watching the video).

26. I think the video will be useful to women with eating disorders.

27. Most of the women in the video found few advantages in trying to change their behavior.

28. The video was boring.

29. This video could help most people understand eating disorders.

30. The video characterizes many of the critical issues associated with recovering from eating disorders.

31. The video would help women with eating disorders expect improvement during treatment.

32. Some women’s stories were disgusting to me.

33. The video demonstrated that working to change your problems can pay off.

34. I feel more knowledgeable about what helps women recover from eating disorders after watching the video.

35. The women in the video really did not want to change their behavior.

36. If I were a woman with an eating disorder, I would feel that recovery was either difficult or hopeless after watching the video.

37. For most of the women, things got better if they risked trying something new.
II. Professional Clinicians are requested to complete the four items below.

Please circle a response option for each question below:

1. Assume that a client seeking treatment for an eating disorder has been show this video prior to their treatment. Please rate how therapeutic or nontherapeutic the video would be.

<table>
<thead>
<tr>
<th></th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>+4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>extremely nontherapeutic</td>
<td>neutral</td>
<td>extremely therapeutic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. If you had a copy of this video available to you, how likely is it that you would show it to your client?

<table>
<thead>
<tr>
<th></th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>+4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>extremely unlikely</td>
<td>neutral</td>
<td>extremely likely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. If an eating disorder client of yours was shown this video, what would be its likely impact on her/his ability to express verbally?

<table>
<thead>
<tr>
<th></th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>+4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>extremely negative</td>
<td>neutral</td>
<td>extremely positive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. To what extent does the video cover the critical issues associated with recovery in eating disorders.

<table>
<thead>
<tr>
<th></th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>0</th>
<th>+1</th>
<th>+2</th>
<th>+3</th>
<th>+4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>neutral</td>
<td>most if not all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).
Appendix P:

VAQ Subscale Key
The VAQ is associated with the following Research Questions in the proposed study: Research Questions (RQ) Number 1, 3, 4, 5, 6, 7, 8 and 9 regarding the pretherapy video's: RQ 1) credibility; RQ 3) inspirational impact; RQ 4) identification and affective involvement; RQ 5) ability to increase knowledge of eating disorder recovery; RQ 6) relevance; RQ 7) ability to increase expectations for improvement; RQ 8) overall therapeutic utility; and RQ 9) presence of critical themes. This appendix provides a subscale key of how VAQ items are grouped (i.e., which items answer what research questions).

1. Do both women with eating disorders and a reference group of college women evaluate the pretherapy video as credible, realistic, and believable? This question was addressed by examining group differences on Video Appraisal Questions (VAQ) designed to measure content and face validity. VAQ items #1, 3, 7, 15, 21, and 35.

2. Does viewing the video correlate with a positive change in mood (pre-to-post) in subjects? This question was addressed by comparing subjects’ mood state before and after viewing the video using the Profile of Mood States (POMS).

3. After viewing the videotape, do eating disorder subjects produce higher ratings of inspirational impact than college women? This question was addressed by comparing these two groups on VAQ items designed to measure if the video provided subjects with a understandable and hopeful message. VAQ items #4, 5, 9, 12, 14, 17, 18, 20, 24, and 36.

4. After viewing the videotape, do eating disorder subjects report that the video elicited stronger avowals of identification and empathy than the college women? This question was addressed by VAQ items designed to measure one’s personal similarity, and affective involvement with the recovered women interviewed in the video. VAQ items #2, 6, 8, 13, 16, 19, 22, 28, and 38.

5. Do the eating disorder subjects and college women avow that women can likely learn some keys to recovery, or that recovery knowledge can be gained from watching the video? This question was addressed by the VAQ items designed to measure content and face validity: specifically, the adequacy of knowledge provided about eating disorder recovery.
VAQ items # 33, 34, and 37.

6. Do both women with eating disorders and a group of college women report that the video seemed to be of general relevance and applicability to women with eating disorders? This question was addressed by the VAQ items designed to measure the relevance of the video content.

VAQ items # 5, 12, 14, 17, and 28.

7. Do women with eating disorders believe that the video would likely increase clients' expectations for improvement? This question was addressed by the VAQ items designed to measure increased expectations, and the awareness that recovery efforts produced.

VAQ items # 27, 31, and 37.

8. Do eating disordered subjects, college women subjects, and professional clinicians who treat women with eating disorders evaluate the pretherapy video as having general use or utility? This question was addressed by VAQ items designed to measure the utility of the video. Additionally, this question was addressed through four VAQ questions addressing the practical therapeutic utility of the video, (completed by expert clinicians only).

VAQ items # 17, 26, and 36
Experts Only - VAQ II. items # 1, 2, 3, & 4.

9. Do Experts who treat eating disordered clients evaluate the pretherapy video as containing most of the critical themes believed to be pertinent to recovery from anorexia and bulimia nervosa? This question was addressed by the VAQ Section II item #4, and the VAQ III item #1 (designed to elicit qualitative responses).
Appendix Q:

Eating Disorder Recovery Themes
<table>
<thead>
<tr>
<th>Researcher</th>
<th>Recovery Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beresin, Gordon, &amp; Herzog (1989)</td>
<td>Therapeutic relationship; identification and expression of feelings; empathic, understanding; relationships; development of cohesive sense of self; resolvement of family issues</td>
</tr>
<tr>
<td>Hsu, Crisp, &amp; Callender (1990)</td>
<td>Personality strength; self-confidence; “being ready;” being understood</td>
</tr>
<tr>
<td>Kirk (1986)</td>
<td>Therapy: insight, cognitive, and behavioral (food management); spiritual and supportive activities</td>
</tr>
<tr>
<td>Maine (1985)</td>
<td>Empathetic, understanding relationships; self-responsibility and self-motivation</td>
</tr>
<tr>
<td>O’Bryne (1991)</td>
<td>Realizing the behavior and generating action (contemplation stage); taking action and subsiding (action stage); stopping, choosing health, awareness, relapsing, and functioning better (recovered stage); eating, exercising, and monitoring feelings (maintenance stage)</td>
</tr>
<tr>
<td>Peters (1991)</td>
<td>Growing health concerns; “burnout;” influence of prior treatments; “telling the secret;” relationships; interruption of bulimia; individual therapy; antidepressants; support groups; spiritual experience; change in eating habits; development of new coping mechanisms; learning to care for oneself; self-expression; changes in perceptions of the self</td>
</tr>
<tr>
<td>Platt (1992)</td>
<td>Feeling understood and validated; honest self-disclosure; education and strategies for healthy food and eating habits; modeling and encouragement of self-acceptance and integrity; acknowledgment of family of family pain and her place in the system; assumption of personal responsibility</td>
</tr>
<tr>
<td>Rorty, Yager, &amp; Rossotto (1993)</td>
<td>“Hitting rock bottom;” fear of negative medical, social, or professional consequences; increased self-esteem; support</td>
</tr>
</tbody>
</table>

**Figure 2.** Eating disorder recovery themes.
Appendix R:

EDL--Video Outline
<table>
<thead>
<tr>
<th><strong>OPENING</strong></th>
<th>1-T.J. #31 11.25-11.50</th>
<th>2-P.M. #20 28.25-28.57</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEGINNING</strong></td>
<td>1-T.J. #31 17.38-18.18</td>
<td>2-D.D. #28 2.56-3.08</td>
</tr>
<tr>
<td></td>
<td>3-P.M. #20 15.04-15.56</td>
<td>4-T.J. #31 13.59-14.39</td>
</tr>
<tr>
<td></td>
<td>5-J.B. #35 12.28-12.43</td>
<td></td>
</tr>
<tr>
<td><strong>TIRED OF IT</strong></td>
<td>1-L.G. #26 1.55-2.18</td>
<td>2-L.M. #14 25-1.30</td>
</tr>
<tr>
<td><strong>THERAPY</strong></td>
<td>1-T.J. #31 17.17-17.34</td>
<td>2-L.G. #26 10.01-10.16</td>
</tr>
<tr>
<td></td>
<td>3-T.J. #31 29.06-29.36</td>
<td>4-C.H. #29 21.33-22.26</td>
</tr>
<tr>
<td></td>
<td>5-J.B. #35 11.55-12.09</td>
<td>6-T.J. #31 25.04-25.48</td>
</tr>
<tr>
<td><strong>MAINTENANCE</strong></td>
<td>1-P.M. #20 16.00-17.14</td>
<td>2-L.C. #12 28.55-30.06</td>
</tr>
<tr>
<td><strong>SELF-ESTEEM</strong></td>
<td>1-B.H. #32 9.15-10.13</td>
<td>2-T.J. #31 6.07-6.26</td>
</tr>
<tr>
<td></td>
<td>7-B.H. #32 8.22-8.49</td>
<td></td>
</tr>
</tbody>
</table>
HEALTHY EATING HABITS

1-N.H. #21 18.43-20.04
2-L.G. #26 20.05-21.52 \( \checkmark - \gamma \)
3-T.J. #31 5.19-5.44 \( \checkmark - \gamma \)

RELAPSE

1-M.P #25 28.56-29.18
2-N.H. #21 8.41-9.15 \( \checkmark - \gamma \)
3-P.M. #20 18.05-19.08 \( \checkmark - \gamma \)

EMOTIONAL MANAGEMENT

1-T.J. #31 23.10-23.33 \( \checkmark - \gamma \)
2-D.D. #28 9.47-9.56
3-S.M. #19 31.05-31.47
4-J.W. #13 28.36-28.59
5-A.A. #18 20.16-20.40
6-J.W. #13 37.17-37.29 \( \checkmark - \gamma \)

SPIRITUALITY

1-M.P. #25 17.58-18.32 \( \checkmark - \gamma \)
2-N.L. #16 14.38-15.15

SOCIAL SUPPORT

1-C.H. #29 31.57-32.58
2-L.M. #14 10.35-10.52 \( \checkmark - \gamma \)
3-J.B. #35 7.13-7.37
4-N.H. #21 20.51-21.21 \( \checkmark - \gamma \)
5-J.B. #35 7.50-8.05 \( \checkmark - \gamma \)
6-T.J. #31 23.49-24.23 \( \checkmark - \gamma \)

MOTIVATIONAL

1-S.M. #19 30.20-30.46 \( \checkmark - \gamma \)
2-F.L. #34 18.52-19.30
3-T.J. #31 27.29-28.13 \( \checkmark - \gamma \)
4-B.H. #32 26.19-27.59
Appendix S:

EDL Video Components: Visual and Audio
<table>
<thead>
<tr>
<th>Visual</th>
<th>Time Code</th>
<th>Audio</th>
<th>Time Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title Graphic</td>
<td>1:25-11:50</td>
<td>V Full</td>
<td>1:25-11:50</td>
</tr>
<tr>
<td>The Problem</td>
<td>28.25-32.37</td>
<td>V Full</td>
<td>13:59-14:39</td>
</tr>
<tr>
<td>Leve &amp; Benita Intro</td>
<td>1:53-1:54</td>
<td>V Full</td>
<td>1:53-1:54</td>
</tr>
<tr>
<td>Recovery Phases</td>
<td>2:38-2:49</td>
<td>V VO-1 Recovery Phases</td>
<td>14:14-14:14</td>
</tr>
<tr>
<td>Recovery Themes</td>
<td>2:49-2:59</td>
<td>V VO-2 Recovery Themes</td>
<td>14:14-14:14</td>
</tr>
<tr>
<td>Beginning Graphic</td>
<td>2:59-3:03</td>
<td>V VO-3 Beginning</td>
<td>14:28-14:28</td>
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<tr>
<td>TJ #1</td>
<td>16:09-16:12</td>
<td>V Full</td>
<td>16:09-16:12</td>
</tr>
<tr>
<td>DO #28</td>
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<td>V Full</td>
<td>16:12-16:14</td>
</tr>
<tr>
<td>PM #20</td>
<td>16:14-16:16</td>
<td>V Full</td>
<td>16:14-16:16</td>
</tr>
<tr>
<td>TJ #31</td>
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<td>16:16-16:18</td>
</tr>
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<td>16:18-16:20</td>
</tr>
<tr>
<td>LG #26</td>
<td>16:20-16:22</td>
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<td>16:20-16:22</td>
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<tr>
<td>TJ #35</td>
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<td>16:22-16:24</td>
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<tr>
<td>LJ #21</td>
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<td>16:24-16:26</td>
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<td>V VO-4 Maintenance Graphic</td>
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<td>V VO-6 Maintenance Graphic</td>
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<tr>
<td>Therapy Graphic</td>
<td>16:32-16:34</td>
<td>V VO-7 Therapy Graphic</td>
<td>16:32-16:34</td>
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<td>V VO-8 Therapy Graphic</td>
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<tr>
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<td>16:36-16:38</td>
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<td>16:36-16:38</td>
</tr>
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<td>16:38-16:40</td>
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</tr>
<tr>
<td></td>
<td>T I M E  C O D E</td>
<td>A U D I O</td>
<td>T I M E  C O D E</td>
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<td>1</td>
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</tr>
<tr>
<td>2</td>
<td>LM #14</td>
<td>25:26-25:59</td>
<td>U Full</td>
</tr>
<tr>
<td>3</td>
<td>TJ #31</td>
<td>9:40-9:56</td>
<td>U Full</td>
</tr>
<tr>
<td>4</td>
<td>BH #22</td>
<td>8:22-8:49</td>
<td>U Full</td>
</tr>
<tr>
<td>5</td>
<td>Healthy Eating Graphic?</td>
<td>10:44-10:44</td>
<td>U Full</td>
</tr>
<tr>
<td>6</td>
<td>NH #21</td>
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<td>U Full</td>
</tr>
<tr>
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</tr>
<tr>
<td>8</td>
<td>TJ #31</td>
<td>5:19-5:45</td>
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### Tape Log Sheet

#### Multimedia & Distance Learning Services

**EDIT WORKSHEET**

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Project Title: [Title]
Date: [Date]

Show Title: [Title]
W.O. #: [W.O.]
Date Shot: [Date]

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Appendix U:

Instructions for Video Study
1) Pass out packet(s)

1) Have subject(s) read and sign consent form before beginning study.

2) Subject(s) complete demographic fact sheet.

3) Subject(s) complete the mood/feeling questionnaire (pre) on the purple scantron form. Subjects will mark their responses to items 1 - 65 on the front of the purple scantron form. Do not put name on questionnaire or scantron form.

4) Subject(s) view the 36-minute video.

5) Subject(s) respond to the mood/feeling questionnaire (post) on back of the same purple scantron form beginning with item 101 through item 165.

6) Subject(s) respond to the Video Appraisal Questionnaire (VAQ) on the blue scantron form beginning with item 1 through item 37.
   a) Do not put name on questionnaire or scantron form.
   b) Mark sex (M or F) in block at top middle section of scantron form
   c) Mark age under the "YR" block at bottom left corner of scantron form
   d) College students ONLY - mark student ID# under the blocks designated as "A-I" under the section IDENTIFICATION NUMBER at bottom left corner of scantron form. Do not leave any blanks or write in dashers (numbers only).
Appendix V:

VAQ III Clinician Comments
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).
   - Example of "Healthy Eating" of Red meat & little diary may be misinterpreted as "healthy eating means you should eat red meat & milk.
   - List under Emotional Moment are first item if something not to do - 2nd & 3rd example are things needed to do - but it's not listed that way i.e.
   - Should put do not have guilt excessive, etc.
   - No conclusion felt left hanging @ the end

Overall good job!
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.

   \( \checkmark \) Sexuality
   \( \checkmark \) Support from family or other family system

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).

   \( \checkmark \) Showing video—real stories are powerful hope to other women
   \( \checkmark \) Realistic especially about recovery & relapse
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.

- Piece on spirituality could be expanded
- More emphasis on facing fears and "avoidance" patterns may help
- Forgiveness of self and others not addressed
- Resolution of abuse/trauma or other very life events given little focus

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).

- Strengths
  - Many clients involved really helped
  - Increase hope in viewers of video
  - Nice, simple recovery model and concepts

- Weaknesses
  - Understanding of clients not too "deep" - no glimpses of their true emotional story, background
  - True personal Eating Disorder etiology

- In general: Excellent! Useful! Thank you!
II. Professional Clinicians are requested to complete the four items below.

Please circle a response option for each question below:

1. Assume that a client seeking treatment for an eating disorder has been shown this video prior to their treatment. Please rate how therapeutic or nontherapeutic the video would be.

   -4  -3  -2  -1  0  +1 +2 +3 +4
   extremely nontherapeutic neutral extremely therapeutic

2. If you had a copy of this video available to you, how likely is it that you would show it to your client?

   -4  -3  -2  -1  0  +1 +2 +3 +4
   extremely unlikely neutral extremely likely

3. If an eating disorder client of yours was shown this video, what would be its likely impact on her/his ability to express verbally?

   -4  -3  -2  -1  0  +1 +2 +3 +4
   extremely negative neutral extremely positive

4. To what extent does the video cover the critical issues associated with recovery in eating disorders.

   -4  -3  -2  -1  0  +1 +2 +3 +4
   not at all neutral most if not all
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.

   The tape was very good at addressing other critical issues.

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).

   The tape appeared to still be too attached to traditional standards re: beauty. Very heavily made up, hair made up. May appeared to still buy into concept that they have to change their body drastically in order to be beautiful or acceptable.

   We wonder if this would have a negative impact on others or if others further along in their healing would feel that they couldn't relate. It would have
It was nice to see some of the issues that were further along. This issue in that directly spoke to the issue of releasing themselves from societies more realistic/expressive views of bodies.

I am a psychologist in private practice, who has training and experience in the area of eating disorders.

Strengths:
- Both presenters have a nice calm, professional demeanor. Appeared to be knowledgeable and caring.
- Viewer has a nice balance of appearing professionally done but not so prof. due to it being real. Nice, casual approach allows you to relate to the as real people.
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.

   / Family issues
   / Sexual abuse

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).

   / I liked the question about why should one recover; I especially liked the section about the process of recovery - it was the most interesting to me. I liked the way you organized the subject matter into the phases of treatment - it was very understandable, and your comments/points were delivered but short enough to remember.

   / Voices were sometimes hard to hear, especially with the street noise in the interview outside.

I am a head and census, diagnose, and write social history on every women that is admitted to our eating disorder facility. I treat eating disorder patients on an outpatient basis, as well, in my private practice. I am currently treating about 5 eating disorder
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.

- [ ] Anger management
- [ ] Setting and maintaining boundaries
- [ ] Time frame - the window didn't show how long it took - maybe at some point needing to be addressed is how long it took

- [ ] More time frame of window - how long did it take before they started

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).

- [ ] Good model of window shown in this - 20
- [ ] Speech could have been had sooner in the setting

[ ] Needs something about nutrition as part of process.
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.
   1. Are you not including compulsive eating as an eating disorder?
   2. Anything about overexercise or overactive life?

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).

   Strengths:
   1. Qualitative information is so powerful.
   2. The women came from different cultural backgrounds.
   3. Some attention paid to the issue of perfectionism.

   Weakness/Question:
   Spiritual issues? How tied is this issue to cultural issues? (i.e., how does a more religious focus in the population than other areas).

   Capacity: PhD Coun Psychologist - Univ. Coun. Center
   Clients: Currently - 35
   Post - 40-50

OVER
Great job Benita! Looks like a wonderful and creative dissertation project. Let me know when you are done. I'd love to have a copy of the tape when you do. I can see how useful this would be for my group.

Some of the survey questions were unclear as to whether they were directed at a client or therapist. Also, a few were ungrammatical or confusing. Have you seen DeVellis' book on survey/questionnaire construction? It is a great publication and maybe useful for item construction. (There is a section in this book on this.)

Great job. Best wishes on your analyses and internship.
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.

   I liked the content areas you covered in the video.

   I might add something like how to impact one's body image perceptions/distortions.

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).

   - Valuable integration of summary points on screen that break up the woman's comments into segments. Maybe: when you are on screen, look into the camera as if it was the most important person with whom you interact - change camera angle to face
   - Have more direct eye contact to help engage the viewer more with each participant.
   - Maybe show the interviewer from the side ocasionally, as it is not just on screen.
   - For clinical use age, a length of 8-12 min would be more helpful, may hold interest better.
III. Professional Clinicians are requested to complete the two items below.

1. Please list any critical recovery issues or themes that you thought were missing from the video.
   
   Recovery was perhaps shown as too easy.
   Perhaps more accounts of the difficulty and yet final success.

2. Please list strengths and/or weaknesses of the video (except missing critical themes mentioned above).
   
   The female narrator seemed a bit unsure.
   Need held in awkward position - lack of connection with problem and audience.
VITA

Benita J. Quakenbush

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EDUCATION

Ph.D.  Combined Clinical/Counseling/School Psychology
Utah State University, Logan, Utah
Expected 1998
Dissertation:  Therapy Videotape Presentation for Eating Disorder
Clients: Development and Evaluation

M.S.  Counseling Psychology
Utah State University, Logan, Utah
1996
Thesis:  Anorexia Nervosa and Bulimia Nervosa: Patient’s
Perspective

B.S.  Mental Health
Georgia State University, Atlanta, Georgia

PROFESSIONAL EXPERIENCE

1/98-2/98  Psychology Intern: East Sector Base Community Mental Health Center,
Christchurch, New Zealand
  Full-time position.  Responsibilities included assessment and
treatment of adults with a variety of behavioral and emotional
problems.
  Supervisor: Wendy Croft, Senior Clinical Psychologist

9/97-1/98  Psychology Intern: Acute Inpatient Services, Sunnyside Hospital
Christchurch, New Zealand
  Full-time position.  Responsibilities included general assessment,
neuropsychological assessment, and development of behavioral
treatment plans for acutely mentally ill patients.
  Supervisor: Jacqueline Horn, Ph.D., Senior Clinical Psychologist
PROFESSIONAL EXPERIENCE (continued)

3/97-9/97 Psychology Intern: Anxiety Disorder Team, Princess Margaret Hospital Christchurch, New Zealand
Responsibilities included general assessment, psychometric assessment, and individual and group treatment of clients with a wide range of anxiety disorders.
Supervisor: Ronald Chambers, Senior Clinical Psychologist

10/95-2/97 Psychology Intern: Utah State University Counseling Center Logan, Utah
Half-time (20 hr/wk) position. Responsibilities included providing individual, marital, and group therapy for college students presenting with a variety of behavioral and emotional problems. Co-lead group therapy. Completed intake interviews and reports, supervision of peer counselors, and case presentations at weekly staff meetings. Walk-in crisis coverage one-half day a week. Assisted in development and implementation of comprehensive outpatient eating disorder program.
Supervisors: Mary E. Doty, Ph.D., Licensed Psychologist; Gwena C. Couillard, Ph.D., Marriage and Family Therapist; David W. Bush, Ph.D., Licensed Psychologist; Mark Nafziger, Ph.D., Licensed Psychologist.

1994-1995 Inpatient Practicum: Behavioral Health Unit, Logan Regional Hospital Logan, Utah
Co-lead group therapy with adolescents and adults in an inpatient locked facility. Complete psychological assessments and dictate psychological reports. Participate in multidisciplinary team treatment meetings.
Supervisor: Bruce Johns, Ph.D., Licensed Psychologist.

1995-Present Utah Critical Incident Stress Debriefing (CISD) Team-Member.
Facilitate post-critical incident debriefings for emergency service personnel including police, firefighters, emergency medical technicians, and emergency room medical staff.

1994-1995 Counseling Center Practicum: Utah State University Counseling Center Logan, Utah
Responsible for providing therapeutic support for university students presenting with various emotional and behavioral problems. Completed intake interviews and reports. Conduct case presentations.
Supervisor: Mary E. Doty, Ph.D., Licensed Psychologist.
PROFESSIONAL EXPERIENCE (continued)

1994-1995  Psychological Specialist: Clinical Services Program of the Division of Services, Center for Persons with Disabilities
            Logan, Utah
            Part-time (20 hr/wk) position. Responsible for the coordination of multidisciplinary evaluation teams. Complete comprehensive psychological and psychoeducational evaluations including comprehensive intake interviews. Complete client follow-up, including individual and/or family therapy and behavioral management training for children and adolescents experiencing various handicapping conditions and/or emotional disturbances. Complete comprehensive evaluation reports. Participate in inservice training and case presentations. Provided supervision to practicum trainees.
            Supervisor: Phyllis Cole, Ph.D., Licensed Psychologist.

1994-1996  Carolyn Barcus, Ph.D., Licensed Psychologist
            Logan, Utah
            Co-therapist with Dr. Barcus for Sexual Abuse Survivors Group. Responsible for co-leading group process for a group focusing on issues related to the recovery from sexual trauma. Group consists of approximately six female members and meets weekly for two hours.
            Supervisor: Carolyn Barcus, Ph.D.

1993-1994  School Psychology Practicum: Clinical Services Program of the Division of Services, Center for Persons with Disabilities.
            Logan, Utah
            Participated on multidisciplinary team to conduct comprehensive evaluations for children, adolescents, and adults with disabilities. Responsible primarily for conducting intake interview, administering psychological and educational assessments, writing reports and recommendations based on results of the evaluation and case presentations at weekly staff meeting. Completed follow-up therapy with children, adolescents, and family when needed.
            Supervisor: Phyllis Cole, Ph.D., Licensed Psychologist, and John Neece, Ph.D.

1992-1993  Psychology Practicum: Utah State University Psychology Community Clinic, Department of Psychology, Logan, Utah.
            Responsible for individual therapy for adults and children presenting with various emotional and behavioral problems.
PROFESSIONAL EXPERIENCE (continued)

Completed intake interviews and psychodiagnostic assessments. Write comprehensive psychological evaluation reports. Conduct case presentations. Supervisors: Susan L. Crowley, Ph.D., Licensed Psychologist and David M. Stein, Ph.D., Licensed Psychologist.

1992-1994  Research Assistant: Department of Psychology, Utah State University. Logan, Utah
Part-time (20 hr/wk) position. Responsible for coordination of undergraduate assistants involved in several research projects, data entry, literature reviews, and assisted in preparation of professional presentations. Supervisor: David M. Stein, Ph.D., Licensed Psychologist.

TEACHING EXPERIENCE

Summer 1993 Instructor, Psychology 321--Abnormal Psychology, Utah State University Com-Net Program. Logan, Utah.
Responsible for preparing and presenting weekly lectures, designing and grading tests, and assigning final class grades.

CONSULTATION EXPERIENCE

1994-Present  Early Intervention Research Institute, Utah State University. Logan, Utah.
Administer a variety of psycho-educational assessments to children and parents for several research projects including follow-up studies investigating the effects of early intervention and evaluating the progress of children enrolled in Headstart. Supervisor: Mark Innocenti, Ph.D.

Provided educational, psychological, and child sexual abuse assessments.
PROFESSIONAL PRESENTATIONS AT REGIONAL AND NATIONAL CONVENTIONS


Stein, D. M., & Quakenbush, B. J. (1993, April). Bulimia prevalence in domestic and international populations. Presentation at the Western Psychological Association Conference, Phoenix, AZ.

REFERENCES

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