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Reconstructing the World of the Anorectic Outpatient: Procedures for Enhancing Trustworthiness and Credibility

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Conducting in-depth interviews with clinical populations often poses a number of problems for qualitative researchers. Because of the skewed perception of themselves and the world around them, and because of their propensity to distort and deny the pathology of their illness, anorexic women are an example of one such group that can create possible problems for researchers, particularly those concerned with the trustworthiness and credibility of their analysis. How should qualitative researchers approach this population? How can a credible reconstruction of reality be produced? This paper explores and discusses the procedures utilized by the authors during an 18-month project in which semi-structured, ethnographic interviews were conducted with 28 outpatients at an eating disorder treatment facility. This paper describes the methods employed by the authors to enhance the epistemological authority and trustworthiness of the analysis. These included: 1) a multi-disciplinary team approach with researchers and consultants from mass communication, family science, and clinical psychology, 2) weekly researcher team debriefing sessions to analyze and interpret recently completed interviews, 3) the exchange of thoughts and ideas from researcher diaries, journals, and coding memos, 4) the use of recovered anorexic patients as research assistants to help in the interpretation of interviews and to perform "member checks," and 5) periodic debriefing sessions with therapists at the center where the project's informants were being treated.

Keywords

qualitative research

Reconstructing the World of the Anorectic Outpatient: Procedures for Enhancing Trustworthiness and Credibility

by

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Abstract

Conducting in-depth interviews with clinical populations often poses a number of problems for qualitative researchers. Because of the skewed perception of themselves and the world around them, and because of their propensity to distort and deny the pathology of their illness, anorexic women are an example of one such group that can create possible problems for researchers, particularly those concerned with the trustworthiness and credibility of their analysis. How should qualitative researchers approach this population? How can a credible reconstruction of reality be produced? This paper explores and discusses the procedures utilized by the authors during an 18-month project in which semi-structured, ethnographic interviews were conducted with 28 outpatients at an eating disorder treatment facility. This paper describes the methods employed by the authors to enhance the epistemological authority and trustworthiness of the analysis. These included: 1) a multi-disciplinary team approach with researchers and consultants from mass communication, family science, and clinical psychology, 2) weekly researcher team debriefing sessions to analyze and interpret recently completed interviews, 3) the exchange of thoughts and ideas from researcher diaries, journals, and coding memos, 4) the use of recovered anorexic patients as research assistants to help in the interpretation of interviews and to perform "member checks," and 5) periodic debriefing sessions with therapists at the center where the project's informants were being treated.

Introduction

Conducting in-depth interviews with clinical populations often poses a number of problems for qualitative researchers concerned with issues of trustworthiness and credibility (Lincoln & Guba, 1985; Vitousek, Daly, & Heiser, 1991). Because of skewed perceptions of themselves and much of the world around them, and because of an intense desire to present a particular public persona that often entangles them in a web of distortions, anorexic outpatients are an example of one such group that can create a number of potential problems for researchers.

How should qualitative researchers interested in studying eating disorders approach this group? How can a credible reconstruction of reality based on self-reports be produced? This paper explores and discusses the procedures utilized by the authors during an 18-month project in which semi-structured, ethnographic interviews were conducted with 28 outpatients at an eating disorder treatment clinic in the western United States. The goal of the project was to understand the impact of the mass media in the patients' lives and the ways in which these women have used the media to shape their identities and to reinforce their eating-disordered cognitions and

behaviors. This paper describes the methods employed by the authors to enhance the epistemological authority and trustworthiness of their analysis.

The Research Challenge

Vitousek et al. (1991) have argued that because of the extent to which anorexics deny the very existence of their disorder, and the pathological behaviors that accompany it, researchers should proceed cautiously, and even skeptically, when utilizing any method that relies on self-reporting by anorexic women. They explain:

The challenge of getting eating disorder clients to tell us what they think and feel-and the difficulty of trusting them when they do-have long figured prominently among the concerns of clinicians and researchers who work with this population. Anorexics in particular are notoriously protective of their private experience. They often refuse to concede that they suffer from a psychiatric disorder, deflect inquiries into the nature and extent of their symptomatology, and decline attempts to assist them in recovering from it. (pp. 647-648)

Such is the degree of this denial that Crisp (1980, in Vitousek et al., 1991) concludes:

. . .In no other morbid condition is the outsider more effectively and so frequently denied access to an appreciation of the relationship between behavior and manner on the one hand and inner experience on the other. (p. 648)

Vitousek et al. (1991) explain that this denial motivates and leads these women to omit, conceal, distort, or misrepresent facts related to their behaviors and internal experiences. These conscious, willful misrepresentations make it difficult to link symptoms with causal factors. Anorexics, they continue, become masters at concealing their feelings and at avoiding any circumstances where such revelations may occur. Most anorexics are aware to a certain degree of the strangeness of their behavior and, therefore, are cautious not "to give their inquisitors enough information to indict them" (p. 650) or force them to come to grips with the reality of their experiences.

A second threat to trustworthiness suggested by Vitousek et al. may come as a result of the effects of starvation. A number of researchers have suggested that starvation limits thought content and reduces an individual's capacity for abstraction (See, for example, Polivy, 1996). This, in turn, may limit the subject's ability to provide an accurate account of their experiences. In other words, they may misrepresent experience because they are not "fully cognizant of the forces governing their behavior" (Vitousek et al., 1991, p. 650).

A third threat to trustworthiness discussed by Vitousek et al. (1991) may occur as a result of the temperament and personality factors commonly found among anorexic women. Research suggests anorexic women, because of their concern with how they are viewed by others, are often overly eager to please and be compliant (See, for example, Connors, 1996). This desire to "please" may lead them to be overly prone to report what they believe the researcher would like to hear rather than what might be their actual experience or feelings.

Despite these potential impediments, Vitousek et al. (1991) suggest that researchers may actually have an "enormous tactical advantage" because they are, in reality, "outsiders" in the treatment and recovery process. Researchers who are viewed as "non-combatants" in the patients' ongoing struggle with family, friends, and therapists are often perceived as non-threatening. As a result, anorexic women may be willing to let down their guard and open up to an individual who appears to pose little or no real threat.

Some may even welcome such interactions as an opportunity to talk more about their experiences without incurring the risk that their admissions will be used in evidence against a defended position. (pp. 655-656)

The Research Project

As previously indicated, the goal of this research project was to accurately describe and reconstruct the experiences our group of anorexic outpatients had had with the mass media, specifically women's beauty and fashion magazines and television programs that promote a "thin ideal." A growing body of research has discussed the role of magazines and televisions in the etiology of eating disorders, but few of these projects have actually studied anorexic populations (See for example, Anderson & DiDomenico, 1992; Harrison & Cantor, 1997; Myers & Biocca, 1992; Silverstein, Perdue, Peterson, & Kelly, 1986). Our primary interest was in exploring and understanding how these outpatients had "used" the media and how that use had influenced the initiation and perpetuation of their eating disorders-from the patients' perspectives. Our methodological approach was to rely on semi-structured, in-depth interviews conducted over an 18-month period. These interviews included taking a brief clinical history and discussing other issues related to family life, peers interaction, and self-identity. Our ultimate goal was to develop a grounded theory we hoped might better explain the impact of the mass media in anorexia.

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Trustworthiness and Rigor

"The basic issue in relation to trustworthiness is simple," write Lincoln and Guba (1985). "How can an inquirer persuade his or her audience (including self) that the findings of an inquiry are worth paying attention to, worth taking account of (p. 290)?" Concerned about the challenges

posed by working with anorexic women, we turned to the "Model of Trustworthiness of Qualitative Research" proposed by Guba (1981) and Lincoln and Guba (1985) and further discussed by Krefting (1991) and Belk, Sherry, and Wallendorf (1988).

According to Lincoln and Guba and Krefting, this model identifies four primary components of trustworthiness that are relevant to qualitative research: 1) truth value, 2) applicability, 3) consistency, and 4) neutrality.

"Truth value," Krefting (1991) explains, is based on the degree to which the researcher is confident that he or she has accurately reconstructed and represented the multiple realities revealed by the study's informants. Lincoln and Guba (1985) point out that those reconstructions must also be credible to the constructors themselves. "Truth value," then, must be subject-oriented. In qualitative research, we refer to this as "credibility."

. . .A qualitative study is credible when it presents such accurate descriptions or interpretations of human experience that people who also share that experience would immediately recognize the descriptions. Truth value is perhaps the most important criterion for the assessment of qualitative research. (Krefting, a href="thomsen.html#krefting">1991, p. 216)

Quantitative researchers often talk about external validity, or one's ability to generalize findings to larger or parent populations. Because qualitative research most typically relies on non-probability sampling, we often speak not of generalizability but rather of "applicability," which tests whether our findings can be applied to other contexts or settings (Krefting, a href="thomsen.html#krefting">1991). Lincoln and Guba refer to this as "transferability" and place a responsibility on the researcher/writer to provide thick description, an adequate "data base," and an explication of context to enable the "transfer" of findings from one context to the next.

"Consistency" is most often associated with reliability or replicability. This, too, exposes some of the primary paradigm issues related to the quantitative-qualitative research debate. Quantitative researchers often attempt to control variation in an attempt to explore a single, knowable reality. Qualitative researchers, however, are interested in the complete range and variety of human experiences. Rather than controlling for variability, qualitative researchers seek insight by exploring as much variation in experience as possible. We refer to this as "dependability."

In quantitative research, "neutrality" reflects the degree to which the researcher can remain free from bias and detached from the research subjects. In qualitative research, however, the goal is to reduce the distance between researcher and subject, usually through prolonged contact and lengthy observation. Rather than the neutrality of the investigator, the concern focuses on the neutrality of the data (Lincoln & Guba, 1985; Krefting, 1991). Lincoln and Guba refer to this as "confirmability."

Lincoln and Guba (1985) and Krefting (1991) identify a number of strategies that can be used by qualitative researchers to enhance credibility, transferability, dependability, and confirmability. Among others, these include prolonged and varied field experiences, the use of field journals,

triangulation, member checks, peer examination, reflexivity, and referential adequacy. The application of these strategies to our study will be discussed in the following section.

Strategies for Trustworthiness and Rigor

The Research Team. "Triangulation" is most often associated with the combined use of multiple methodologies within a single research project. However, both Lincoln and Guba (1981) Belk et al. (1988) suggest that triangulation also can include the composition of the research team and the disciplines and expertise represented by each member. In their study of buyer and seller behavior at Southwestern U.S. swap meets, Belk et al. assembled a research team that represented a variety of backgrounds that included psychology, sociology, and anthropology. The research team for our study represented the fields of mass communication, clinical psychology, and family science. In addition to the three primary researchers, the team included a number of undergraduate and post-graduate research assistants. Several of the research assistants were selected, in part, because of their own past histories with eating disorders. This "team" approach provided several checks and balances and advantages in the data collection and analysis processes of this study. In the construction of the interview schedule, for example, each question and its potential contributions were analyzed from the perspectives of each of the disciplines. In many ways, the multi-disciplinary nature or the team may have been the project's strongest asset.

The naturalist sees it as perfectly possible to use multiple investigators on part of a team, with provisions being made for sufficient intrateam communication to keep all members moving together. The fact that any one team member is kept more or less "honest" buy other team members adds to the probability that findings will be found to be credible. (Lincoln & Guba, 1985, p. 307)

Selection of Informants. Knowing the challenge of finding anorexic women who would be willing to be open and frank about their experiences with their eating disorders, we approached the directors and therapists of a large eating disorder treatment facility near our campus. After consulting with the staff there, we decided it would be best to interview women who had demonstrated some progress in their treatment and whom the counselors felt might be more accurate and lucid in their discussions. Each of the 28 women interviewed in the study had all been seen, or were being seen, on an outpatient basis at this center. Each was recruited by the therapists at the center. The therapists explained the voluntary nature of the study and the procedures that had been established for confidentiality and anonymity to each perspective informant. Those who expressed an interest and desire to participate were then referred to the research team. Each informant was given the opportunity to choose the location of her interview. We felt that most would select a non-threatening, comfortable environment where they would be more likely to open up and where "trust" (Lincoln & Guba, 1985) between researchers and informants could easily be developed. Interestingly, most chose to have the interviews in a department conference room on campus (nearly all our patients were college students). Other interviews were held in the informants' homes or at the eating disorder treatment facility.

In addition to being briefed by representatives from the center, one of the research team members posted a message to an Internet newsgroup for individuals who treat eating disorder patients. The

message explained the nature of the research project and requested suggestions, from those experienced at interviewing anorexic women, on how to overcome barriers to accuracy and trustworthiness. While the responses were initially discouraging, much of the information was used to help construct the interview schedule and its accompanying probes.

Reflexivity. Belk et al. (1988) define reflexivity as the "assessment of the investigator's own background, perceptions, and interests on the qualitative research process" (p. 218). Because research situations are dynamic and because the researcher functions as participant and not just an observer, he or she "must analyze himself or herself in the context of the research" (p. 218). For this study, this was done via the use of research journals (See Appendix A), coding memos (See Appendix B), and weekly team meetings.

During the 18 months of the research process, team members met weekly to discuss the progress of the interviews, share experiences, review the coding process, and to consider emerging findings and theory development. Interviews with each informant were tape-recorded and immediately transcribed. Transcripts (See Appendix C) were distributed to each team member. These were to be coded and then discussed at the next team meeting.

The accuracy of the self-reports by the informants was a frequent topic of discussion by team members during these weekly sessions. Team members were instructed to record their feelings and observations immediately after the interviews and share them with the other researchers and the next meeting. In a journal entry, dated January 16, 1998, one of the research team members wrote the following observations and feelings after completing an interview with Patient #12 (the complete entry is in Appendix A):

The interview went pretty well, lots of interesting information. Very angry with parents because of verbal and sexual abuse, and a generally dysfunctional home environment. Sexual abuse came from both mother and father and continued throughout her child and adolescence. I was not sure how much detail about this I should pursue; she seemed fairly open about it but vague. She said that as long as she does things that make her feel like she is bad (not regarding drugs or sex or such) it was easier to face how she was treated growing up. . .

At this point in the research process, the team had spent a great deal of time discussing the issues of informant denial and possibility that some information presented to us may be skewed or distorted. We also had become acutely aware of the informants ability to shade or withhold information that they felt might be overly revealing about the nature of their disorders and their media use. At the suggestion of one of our research assistants, who a number of years earlier had been treated for both anorexia and bulimia, we purchased a number of popular women's beauty and fashion magazines. This research assistant marked the pages she thought might have a particular impact on our informants. We then used these magazines during the interviews, showing them to the informants and then asking them to talk about the images and their feelings. This modified form of "autodriving" (See Belk et al., 1988) allowed the informants to reflect more accurately on past and present experiences with the media.

Another advantage to this form of "autodriving" was its ability to allow us to make observations about statements made by our informants, particularly when we had concerns about the accuracy

of what we were being told. This was particularly true of Patient #12, whose behavior and comments, once given a copy of *'Teen* magazine, contradicted earlier statements. In the January 16 journal entry, the researcher who conducted the interview with Patient #12, noted the contradictions and made the following observations:

During the interview she indicated she could not afford magazines, but generally looked at magazines about movies and movie stars, particularly focusing on the pictures of male actors only. During the interview she talked about movies and the importance to her of inspirational movies like "Rudy." She said that she didn't look at magazines much other than movie magazines, however, after the interview was over, she was flipping through the *'Teen* magazine I had brought in and indicated that she was looking for the Teen Model contest (she had won the contest earlier), I asked her if she ever looked at the magazines and she said that she did look at them in the stores. I asked if she liked looking at the models, she said that in some ways she wanted to look like them, but not if it drew attention toward her.

In the early weeks and months of the project, a great deal of effort was made to refine the "coding scheme," which allowed us to identity major themes and concepts. As the coding scheme became more refined, the decision was made to have each researcher focus on his or her field of expertise. Each, then, would code or "map" one specific aspect-issues related to the media, history of family interaction styles, or the emergence of affective problems, for example. The results were "coding memos" (See Appendix B) that included researcher thoughts, feelings and potential theoretical observations. The following is an example taken from one of the researcher's coding memos written about Patient #7:

Like many of the patients, it appears that the divorce changed how she perceived her role in the home. Note: this role change is consistent with our ideas on the shift from being protected to being the protector. Listen to her comments: "I think my whole entire life I've felt like I was inferior and it was my job to make everybody feel better and it was always my job, you know, I was always like the care-giver kind of person because I thought if I, at least if I can make other people feel good because that made me feel good to make other people feel good. So I was always trying to make other people feel like they were something special because that's what I wanted, I guess."

She says she felt it was her job to make her mother happy because she couldn't, she felt her life was out of control. I think the divorce may have had a strong impact because she does mention her fear that people would leave her.

Another example comes from what one researcher team member wrote regarding Patient #10, an 18-year-old college student who had been treated on both an inpatient and outpatient basis:

Patient #10 struck me as someone with a low tolerance of hypocrisy-she seemed to see it all around her and that made her angry. As I recall, this was one of the informants who began to make me wonder if a common element of anorexia was that these young women are really disappointed with the world-that might fuel a desire to be protected from that disappointment or at least to try to control as much of it as they can, even if it just means their bodies.

It was during the weekly sessions that each team member would discuss the coding process and results from the perspective of his or her own discipline. Often this would involve explaining to colleagues the implications of theories and observations that might take a perspective unique to a particular field. This actually turned out to be an outstanding mental exercise in which no assumptions, regardless of how intuitive they might be to researcher from a specific discipline, were taken for granted. For example, in one session, the research team member from family science challenged many of the a priori assumptions made by another investigator who was "coding" from the perspective of the uses and gratifications tradition of media effects research. As a result, this caused the entire team to spend more time considering the implications of this particular school of thought.

Peer Evaluations. In all, research team members conducted 28 interviews during a period that extended from August 1997 to December 1998. As we neared the final interviews, the focus of our weekly meetings shifted to the issue of "redundancy" (Lincoln & Guba, 1985). As a team, and from our varied perspectives, we were reaching consensus that it would be possible to terminate the sampling and interview processes. As Lincoln and Guba explain:

In purposeful sampling the size of the sample is determined by informational considerations. If the purpose is to maximize information, then sampling is terminated when no new information is forthcoming from newly sample units; thus redundancy is the primary criterion. (p. 202)

By the time we had completed about 25 interviews we had sketched out the details of what appeared to be our emerging grounded theory. As we wrote more detailed coding memos, these were eventually compiled into a narrative description explicating our theoretical explanation of media use and its implications. At this point, we contacted the treatment facility that had provided us access to its outpatients and submitted a copy of our preliminary findings to one of the center's directors and chief therapists. This particular therapist had worked directly with a number of the women we had interviewed and was familiar with the cases of nearly all the others. In a meeting with one of the research team members, the director/therapist reviewed the preliminary findings, suggesting minor revisions and enthusiastically confirming the written observations. Additional contacts were made with the center to discuss and review findings.

Member checks. Perhaps one of the most important tactics for establishing trustworthiness and credibility involved what Lincoln and Guba (1985) have described as "member checks."

The member check, whereby data, analytic categories, interpretations, and conclusions are tested with members of those stake-holding groups from whom the data were originally collected, is the most crucial technique for establishing credibility. If the investigator is to be able to purport that his or her reconstructions are recognizable to audience members as adequate representations of their own (and multiple) realities, it is essential that they be given the opportunity to react to them. (p. 314)

Throughout the analysis and writing process we used the weekly team meetings, as well as other opportunities, to bounce ideas, observations, and tentative conclusions off the former anorexic patients who served as our research assistants. As we neared completion of the initial manuscript produced to summarize the results we sought out the assistance of some of the informants, one of

whom had joined the research team mid-way through the project. In a private setting, the manuscript, with its observations and findings, was read to this informant (formerly Patient #5) to confirm that the results did, in fact, make sense to her and to those who were studied. Feedback from this "member"/former patient was used to make refinements to the final manuscript.

Conclusions

On balance, we feel that our tactical strategies-use of a multi-discipline research team, weekly team meetings, research journals, coding memos, peer evaluations, and member checks-contributed to our confidence in the trustworthiness, truth value and credibility of our analysis. We believe that we were able to accurately capture a range of experiences that anorexic women have with the media and to correctly reconstruct those experiences in such a way as to enhance our understanding of the mass media's influence and role in the etiology of their eating disorders (Thomsen, McCoy, Williams, & Gustafson, 1999). In retrospect, however, we acknowledge that some important issues remain unresolved and warrant additional discussion.

Lincoln and Guba (1985) and Krefting (1991) both address the tactic of "prolonged engagement" as essential to the enhancement of trustworthiness and credibility. A potential weakness of our study may be the limited time we had to spend with each outpatient. Each interview lasted between two and three hours. While many of the patients were comfortable talking about their disorders, others were not. Many agreed to only a single session with researchers, limiting the time needed to prolong the engagement. In addition, most chose to have the interviews conducted on campus, which also limited the time available. Ideally, we might have been better served to have had several shorter sessions in environments that were more "natural" to the informants. This, however, would have necessitated greater intrusion into the lives of women who are, by the nature of their disorder, guarded and even secretive about their personal lives. Future research with this population must address this dilemma.

Another issue centers on the degree to which we developed a "trusting" relationship with our informants. It was clear to us that many of the women were far more open and comfortable during the interviews than others. When researchers are limited in their contact time with these patients, it may reduce the level of trust between interviewer and informant. However, because we worked through the directors and therapists at the treatment center, we felt we had overcome this problem to some degree. Most of our patients had been involved at the center (both as inpatients and outpatients) for several months to several years. They were approached by the staff at the center, not our research team, about the project. We hoped, then, that the trusting relationship between staff, therapists and the patients would extend to our research setting. Prior to conducting the interviews, each researcher spent 5 to 10 minutes explaining how the confidentiality of each patient would be guarded and how the data would be used. These seemed to put these women at ease in most cases.

A third issue returns us to a primary concern expressed by Vitousek et al. (1991) regarding the ability of anorexic patients to make accurate and credible self-reports. Even if we had been able to spend enough time with our informants to develop a trusting relationship, what they told us may still have represented nothing more than a skewed or distorted perception of events in their

lives. Interviewing, it has often been argued, is about the "world" of the interviewee and, as such, presents serious limitations to researchers seeking to reconstruct trustworthy representations of reality. In retrospect, our analysis would have been aided by a triangulation of multiple data sources or methods. For example, by also interviewing intimates, family members, and friends of our anorexic outpatients, we would have been able to corroborate and contextualize facts and details surrounding key events in the lives of these women. Participation in large group counseling sessions with patients and family members, or field observations at the eating disorder treatment facility where the patients spent a great deal of time, also may have provided important insights that would have guided and informed our analysis of the interviews. While we did not employ any of these during our study, we did discuss them several times during our debriefing sessions. Frequently, for example, we agreed that it would have been advantageous to be privy to a parent's explanation and interpretation of many of the events connected to the family life of a patient.

One final issue, which is also related to those discussed above, focused on our concern over how experiences with therapy may have shaped the responses of our informants. On numerous occasions throughout the interviews and weekly meetings we addressed this potential problem. As previously mentioned, many of our patients had spent several years in outpatient counseling. Several of these women had accompanied the center's staff members to speaking assignments at on-campus eating disorder awareness programs and with other groups. Because some of these women had "shared" their stories in the past, we worried that some answers to our questions may have been somewhat rehearsed or constructed to reflect what they had learned in therapy. Future research must address this problem. We realize that because of the nature of this disease it would have been difficult to find a large enough population of potential informants had we not gone to the center. Future research might explore how new versus long-term patients respond in qualitative research settings.

Despite these challenges, we feel that clinical populations do warrant study by qualitative researchers (See also Chenail, 1992; Hepworth, 1994). Because of the broad range of realities experienced by our patients, and because eating disorders appear to be as much a social construction as a bio-physical illness, qualitative explorations may have been the most efficient and productive means of understanding this perplexing disorder. As Hepworth argues, "the main strength of this approach (qualitative) is in its ability to theorize relations between social processes and individual subjectivity" (p. 180). In pursuing clinical and challenging populations, then, qualitative researchers should continue to seek strategies and tactics to enhance the rigor, trustworthiness and credibility of their research and results.

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Appendix A

An example of a researcher journal/diary entry.
Anorexia Nervosa Group
Post Interview Diary
January 16, 1998

Patient #12

The interview went pretty well, lots of interesting information. Very angry with parents because of verbal and sexual abuse, and a generally dysfunctional home environment. Sexual abuse came from both mother and father and continued throughout her childhood and adolescence. I was not sure how much detail about this I should pursue; she seemed fairly open about it but vague. She said that as long as she does things that make her feel like she is bad (not regarding drugs or sex or such) it was easier to face how she was treated growing up, somehow she could then feel like she deserved what she got. Bad included being dirty, messy and ugly, as well as performing poorly. If she felt good about herself then she had a difficulty dealing with her past.

During the interview she indicated that she could not afford magazines, but generally looked at magazines about movies and movie stars, particularly focusing on the pictures of male actors only. During the interview she talked about movies and the importance to her of inspirational movies like "Rudy." She said that she didn't look at magazines much other than movie magazines; however, *after the interview was over*, she was flipping through the *'Teen* magazine I had brought in and indicated that she was looking for the Teen model contest (she had won the contest earlier), I asked her if she ever looked at the magazines and she said that she did look at them in the stores. I asked if she liked looking at the models. She said that in some ways she wanted to look like them, but not if it drew attention toward her. She hated attention of any kind, such as being told she was looking skinny, but she also hated being told that her figure looked good. So she was always struggling to stay in a state where she was not considered attractive, but also not considered weird and under nourished. This is a good metaphor for her; she was full of contradictions. She had wanted to be an actress from the time she was 8, but also hated drawing attention to herself (she said that when she was acting she wasn't drawing attention to herself because she was being somebody else). She wins a teen modeling contest, but never considered herself to be pretty, only ugly. She purposely attempts to look ugly by not wearing makeup, not washing her hair and by always dressing down. She has a real issue with her mother and has trouble attending relief society (the women's group at her church) because there are too many women in one room. This is particularly a problem if there are women in the fortyish range. She also says that she feels more comfortable with men, but has a strong belief that men will take advantage if you ever let your guard down. She feels very confident in many areas, but refuses to try very had because she believes that people will hate her when she does something better than they do.

Appendix B

Coding Memo for Patient #7.

Patient #7

Patient #7 is a 31-year-old woman who is married (11 years) with three children (all boys-10, 7, 3). She says she has suffered from anorexia since she was 13-18 years. Was also bulimic, particularly while in college and about the time she got married. Parents divorced when she was 11-12 years old. Lived with her mom. Step-father complicated things because of the baggage he brought along from his previous marriage. After the divorce, she may have been shunned by people in her ward. She would disavow her siblings and tell people she was an only child. May have been molested by a babysitter who was a friend of her brother. Brother is an alcoholic. Said she was the caregiver. She graduated from college and currently is a elementary school teacher. She says she went back to school to get a master's in counseling to help her deal with her problem. Was admitted to hospital (by husband) at 28 because of the problem. Was an overachiever in an attempt to compensate for feelings of inadequacy. Said she liked to lead boys on is a sexual sort of way-without actually making it to the "deed"-in high school. Says she has a hard time being intimate with her husband; breastfeeding makes her feel "dirty." Her guilt made her feel as if she did not deserve any kind of pleasure (food, etc.). Has attempted suicide more than once. Patient may have ADD. Husband has had some involvement with pornography and

Internet pornography. Early in her marriage she physically beat her husband. Her husband has left her, but I'm not sure if he's currently back. LDS.

Like many of the patients, it appears that the divorce changed how she perceived her role in the home. Note: this role change is consistent with our ideas on the shift from being protected to being the protector. Listen to her comments: "I think my whole entire life I've felt like I was inferior and it was my job to make everybody feel better and it was always my job, you know I was always like the care-giver kind of person because I thought if I, at least if I can make other people feel good because that made me feel good to make other people feel good. So I was always trying to make other people feel like they were something special because that's what I wanted, I guess." (p. 2) She says she felt it was her job to make her mother happy and because she couldn't, she felt her life was out of control. I think the divorce may have had a strong impact because she does mention her fear that people would leave her.

Magazines

Obsession. Says she started reading *'Teen* magazine when she was 13, which was about the time that she started obsessing about her body. "Teen magazine, I never missed an issue of it. In fact, our library at school carried it." (p. 11) She says she read the magazines before her eating disorder, but she says, "it became a total obsession afterwards, a total obsession." (p. 11).

She now has to avoid the other magazines. It's interesting, because as she talks I think of the way alcoholics go to great lengths to avoid alcohol. Referring to the fact that Suzanne had placed copies of *Shape* and *Self* on the table before the interview, Patient #7 explains, "This is my obsession now when I saw these when I walked in-shape and self. Those are the two magazines now that, I can't buy vogue because it just, like this, I can't look at this. It's just in one way it's like I can't stand them because they are skinnier than I am and I used to have that and I don't have it now and you know, it just really makes me mad.. . .I mean it becomes an obsession so quickly. So quickly." (p. 11-12).

She says she read the magazines because they showed her the way she "was supposed to be." (p. 22). She says this was reinforced by her mother, who was very focused herself on appearance and looking right, particularly in public. Patient mentions these magazines may have also contributed to a shopping addiction--$81K on her credit cards.

To me, the following statement indicates the degree to which the magazines had power over her. She was talking about the lies she had created about who her real father is (she pretended her step-father was her biological father because she liked him better) and how she believes those lies. She then says, "Oh, I lived a huge lie, a huge lie. I did. I don't want to live a huge lie anymore. That's something I don't want to do again, yet when I look at the pictures like that, its like, 'yes it is. That's what I want to do.'" (p. 14)

She also read *Seventeen*. She said she also had a fad for *Globe* and *Cosmopolitan*.

She says magazines make her mad now. I'm pretty sure that must be a bi-product of therapy. "Well, I look at these kind of ads you know. At first, the first thought that goes through my mind

is, 'that's not fair 'cause she's still skinny and I'm not' and then the next thing is like it makes me mad that it still triggers me. It really does. It makes me angry." (p.10) She must still read them, though. She talks about was draws her attention to a magazine, "I'll buy a magazine 'cause of something it says on the, like the this one, 'Weight Loss: Questions and Answers,' I would say, 'oh cool.' I'd read that magazine but I'd never be caught dead reading a magazine in line. See if I really wanted a magazine, I would buy it and take it home and then (read it in private)." (p. 22)

Comparison. She makes comparisons like the others, but I think some of these comparisons are rooted in her deeper-seated fears. When Suzanne asks her about how she feels about one of the models in the sample magazine she says that "in her eating disordered mind" the model is still attractive, but in her other mind she becomes angry. "She looks like someone who would take my husband away and that's the other thing that makes me mad." (p. 11)

Magazines and EDs. Regarding the magazines, she explains, ". . .I don't think they cause eating disorders, but I think if you are predisposed to an eating disorder by looking at these magazines articles you can totally, I mean, like the magazine pictures, you totally can buy into it. Especially if you're fifteen, sixteen years old." (p. 11)

Television

Like the other patients, she says she does not watch much television. Says she mostly watches the news and newsmagazine type programs. "I just really enjoy social types of things, finding out what's going on in the world." (p. 19). Says she has a hard time sitting still or relaxing. In her home, TV is seen as a waste of time.

TV Commercials.

She does say that she is pretty aware of TV commercials, perhaps more so now than in the past. Says she really bought into some of the messages-particularly when she saw skinny people looking happy. She says she was pretty influenced by products related to dieting and weight control. She explains, "I'd do different kinds of pills and medications, um, Diet Coke-types of things. Oh Jenny Craig. I was like Jenny Craig's poster child for a while because I went there after I had my baby and I was losing weight so fast and I didn't ever eat any of their food. In fact it was something I didn't enjoy because it scared me because of how many fat grams it had in it, but I still went back every week, because it was like a positive thing. Like I'd go and I would have lost weight and they were like, 'Oh, you're doing so well. You're doing so great.' It was exactly what I needed to hear to keep my eating disorder up type of thing." (p. 19)

Appendix C

An excerpt from the interview transcript for Patient #1 with coding notes included. In this segment, the interviewer is talking with the patient about her favorite television programs and characters. This segment identifies a television "use" coded as "parasocial identification," which reflects the need to connect with individuals who understand or share the patient's experiences.

Patient #1: Yah, "ER," I like to see the guts and the blood and all that.

Thomsen: Why do you suppose that is?

Patient #1: I don't know. Because I'm just a blood freak. I don't know why I am.

Thomsen: Ok, I should make a note of that (laughter). Blood freak.

Patient #1: No. *When I was working at the doctor's office that was like my passion was to draw people's blood.* It was just really interesting to me.

Thomsen: What do you think of the characters on ER. Any particular characters that you think you relate to better than others?

Patient #1: Oh yes probably. *Nurse Hathaway.*

TV Uses. *Characters's experiences resonate with her own.*

Thomsen: Nurse Hathaway. Do you think you and she are a lot alike or a lot different?

Patient #1: No. I don't know if we're a lot alike. I don't sit there and think, *she's so much like me,* but the first time ER came on I felt, I don't know if you remember seeing it, but she tried to kill herself. Do you remember that?

Patient #1 also tried to commit suicide

Thomsen: I was a late-comer to ER. My kids watch it.

Patient #1: *But she tried to kill herself and I just, for some reason she just became my favorite character.*

Parasocial Identification

Thomsen: Now that's interesting because you tried to kill yourself. So do you feel there's a kind of kinship between you two?

Patient #1: No. She's just a, I don't know. That seems unfair, because it seems as if I'm obsessed with some girl on TV. And I'm not.

Thomsen:	I'm not implying that.	
Patient #1:	I don't feel a kinship, *but I feel like I can* relate to her character.	Parasocial identification
Thomsen:	Do you think that if you could somehow step into the world of TV, that you and her character could be friends?	
Patient #1:	Oh, yah.	
Thomsen:	If you were friends, what kinds of things do you think you would talk about?	
Patient #1:	*I think if I could, if we talked, it would be, definitely we could talk about our feelings and why we always, I don't think you guys can understand the feelings that people feel when they come to the point where they try to take their own life. So it's really hard to explain to somebody how you're feeling and why you want to do this and it would be really nice to be able to connect with somebody that had those same feelings.*	*TV character would understand her feelings* *Need to "connect"*