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**UNDERSTANDING THE EXPERIENCES OF WOMEN WITH ANOREXIA NERVOSA
WHO COMPLETE AN EXPOSURE THERAPY PROTOCOL IN A NATURALISTIC
SETTING**

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May 2017

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ABSTRACT

UNDERSTANDING THE EXPERIENCES OF WOMEN WITH ANOREXIA NERVOSA WHO COMPLETE AN EXPOSURE THERAPY PROTOCOL IN A NATURALISTIC SETTING

Gina B. Polychronopoulos
Old Dominion University, 2017
Chair: Dr. Ed Neukrug

Anorexia Nervosa (AN) is a serious mental health concern in the United States, with the highest mortality rate of all mental disorders. Females comprise the vast majority of people with AN, although the number of males with the condition is rising. Anorexia Nervosa has a high relapse rate and is often enduring, which makes it challenging to treat successfully; therefore, the mental health profession is in need of innovative therapeutic approaches. Exposure therapy has a growing evidence base for the treatment of eating disorders, including AN; however, there are very few studies that explore body image/mirror exposure specifically in patients with AN. Further, the existing quantitative and qualitative research studies present several methodological limitations, which prompts in depth exploration of this intervention for its specific use with anorexic patients. Using Interpretative Phenomenological Analysis (IPA), the present study explored the experiences of women diagnosed with AN who participated in a novel application of body image/mirror exposure therapy in a naturalistic setting, focusing on the meaning they attributed to the intervention as part of their recovery from AN. The findings may support enhancement of the treatment protocol and inform future outcome studies on the efficacy of using body image/mirror exposure for AN.

Keywords: exposure therapy, females, Anorexia Nervosa

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CHAPTER ONE

STATEMENT OF THE PROBLEM

This chapter will define Anorexia Nervosa, discuss exposure therapy as a treatment intervention for Anorexia Nervosa, and provide definitions of terms that will be used throughout the study. This chapter will also describe the purpose of the study and outline specific research questions. This chapter will conclude by highlighting potential significance and contributions to the knowledge about the experience and therapeutic treatment of Anorexia Nervosa in females, as well as delimitations of the study.

Introduction

Approximately 30 million people in the United States have suffered from an eating disorder at some point in their lives, 20 million women and 10 million men, respectively (Wade, Keski-Rahkonen, & Hudson, 2011). Eating disorders generally affect females more frequently than males (Rikani et al., 2013). Young adult females are particularly at risk for disordered eating, with some estimates of up to 40% reporting experiences of extreme body image concerns, practicing excessive weight-control strategies, and episodes of overeating (Choate, 2012). The typical age of onset for AN is before the mid-20s, which is younger than that of other eating disorders, and adolescence is the peak period of risk (Hudson, Hiripi, Pope, & Kessler, 2007). The most prevalent eating disorders are anorexia nervosa, bulimia nervosa, and binge eating disorder (Rikani et al., 2013). In particular, the AN is one of the most difficult to treat due to poor recovery outcomes and a high mortality rate (Arcelus, Mitchell, Wales, & Nielsen, 2011; Rikani et al., 2013; Smink, van Hoeken, & Hoek, 2012). Anorexia is a dangerous condition with up to 8% of patients dying due to complications directly related to the illness (Herzog et al.,

2000) and about 10% dying within a decade of onset (Sullivan, 2002). Of all the mental disorders, Anorexia has the highest mortality rate (Arcelus et al., 2011).

Some of the psychosocial risk factors for AN include an idealization for thinness, weight concerns, personality traits such as perfectionism and negativity, and peer influence (Keel & Forney, 2013). There is a high comorbidity between eating disorders and anxiety disorders (Swinbourne & Touyz, 2007), and oftentimes people with AN or BN are also diagnosed with at least one anxiety disorder (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004). This could be due to biological and behavioral similarities between anxiety and eating disorders (Strober, Freeman, Lampert, & Diamond, 2007). Frequently comorbid conditions with AN in particular include trauma history (Brewerton, 2007), obsessive compulsive disorder (Kaye et al., 2004), generalized anxiety disorder, and phobias (Pallister & Waller, 2008).

Therapeutic treatment of AN ranges from residential to outpatient care, depending on the severity (Watson & Bulik, 2013). Eating disorders are a complex phenomenon that often requires multidisciplinary interventions (Choate, 2012). There is a high cost for treatment of AN because about half of people diagnosed with AN will require hospitalization and medication, and most of them require some form of outpatient therapy (Agras et al., 2004). Family therapy such as the Maudsley Family-Based Treatment approach has been strongly supported in the literature for its efficacy in the treatment of AN in adolescents (Hurst, Read, & Wallis, 2012); however, further research is needed on efficacious treatments of AN in adults (le Grange & Lock, 2005).

There is an unfortunate deficit in empirical research on the treatment of AN, which could be due to the rarity, medical complexity, and/or chronic nature of the disorder (Wilson, Grilo, & Vitousek, 2007), or perhaps it is due to high attrition rates in studies on AN (Agras et al., 2004). Because of the thin evidence base, the National Institute of Mental Health in 2007 initiated a call

for proposals of innovative therapeutic applications of treatment for AN (Watson & Bulik, 2013). Some of the approaches have recently been applied for the treatment of AN, including cognitive remediation to improve cognitive flexibility, emotion acceptance behavior therapy, enhanced CBT (CBT-E), and exposure and response prevention (Berg & Wonderlich, 2013), also referred to as exposure therapy.

Exposure therapy, sometimes referred to as prolonged exposure (PE) or exposure and response prevention (ERP), was developed in the mid-1980s by Edna B. Foa with a theoretical basis in cognitive-behavioral therapy (Neukrug, 2015). It is a kind of intervention that aims to reduce one's anxiety and fear that is associated with some stimulus (Koskina, Campbell, & Schmidt, 2013). Exposure therapy assumes that, through learned experiences, the person will come to understand that whatever consequence he or she fears will not in fact occur (Abramowitz, Deacon, & Whiteside, 2011). Exposure therapy can be done in vivo (i.e., live situations), in virtual reality (i.e., with the use of virtual reality technology), or imaginal such as the use of mental imagery (Laborda & Miguez, 2015). The goal of exposure therapy is to facilitate the process of *extinction*, which means that one's anxiety will be significantly reduced when they are exposed to the fearful stimulus (Abramowitz, 2013).

Exposure therapy has a strong evidence-base for the treatment of trauma and other complex diagnoses such as Post-Traumatic Stress Disorder, or PTSD (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Exposure therapy is noted as a flexible treatment that can be applied across populations in various settings (Rauch, Eftekhari, & Ruzek, 2012), which supports the rationale for applying this intervention to other mental disorders in which fear or anxiety are key features. There has been a recent trend in the literature on the use of exposure therapy for the treatment of eating disorders in general (e.g., Gorini, Griez, Petrova, & Riva, 2010; Hildebrandt,

Loeb, Troupe, & Delinsky, 2012b; Marek, Ben-Porath, Federici, Wisniewski, & Warren, 2013). Generally, there are two kinds of exposure therapy for people with eating disorders: food exposure and body image (mirror) exposure. This is because what typically contributes to distress in people with eating disorders is food/eating, body image, or both. Although there is a strong rationale for the use of exposure therapy for AN (Steinglass et al., 2010), only a few studies have focused on AN exclusively and separately from other eating disorders. Further, the majority of studies that do focus on AN investigate food exposure, not body image/mirror exposure. In an extensive search of the literature, only two studies focused on the use of mirror exposure in patients with AN (i.e., Key et al., 2002; Morgan, Lazarova, Schelhase, & Saeidi, 2014). This is surprising, as body image disturbance is a core feature of AN (American Psychiatric Association, 2013) and one of the most noted predictors of relapse in disordered eating (Fairburn, Cooper, & Shafran, 2003).

As research is extremely limited on the use of mirror exposure therapy for AN, it may be helpful to explore the intervention qualitatively. The majority of phenomenological research on the experiences of eating disorders focuses on females with AN. Some of those studies were retrospective, in which participants reflected on their experiences from months or years prior to being interviewed, and others included participants who were in treatment at the time. The interpretative phenomenological analysis (IPA) approach was employed in many of the studies that explored the experiences of women with AN, and what meaning they attribute to some aspect of their experience (e.g., Fox, Larkin, & Leung, 2011; Spivack & Willig, 2010; Sternheim, Konstantellou, Startup, & Schmidt, 2010). Fox and Diab (2015) concluded that people with AN find great value in working with clinicians who deeply understand their experiences, which supports the rationale for using an IPA approach.

Very few studies qualitatively explored the experience of undergoing a specific therapeutic intervention in people with AN (i.e., Godfrey et al., 2015; McIver, McGartland, & O'Halloran, 2009; Proulx, 2007). None of those studies focused on exposure therapy for AN, which was the phenomenon of interest in the present study (i.e., mirror exposure in a naturalistic setting). Only one mixed methods study made mention of a qualitative inquiry of participants' experiences of a 10-session body image exposure therapy program (Morgan et al., 2014), and there were several methodological concerns regarding the qualitative portion of the study. Incorporating exposure therapy in a naturalistic setting and personalizing therapy helps it to be more effective (Rikani et al., 2013). Furthermore, no studies have been published that explore body image exposure therapy performed in a naturalistic setting for women with anorexia.

Given the lack of qualitative research on body image/mirror exposure for women who are diagnosed with anorexia nervosa, it was important to design a rigorous and methodologically sound study to further understanding of this phenomenon. Because the focus of the present study is on a particular therapeutic experience for a specific group of people, a traditional phenomenological inquiry might not have captured the desired level of depth and detail. Further, the body image/mirror exposure in the present study was a novel application, in that it occurred in a naturalistic setting (i.e., a department store) rather than a clinical setting. Interpretative Phenomenological Analysis (IPA) can be useful for evaluating therapeutic services for particular groups of people (Larkin & Thompson, 2011). Finally, it was necessary to explore the intervention in depth in order to support future quantitative/outcome studies on its efficacy; therefore, the idiographic nature of IPA was a suitable approach.

Purpose of the Study

The purpose of this study was to explore the perspectives of women diagnosed with anorexia nervosa who had undergone a novel exposure therapy intervention and how they made sense of that experience. It is important to understand how participants make meaning of the process for several reasons, including modification and improvement of the therapeutic protocol itself, determining constructs that may be measured in the future, and gaining a deeper understanding of how the exposure impacts the perceptions and views of someone living with anorexia nervosa. The intent was to fill a gap in the literature, inform future research endeavors, and support potential outcome studies for the use of body image/mirror exposure in patients with anorexia nervosa.

Research Questions

After consulting with the research team members, the primary researcher identified the following research questions, which guided the current study:

1. How do women diagnosed with anorexia nervosa describe their lived experiences of undergoing a body image/mirror exposure therapy intervention?
2. How do women diagnosed with anorexia nervosa make sense of the body image/mirror exposure as part of their recovery?

The first research question was explored through participant initial and follow-up interviews.

The second research question was also explored through the participant interviews, as well as the reflexive journal entries written by the participants after they were interviewed.

Definition of Terms

Eating Disorder is understood as having of one of the three main clinical diagnoses (i.e., Anorexia nervosa, Bulimia Nervosa, and Binge Eating Disorder), assessed by a mental health professional.

Comorbidity refers to the diagnosis of more than one mental disorder for the same individual.

Exposure Therapy is an intervention used for the treatment of mental disorders that are characterized by anxiety due to some kind of environmental stimulus.

Body Image Exposure is a kind of exposure therapy that is used to treat disturbance in body image, often seen in people with eating disorders.

Mirror Exposure is a kind of body image exposure in which the person who has a disturbance in body image is exposed to his or her reflection in the mirror as a form of therapeutic intervention.

Phenomenology is a qualitative methodology that explores the lived experiences of individuals and captures their perspectives in a descriptive manner.

Interpretative Phenomenological Analysis (IPA) is a qualitative research method rooted in phenomenology, hermeneutics, and idiography, in which the goal is depth in understanding the meaning one makes of an experience.

Potential Significance of Study

The current study has several potential contributions, both methodological and clinical, to the field of mental health counseling. The extant qualitative literature on people with anorexia nervosa is limited due to methodological concerns, including trustworthiness, rigor and depth. It was important to explore this intervention rigorously before designing outcome studies on its

efficacy. Given that there is limited qualitative research on the experience of exposure therapy for any eating disorder, there are promising opportunities for discovery. Also, body image/mirror exposure therapy had not been explored thoroughly in the literature for use with anorexia nervosa. It had mostly been investigated as a treatment for body image dissatisfaction in other eating disorders (i.e., bulimia nervosa and binge eating disorder) and nonclinical populations. Finally, the specific exposure protocol is a novel variation of the intervention (i.e., body image/mirror exposure in a naturalistic setting), which is typically employed in a clinical or controlled setting. Because there are virtually no research studies on how people with anorexia nervosa experience body image/mirror exposure therapy, particularly in a naturalistic setting, it was important to explore the intervention qualitatively in order to achieve depth in understanding and address the current gap in research. There was potential to identify constructs that may not have been discovered in previous studies due to restrictive and reductionistic methodologies. Such in depth exploration may support future outcome-based research on the use of mirror exposure for patients with Anorexia Nervosa.

Regarding potential clinical contributions, understanding how women with anorexia nervosa experience a body image-mirror exposure therapy protocol could not only identify new or existing constructs that have yet to be explored, but it could also inform the modification and improvement of the exposure treatment. It is important to understand what aspects of therapeutic treatment are meaningful, particularly to people who have AN. Finally, findings from the current study could offer comparison points of reference for future studies on the novel body image/mirror exposure with other eating disorder populations.

Delimitations

Delimitations for the present research study were as follows: requirements that participants be female, ages 18 to 30, diagnosed with Anorexia Nervosa, and participation in the specific exposure therapy protocol no more than once. This excluded males, anyone who was outside of the age range, people who were diagnosed with another eating disorder, and those who had not participated in the exposure therapy protocol or had participated more than once. The idiographic method of Interpretative Phenomenological Analysis necessitates a homogenous sample in order to explore the particular phenomenon in depth; therefore, the sample was purposively selected with the aforementioned inclusion/exclusion criteria.

CHAPTER TWO

LITERATURE REVIEW: INTERPRETATIVE PHENOMENOLOGICAL APPROACH AND STRUCTURE

The structure of this chapter follows the guidelines for research studies using Interpretative Phenomenological Analysis (IPA), as outlined by Smith, Flowers, and Larkin (2009). The purpose of the literature review in IPA research is to serve as an introduction to the topic of interest and develop an argument, which builds into the rationale for studying a phenomenon in depth. The literature will be viewed with a critical lens and summarized concisely in an effort to support the rationale and research questions for the present study. A particular issue that is either problematic or missing from the literature will be identified, and the current study aims to address the need for further exploration. Then, the IPA method will be explained further, including a justification for why this approach is appropriate to investigate the phenomenon of interest. Finally, the research questions will be outlined specifically, based on the culmination of previous studies and rationale for the present study (Smith et al., 2009).

The nature of a qualitative literature review is flexible and fluid, reflecting the *cycle of inquiry* (Marshall & Rossman, 2010, pp. 55-88). It serves as a platform to which the author will return throughout the research process, as new insights are discovered during data collection and analysis. Thus, the literature review will be updated and evolve as a whole to identify additional studies that may either bolster or challenge initial insights. To begin, the following eating disorders will be briefly defined, as classified in the *Diagnostic and Statistical Manual of Mental Disorders*: Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Binge Eating Disorder, Bulimia Nervosa, and Anorexia Nervosa (5th ed.; DSM-5; American Psychiatric Association, 2013). Then, standard therapeutic interventions for eating disorders will be

introduced, and the recent use of exposure therapy, or prolonged exposure, as a treatment for eating disorders will be highlighted. Greater emphasis will be placed on AN, as well as the treatment of AN, because the population of interest in the current study are young adult females who are in treatment for AN and participate in an exposure therapy protocol. Finally, key contributions of existing qualitative research studies will be discussed and summarized, focusing on IPA studies about the experiences of women with AN.

DSM-5 Feeding and Eating Disorders

With regard to feeding and eating disorders, the present study focuses on how female patients with a specific eating disorder, Anorexia Nervosa, describe their experiences of participating in exposure therapy. This section will contextualize AN within the broader spectrum of feeding and eating disorders, as described by the *DSM-5*; therefore, Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder (ARFID), Binge Eating Disorder (BED), Bulimia Nervosa (BN), and Anorexia Nervosa (AN) will be briefly defined. Anorexia Nervosa will then be discussed in greater detail, as it relates to the current study.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, feeding and eating disorders can be generally described “a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning” (American Psychiatric Association, 2013, pp. 329). The following disorders belong to this category: Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder (ARFID), Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), and other specified and unspecified feeding or eating disorders. These diagnoses are mutually exclusive, i.e., one cannot be diagnosed with two or more at the same time (with the exception of Pica). The following is a brief description of

each feeding and eating disorder. For a full description of diagnostic criteria, please refer to pp. 329-355 in the *DSM-5*.

Feeding and eating disorders are grouped into two subsets: feeding disorders and eating disorders. Pica, rumination disorder, and avoidant-restrictive food intake disorder belong to the subset of feeding disorders. Anorexia nervosa, bulimia nervosa, and binge eating disorder belong to the subset of eating disorders. Other specified and unspecified feeding or eating disorders can describe any disturbance in feeding/eating behavior that do not fully meet the criteria for any of the outlined disorders in this category. Pica is a condition that can occur among children and adults in which nonfood items that offer no nutritional value are consumed persistently for at least one month. Rumination disorder involves regurgitating food repeatedly and then re-chewing, swallowing, or spitting the food out, for a period of at least one month.

Avoidant/Restrictive Food Intake Disorder (ARFID) is characterized by disturbance in eating or feeding and consistently not meeting nutritional needs, resulting in at least one of the following: losing (or not gaining) weight, deficiency in nutrition, depending on supplements or feeding tubes for nutrition, and/or interfering with one's psychosocial functioning (American Psychiatric Association, 2013). Because the present study explored the experiences of women who are diagnosed with the eating disorder anorexia nervosa, the following section will outline eating disorders in greater detail in an effort to provide context for the diagnosis within the category.

Eating Disorders

Approximately 20 million women and 10 million men in the United States, at some point in their lives, will suffer from an eating disorder (Wade et al., 2011). Eating disorders include Anorexia Nervosa, Bulimia Nervosa, Binge Eating disorder, and Other Specified or Unspecified Eating Disorders (APA, 2013). The lifetime prevalence rates for eating disorders are 0.9% for

Anorexia, 1.5% for Bulimia, and up to 3.5% for Binge Eating Disorder (Rikani et al., 2013).

Body image dissatisfaction is understood as the greatest contributor to Anorexia and Bulimia Nervosa (Stice, 2002). The eating disorders are further described below, as they are outlined in the *DSM-5* (American Psychiatric Association, 2013).

Anorexia nervosa (AN) is an eating disorder that involves restricting one's food intake to achieve low body weight, a strong fear of becoming fat or gaining body weight, and a disturbance in the way he or she perceives his or her body weight or shape. The body image disturbance overly influences one's self-evaluation. There are two subtypes of AN, including restricting type and binge-eating/purging type. In the restricting type, one achieves weight loss by restricting his or her eating but does not experience episodes of binge-eating or purging. In the binge-eating/purging type, one will engage in binge eating and then purge to compensate for the calories consumed by forcing himself or herself to vomit or misusing laxatives, for example (APA, 2013).

Bulimia nervosa (BN) involves recurrent binge eating, performing compensatory behavior to avoid gaining weight, and undue influence of one's body shape in his or her self-worth. Binge-eating episodes are the same as those described above in BED, where an excessive amount of food is consumed in a given period of time. During the episodes, the person feels out of control over his or her eating, e.g., that he or she cannot stop the behavior. However, the main difference is that, because the person fears gaining weight and feels ashamed of the bingeing behavior, he or she will compensate for the binge-eating behavior, which is called *purging*. Some examples of purging behaviors include vomiting, using laxatives, excessively exercising, fasting/extreme dieting, and using diuretics (APA, 2013).

Binge eating disorder (BED) involves binge-eating episodes recurring at least once per week for at least three months. A binge-eating episode is characterized by the following: consuming a significantly large amount of food (i.e., significantly more than an average person in a similar situation) and within a specific amount of time (e.g., one or two hours). The person who is binge eating also feels out of control over his or her eating behavior during an episode. The individual is typically distressed while binge eating, and he or she does not engage in compensatory behavior to avoid weight gain, as one with Bulimia Nervosa would do (further explained below). Finally, in order to be considered a binge eating episode, at least three of the following attributes must be present: the eating behavior is more rapid than usual, the individual eats until he or she feels very full, large quantities of food are eaten when not physically hungry, eating in private due to embarrassment about the binge-eating behavior, and experiencing negative feelings about oneself after the episode, including depressed mood, guilt, and disgust (APA, 2013).

When someone experiences symptoms that cause significant impairment or distress in his or her life, but they do not fully meet criteria for one of the outlined disorders, then the diagnosis would be “other specified feeding or eating disorder.” The clinician must note the reason that the patient’s symptoms do not fit into one of the other disorders. Examples may include lower frequency of binge eating or purging episodes, being of normal or above normal body weight in anorexia, or purging to lose weight without engaging in binge eating. The diagnosis of “unspecified feeding or eating disorder” is similar to “other specified,” only the clinician does not outline the reason that the patient does not meet criteria. This is often due to lack of information obtained in the setting (APA, 2013).

Anorexia Nervosa: A Closer Examination

The present study explored the experiences of females who have been diagnosed with anorexia nervosa (AN), who had undergone an exposure therapy protocol. Therefore, this section will describe AN in detail, including etiology and comorbidity of the disorder, in an effort to contextualize the phenomenon of interest. Anorexia nervosa is characterized by an overwhelming fear of gaining weight and becoming fat, and it is diagnosed when an individual persistently restricts his or her food/energy intake, resulting in low body weight relative to one's sex, age, and physical development. Similar to bulimia nervosa, there is also a disturbance in body image, and the person overly values his or her body shape or weight and attributes it to his or her self-worth. As previously noted, there are two types of anorexia nervosa: restricting type refers to when the individual does not binge or purge but mainly restricts his or her intake, engaging in dieting and/or excessive exercise to lose weight, and binge-eating/purging type involves recurrent behaviors of binge-eating and intentional purging, e.g., vomiting, misusing laxatives or diuretics. The severity of this disorder is determined based on the individual's Body Mass Index, or BMI, which is calculated by a person's height to weight ratio (APA, 2013).

Of all the eating disorders, the most prevalent are anorexia nervosa, bulimia nervosa, and binge eating disorder (Rikani et al., 2013). The lifetime prevalence rates of these diagnoses are as follows: 0.9% for AN, 1.5% for BN, and up to 3.5% for BED in both males and females (Choate, 2012). Anorexia nervosa, particularly chronic AN (cAN), is one of the most difficult mental health disorders to treat due to poor treatment outcomes and high mortality rate (Rikani et al., 2013; Smink et al., 2012). It is a dangerous condition, with approximately 5 to 8% of patients dying because of physiological complications directly related to the disease (Herzog et al., 2000) and, even more disturbingly, about 10% die within a decade of onset (Sullivan, 2002). The

recovery rate is discouraging, with less than half of patients reaching full recovery and about one-fifth maintaining the illness chronically (Sullivan, 2002). Although medical co-morbidity is the most common cause of death for people with eating disorders, the second most common is suicide, with up to 20% of patients with AN and up to 35% with BN having attempted suicide at least once (Rikani et al., 2013). Less than half of patients with AN fully recover, and about 20% of patients continued to suffer from AN chronically (Steinhausen, 2002).

Etiology of Anorexia Nervosa

Eating disorders have historically been considered a Western phenomenon, affecting mostly White females; however, in recent years, disordered eating behaviors have appeared more in other groups of people, such as males, members of other ethnic groups, and the lesbian, gay, bisexual, transgender, and queer population (Cachelin & Striegel-Moore, 2006; Grabe & Hyde, 2006; Rich & Thomas, 2008; Swanson, Crow, LeGrange, Swendsen, & Merikangas, 2011; as cited by Choate, 2012). They are complex phenomena, and there is no exact cause of developing an eating disorder. However, psychosocial factors as well as family heritability play major roles in one's risk for developing an eating disorder (Strober, Freeman, Lampert, Diamond, & Kaye, 2014). Regarding AN in particular, some of the psychosocial risk factors include an idealization for thinness, weight concerns, personality traits such as perfectionism and negativity, and peer influence (Keel & Forney, 2013). Further, body dissatisfaction is a risk factor for disordered eating (Fairburn et al., 2003) as well as perfectionism, substance use, impulsivity, and negative affect (Stice, 2002). The age of onset for AN is younger than that of other eating disorders, typically occurring before the mid-20s (Hudson et al., 2007).

Women and anorexia. Eating disorders in general affect women more frequently than men, with the prevalence in females being about three times that of males (Rikani et al., 2013).

For women in particular, the lifetime prevalence rate of AN is approximately 0.9-2.2% (Watson & Bulik, 2013). However, the prevalence rate for AN in males is much lower, at about 0.3% (Hudson et al., 2007). Young adult females in particular are at a high risk for disordered eating, with up to 40% of women reporting that they experience extreme body image concerns, practicing excessive weight-control strategies, and episodes of overeating that they perceive to be out of control (Choate, 2012). According to the sociocultural model, women feel pressure to be thin more often than men; they may feel badly about themselves if they do not meet an ideal body type that is slender and therefore engage in eating patterns to achieve that ideal (Polivy & Herman, 2004). In considering cultural, biological, and social factors, males may experience AN somewhat differently than females (Wooldridge & Lytle, 2012), as empirical research has focused mostly on females. Experiences of body satisfaction may also differ substantially for males (Adams, Turner, & Bucks, 2005), which highlights the potential influence of gender in the experience of AN. In the present study, a homogenous sample was desired in an effort to isolate the experience for females with AN, and future studies may wish to compare and contrast experiences between males and females with AN.

Comorbidity. Research has long supported the relationship between anxiety disorders and eating disorders (Swinbourne & Touyz, 2007). Often, patients with AN or BN are also diagnosed with at least one anxiety disorder, and some researchers speculate that the early onset of an anxiety disorder might be linked to later developing an eating disorder. Social phobia and obsessive-compulsive disorder (OCD) is speculated to have the highest comorbidity with eating disorders, and more specifically, obsessive-compulsive disorder is more often seen in patients with AN (Kaye et al., 2004). The features of OCD, such as obsessive thoughts and compulsive behaviors, demonstrate significant overlap with AN, which could be attributed to similar

neurobiological processes (Swinbourne & Touyz, 2007). Substance use disorders are also prevalent in women with eating disorders, particularly anorexia binge-purge type (Harrop & Marlatt, 2010). Other comorbid mental health concerns include history of trauma (Brewerton, 2007) and generalized anxiety disorder and phobias (Pallister & Waller, 2008).

Treatment of Anorexia Nervosa

With regard to treatment, the present study focused on how women diagnosed with Anorexia Nervosa (AN) describe their experience of a specific exposure therapy (ET) protocol; therefore, it is important to provide some context on how exposure therapy fits into the broader spectrum of treatments for eating disorders. The purpose of this section is as follows: First, I will explain how AN is generally treated. Then, I will outline how exposure therapy in general and highlight how it has been used in the treatment of eating disorders. Next, I will describe previous research examining ET for the treatment of AN, noting how only a few focus on body image exposure for AN, which is the phenomenon of interest. Finally, the section will conclude with a rationale for exploring in depth how women with AN experience body image exposure.

Therapeutic treatment of eating disorders varies, depending on the severity and diagnosis. There are, however, a wide variety of therapeutic services provided at treatment facilities, ranging from residential to outpatient care (Watson & Bulik, 2013). Types of therapy may include individual, group, and family therapies, outpatient, intensive outpatient (IOP), partial hospitalization, day programs, and inpatient/hospital admission. Anorexia nervosa comes with a high cost for treatment, with about half requiring hospitalization and medication, and most patients participate in some kind of outpatient therapeutic treatment (Agras et al., 2004). Because eating disorders are complex phenomena, they often require multidisciplinary interventions (Choate, 2012). Family therapies have a strong evidence base for the treatment of AN in

adolescents, such as the Maudsley Family-Based Treatment approach (Hurst et al., 2012); however, more research is needed on efficacious treatment of AN in adults (le Grange & Lock, 2005). Unfortunately, there is a deficit of empirical research on the treatment of AN in the past few decades, which could be due to the rarity of the disorder, medical complexity, and the chronic nature of the illness (Wilson et al., 2007). Attrition is also very high in research studies on AN, which raises concerns about study conclusions (Agras et al., 2004; Wilson et al., 2007). Recently, some innovative approaches have been applied for the treatment of AN, including cognitive remediation to improve cognitive flexibility, emotion acceptance behavior therapy, enhanced CBT (CBT-E), and exposure and response prevention (Berg & Wonderlich, 2013), also referred to as exposure therapy. The application and use of various forms of exposure therapy in the treatment of AN will be further discussed below, as that was the phenomenon of interest in the present study.

Exposure Therapy

The purpose of this section is to introduce Exposure Therapy (ET) as a treatment intervention for various mental disorders, including anxiety disorders eating disorders. Exposure therapy, also referred to as prolonged exposure (PE) or exposure and response prevention (ERP) in the literature, will first be generally described. Then, its use for the treatment of anxiety disorders and eating disorders will be highlighted, with particular focus on Anorexia Nervosa. Finally, a gap in the literature will be noted, as the vast majority of research on ET and eating disorders is quantitative in nature and does not focus specifically on its use for AN. This supported the rationale for the current study. The terms *prolonged exposure* (PE) and *exposure therapy* (ET) will be used interchangeably in this section.

Exposure therapy was developed in the mid-1980s by Edna B. Foa, which has a theoretical basis in cognitive-behavioral therapy (Neukrug, 2015). It is a kind of clinical intervention that attempts to reduce one's anxiety and fear associated with some stimulus (Koskina et al., 2013). The premise of ET relies upon the theoretical principles of behaviorism, specifically classical conditioning. Through learned experiences, the process involves understanding that whatever consequence the person fears will not in fact occur, leading to a new association with the stimulus that is not fear (Abramowitz et al., 2011). According to Rauch et al. (2012), there are four components to PE: psychoeducation, emotional processing, in vivo (i.e., live) exposure, and imaginal exposure. The focus of psychoeducation are one's symptoms and how she or he experiences those symptoms. In vivo and imaginal exposure involve the confrontation of things that remind the person of the trauma; in vivo is when one confronts them in actuality, and imaginal involves revisiting those reminders by mental imagery. Emotional processing is facilitated by the therapist and involves a discussion of what the patient experienced. The basic premise of PE is that, by confronting a trauma-related stimulus repeatedly and for a prolonged period of time, one's emotional responses will become habituated. That is, they will become used to encountering the stimulus and experience less anxiety over time because the feared consequences are not occurring (Rauch et al., 2012). In other words, the goal of exposure therapy is to facilitate the process of *extinction*, which mean that one's anxiety or fear response will be significantly reduced when they are exposed to the fearful stimulus (Abramowitz, 2013).

Exposure therapy has been utilized most often for the treatment of anxiety disorders (Abramowitz et al., 2011), and research has supported both virtual reality and in vivo exposure as effective treatment interventions (Powers & Emmelkamp, 2008). Prolonged exposure (PE) is a

well-established evidence-based treatment for survivors of trauma and other complex diagnoses, such as post-traumatic stress disorder, or PTSD (Powers et al., 2010). PTSD is a mental disorder characterized by psychological distress when one is exposed to a stressful or traumatic event. The person has either experienced the event directly, witnessed the event happening to others, learned about it happening to someone close to him or her, and/or experienced repeated exposure to stressful or traumatic events. PTSD is etiologically related to anxiety and obsessive-compulsive disorders because of similarities in symptoms and experiences (APA, 2013). In the past few decades, exposure-based therapies are recommended as primary treatment for PTSD, due to strong empirical support (Cukor, Olden, Lee, & Difede, 2010). Rauch et al. (2012) performed a meta-analysis on the use of PE in the treatment of PTSD, which was carried out in an effort to update the guidelines for clinical practice of PTSD for the United States Veterans Administration (Department of Defense). In their extensive literature review, they noted the increasing evidence base for the use of PE, no matter what the trauma or whether there are comorbid diagnoses. They concluded that PE is a flexible treatment that can be applied across populations in various settings (Rauch et al., 2012). The studies cited in their review support the rationale for applying exposure therapy to other mental disorders in which fear or anxiety are key symptoms.

Exposure therapy has been utilized as an intervention for other mental disorders in which anxiety and fear are core elements, such as obsessive-compulsive disorder (Foa et al., 2005), phobias (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008), and panic disorders (Meuret, Wolitzky-Taylor, Twohig, & Craske, 2012). Recently, there has been a trend in the literature toward the use of exposure treatment for people with eating disorders (e.g., Hildebrandt et al., 2012b; Marek et al., 2013; Trentowska, Svaldi, & Tuschen-Caffier, 2014), which is likely due to

the etiological relation between anxiety disorders and eating disorders, as previously noted. However, only a few studies have focused specifically on the use of exposure therapy for anorexia nervosa (e.g., Key et al., 2002; Riva, Bacchetta, Baruffi, Silvia, & Molinari, 1999; Steinglass et al., 2010). The following section outlines the literature on the use of exposure therapy in the treatment of eating disorders, focusing on AN in particular, as the present study explored the experiences of women with AN who participated in exposure therapy for the treatment of AN.

Exposure Therapy and the Treatment of Eating Disorders

The majority of research on exposure therapy as an intervention for eating disorders are quantitative in nature, including randomized controlled trials (RCTs) and other outcome studies that assess various constructs pre- and post-intervention. Koskina et al. (2013) performed a systematic review of the literature on exposure therapy and eating disorders, noting that its evidence base has been inconsistent. The application of exposure therapy to the treatment of eating disorders has included both in vivo (i.e., live) and virtual reality exposure to an anxiety-provoking stimulus. For people with eating disorders, the stimuli typically include something food-related and/or one's body image. As previously mentioned, there were surprisingly few studies that focused specifically on people with anorexia nervosa; the majority of studies looked at patients with bulimia nervosa and eating disorders not otherwise specified, which includes binge eating disorder (Koskina et al., 2013). This is surprising, given the etiological similarities and high comorbidity between anxiety disorders and AN (Kaye et al., 2004; Swinbourne & Touyz, 2007).

Because of the thin evidence base for the treatment of anorexia nervosa, the National Institute of Mental Health initiated a call for proposals of innovative therapeutic applications in

2007 (Watson & Bulik, 2013). Among the novel approaches to treatment was exposure and response prevention therapy (ERP), which employs exposure therapy techniques to address fear related to eating (e.g., Steinglass et al., 2010). Extant literature on exposure therapy for eating disorders has been mostly outcome-based (i.e., quantitative) and focused overwhelmingly on patients with bulimia nervosa, or eating disorders in general.

There are two general kinds of exposure therapy for eating disorders: food exposure and body image exposure. The exposure can occur in vivo (i.e., live), in *virtuo* (i.e., through virtual reality), or imaginal by guided mental imagery (Laborda & Miguez, 2015). As previously noted, there are inherent etiological and phenomenological similarities between anxiety disorders and anorexia nervosa, which supports the use of ET in the treatment of AN. However, only a few studies examine the use of ET for the treatment of AN on its own. Many studies group all of the eating disorders together when examining the efficacy of exposure therapy. Further, those that do focus on AN examine food exposure and not body image/mirror exposure, which was the intervention of interest for the present study, with the exception of two studies. The following sections highlight how various exposure therapy techniques have been used in the treatment of AN.

Food exposure and AN. Food exposure is a method of exposure therapy in which the anxiety-provoking stimulus being systematically introduced is food. The exposure could be to real food, photographs of food, or via virtual reality technology. In a preliminary study, Gorini et al. (2010) compared the effectiveness of real, virtual reality, and photographs of food in patients with eating disorders compared with a control group without eating disorders. They concluded that virtual reality elicits an emotional response more effectively than photographs of food and is similarly effective as real food. Their study highlighted the potential utility of virtual reality as a

method of food exposure therapy (Gorini et al., 2010). Another version of food exposure for AN is inherent in family-based treatment (FBT), in which the patient is exposed to food and eating with his or her family members in an effort to manage anxiety and eating-related triggers to address avoidance behaviors (Hildebrandt, Bacow, Markella, & Loeb, 2012a). In their pilot study, Hildebrandt, Bacow, Greif, and Flores (2014) tested an exposure-based adaptation of FBT in adolescents with AN. The preliminary findings suggested that the exposure-based version of FBT, or FBT-E, may be useful in addressing anxiety and eating disorder symptoms; however, methodological limitations make it difficult to establish whether adding exposure to FBT increased its efficacy (Hildebrandt et al., 2014). It is very challenging to isolate effects of particular aspects of integrative treatment approaches, especially when sample sizes are small and there are so many phases of intervention involved. In situations like this, an in-depth qualitative exploration may be useful to capture the perspectives of patients with AN and what they believe was the most meaningful aspect of their treatment.

Outcome studies employing food exposure have typically focused on either preventing bingeing and/or purging behavior such as with BN, or the gradual introduction of feared foods such as with restrictive AN (Koskina et al., 2013). Although there is a strong rationale for the use of exposure therapy for patients with AN due to etiological similarities with anxiety disorders, studies remain rather uncommon (Steinglass et al., 2010). Many studies on the efficacy of food exposure group eating disorders together (e.g., Gorini et al., 2010; Gutiérrez-Maldonado, Ferrer-García, Caqueo-Urizar, & Moreno, 2010). Only a few studies examine food exposure exclusively for AN, and it is difficult to determine what aspect of the interventions were most helpful due to methodological limitations. For example, Steinglass et al. (2007) looked at change in anxiety for individuals with AN after participating in an exposure and response intervention that was

adapted from a treatment manual for OCD. The treatment lasted for 12 sessions, with the first session being psychoeducational and the remaining 11 included exposure to eating situations that the patient feared. The overall goal was to reduce avoidance and anxiety related to eating. The results of this pilot study supported the importance of addressing pre-meal anxiety to help improve eating behaviors (Steinglass et al., 2011). Results of this study must be interpreted cautiously, as there were only nine participants, and it is difficult to know whether the exposure treatment was responsible for any change because participants were also actively participating in other structured treatments for AN at the time.

Overall, the research on food exposure for the treatment of AN has been limited. There have been pilot studies and preliminary findings, and the results have been inconsistent or weak due to methodological limitations such as small sample sizes and potentially confounding treatments (Koskina et al., 2013). Future outcome research may include larger samples and control groups for comparison. Qualitative exploration of the use of food exposure for patients with AN could also support and inform outcome studies on its efficacy.

Body image exposure and AN. Body image is a construct that is often assessed when working with people who experience disordered eating. Disturbance in one's body image is a common element between anorexia and bulimia nervosa (American Psychiatric Association, 2013; Berg & Wonderlich, 2013). Therapeutic interventions in both individual and group settings consider the various facets of body image disturbance, including perceptions, behaviors, affect, and cognition, and these therapies have become more widely used for the treatment of eating disorders (Morgan et al., 2014). Body image disturbance is one of the most noted predictors of relapse in disordered eating symptoms (Fairburn et al., 2003; Keel, Dorer, Franko, Jackson, &

Herzog, 2005; Morgan et al., 2014); therefore, it is important to address it throughout therapy for eating disorders.

Body image exposure has been examined as a therapeutic intervention for body image disturbance in eating disorder and non-clinical populations (e.g., Hildebrandt et al., 2012b; Moreno-Dominguez, Rodriguez-Ruiz, Fernandez-Santaella, Jansen, & Tuschen-Caffier, 2012; Trentowska et al., 2014). It has been applied in both in vivo (i.e., live) and virtual reality settings (e.g., Ferrer-García & Gutiérrez-Maldonado, 2012; Gutiérrez-Maldonado et al., 2010). The most frequently employed body image exposure therapy is mirror exposure, which is designed to address one's disturbance in body image (a core feature of people with eating disorders). It involves viewing oneself in a mirror and becoming habituated to one's negative emotions related to his or her body image, while refraining from negative behaviors such as checking and avoidance (Hildebrandt et al., 2012b). Women who have eating disorders tend to check themselves in the mirror more frequently than those without eating disorders (Probst, Pieters, Vancampfort, & Vanderlinden, 2008), which could be due to their preoccupation with their body shape and weight.

The vast majority of the research on body image or mirror exposure therapy has looked at eating disorders in general or in non-clinical samples; however, the efficacy of body image exposure for AN exclusively has not been explored, with the exception of two studies. A group led by Adrienne Key at St. George's Hospital Medical School (University of London) investigated repeated mirror exposure as part of an 8-week program for body image to address body dissatisfaction, mirror avoidance, and anxiety. The participants were all Caucasian females diagnosed with anorexia binge/purge type, and they were inpatient at the time of the study. They found that body image improved for patients who participated in the repeated mirror exposure

intervention, compared with those who did not, lending support for the integration of body image interventions in patients with anorexia (Key et al., 2002). In the years following this study, the group at St. George's evaluated and refined the mirror exposure treatment intervention by having fewer participants in the group, increasing the number of sessions from eight to 10, enhancing homework, integrating mindfulness practices, and offering more standard training for the therapists facilitating the intervention (Morgan et al., 2014). To the knowledge of this researcher, the evaluations and subsequent refinements performed by this group were not published; therefore, it the development and basis of justification for those refinements is unclear.

Morgan and colleagues (2014) evaluated the efficacy of the revised, 10-session body image treatment program, called the BAT-10, in adult patients diagnosed with anorexia who had reached weight restoration but were currently inpatient at the hospital. There were 53 female participants and two male, and they included both restrictive and binge/purge type anorexia. After participating in the body image program, participants showed a decrease in body checking, and avoidance behaviors, as well as body image anxiety. They also noted improvements in disordered eating behaviors (Morgan et al., 2014).

The results of this quantitative study were promising regarding the use of body image/mirror exposure therapies for patients with anorexia; however, there were several methodological limitations. First, the body image program was not only comprised of mirror exposure, as there were other therapeutic interventions applied throughout. Although there was an element of mirror exposure included within seven out of the 10 total sessions, it is difficult to conclude the effects of mirror exposure treatments alone on the patients' body dissatisfaction because other therapeutic aspects of the program may have confounded those effects. Further, there was no control group in the study to compare treatment effects of the body image program.

Finally, the authors provided minimal details about the procedures and results of their qualitative exploration of patients' experiences (IPA) in this mixed methods study; therefore, findings about patients' perceptions of the mirror exposure must be interpreted with caution.

In sum, previous research on the use of in vivo body image exposure for eating disorders has been quantitative in nature, and results were inconsistent due to methodological limitations and weak theoretical rationale (Koskina et al., 2013). Only a fraction of studies examine the efficacy of exposure therapy for AN separately from other eating disorders (e.g., Hildebrandt et al., 2014; Steinglass et al., 2011), and those studies employ food exposure, not mirror/body image exposure. Although there is strong empirical support for the use of exposure therapy with patients who have AN (Steinglass et al., 2010), systematic research on its efficacy has been lacking (Berg & Wonderlich, 2013). Furthermore, after an extensive search of the literature, only the two studies outlined above examined the efficacy of mirror exposure exclusively in patients with AN (i.e., Key et al., 2002; Morgan et al., 2014). This is surprising, due to the fact that body dissatisfaction is a key feature of AN (Berg & Wonderlich, 2013). Given the lack of systematic investigation on the use of body image/mirror exposure for patients with AN, rigorous and in depth exploration of this treatment is warranted.

Phenomenological Research on Anorexia and Exposure Therapy

In an effort to address the need for systematic investigation on the use of body image exposure for AN, the present study included an in-depth exploration of mirror exposure therapy for females diagnosed with AN. In contrast to the previous studies, which were exclusively quantitative, this project will introduce a rigorous qualitative methodology that will help address the limitations of previous research on body image/mirror exposure and AN. It is important to contextualize the current study within the scope of existing phenomenological research on

anorexia and exposure therapy. This section will outline phenomenological studies that explore the perspectives of women who have been diagnosed and treated for anorexia nervosa, including a discussion of the limitations for each of those studies. Then, the few existing qualitative studies about people who have undergone exposure therapy treatment (for various conditions) will be described. Finally, a gap in the literature will be highlighted concerning the lived experiences of women who have undergone exposure therapy for AN, which supported the rationale for the present study.

Several research studies have qualitatively explored the lived experiences of people diagnosed with eating disorders, and many of those phenomenological studies utilized interpretative phenomenological analysis (IPA) to explore the meaning of some aspect of AN from the patient's perspective. However, only a handful of studies qualitatively explored one's experiences of undergoing a specific intervention or treatment (e.g., Delinsky & Wilson, 2010; McIver et al., 2009; Morgan et al., 2014; Proulx, 2007). Overall, the research on exposure therapy for the treatment of AN specifically has been limited. There have been a few pilot studies with preliminary recommendations, but the results have been inconsistent or weak due to small sample sizes and potentially confounding aspects of treatment (Koskina et al., 2013). Rigorous qualitative exploration of the use of exposure therapy for patients with AN could not only support but inform future outcome studies on its efficacy, as systematic research on this intervention is in its infancy.

Exploring the Lived Experiences of Anorexia Nervosa

In the past few decades, there have been a growing number of qualitative research studies that explore various experiences of anorexia nervosa in the health care literature. Espíndola and Blay (2009) offer a synthesis of these studies for patients who with anorexia nervosa in an effort

to understand the meaning they attribute to this disease. After completing an exhaustive search through six databases and 3,415 research papers from 1990 to 2005 for qualitative studies on the experience of AN, they performed a systematic literature review of 24 studies, critically analyzed them, and engage in meta-synthesis to develop second- and third-order themes across those studies. The vast majority of participants were female (with 369 females and 13 males), and the ages ranged from 13 to 63 years old. Most of them facilitated semi-structured interviews as a primary source of data. Two main categories emerged after third-order interpretation: *disease as identity* and *systems of control*. The authors discussed how AN was experienced as somewhat of a lifestyle, carrying with it a functional purpose. Also, ambiguity was a common feeling attributed to AN by patients, noting both positive and negative aspects of the disease in one's life. Overall, they concluded that it is very important for AN not to be explored solely from a reductionistic perspective due to the complex nature of the experience (Espíndola & Blay, 2009). Their conclusion supports the rationale for qualitatively exploring the experiences of females with AN who participate in exposure therapy.

The majority of phenomenological research on the experiences of eating disorders focuses on females with Anorexia Nervosa (AN), which might be attributed to the high ratio of females to males diagnosed, the serious mortality rate, and the inherent difficulty in treatment of this condition (as previously discussed). Many of those studies are retrospective; that is, they asked participants to reflect on their experiences from when they received treatment months or years prior to being interviewed. Other qualitative studies included participants who were in treatment at the time of the interview. Very few studies explore how people with eating disorders describe and perceive the experience of receiving a specific therapeutic intervention (e.g., Godfrey et al., 2015; McIver et al., 2009; Proulx, 2007). Further, none of those studies focus

exclusively the experience of exposure therapy for the treatment of AN, which was the focus of the present study (i.e., mirror exposure in a naturalistic setting). Only one mixed methods study made mention of a qualitative inquiry about the experiences of participants who went through a 10-session body image exposure therapy program (Morgan et al., 2014), and there were several methodological concerns regarding rigor and depth of their qualitative inquiry. This section will first outline phenomenological studies on the experiences of recovery for females with AN. Those studies that employ the interpretative phenomenological analysis (IPA) approach will be highlighted, as that was the methodology for the present study. Finally, the few qualitative studies on exposure therapy will be described, noting the gap in literature (i.e., the experiences of female patients with AN who undergo an exposure therapy for the treatment of AN). This supported the rationale for the current study.

Several studies explored how people who have been diagnosed with anorexia nervosa describe the experience of recovery. Lamoureux and Botorff (2005) interviewed nine women who viewed themselves as having recovered from AN about the process of recovery using a grounded theory approach. A grand theme of “becoming the real me” emerged, which described the process of discovering and redefining oneself throughout recovery. Other findings supported the importance of a strong therapeutic alliance, readiness to change, and autonomy. The authors described a rigorous procedure of data collection and analysis, including lengthy interviews, member-checking, and open and axial coding; however, the sample size is relatively small to be considered a grounded theory design, which raises methodological concerns for saturation and fidelity of research design. The study was more reflective of a phenomenology than a grounded theory; therefore, caution should be taken when interpreting the findings. Also, the women who

participated in this study believed that they were recovered from AN already, offering retrospective accounts of the recovery process which are subject to recall bias.

Similarly, Tierney (2008) explored the reflections of young people who had received both inpatient and outpatient treatment for AN in the previous three years. Nine females and one male were interviewed in various stages of their recovery, and the researchers performed a thematic analysis to conceptualize the data into five themes. Themes included obtaining access to specialized care, finding a balance between focusing on the physical and psychological aspects of their condition, recognizing helpful qualities in health care professionals, receiving help from nonprofessionals, and perceptions of progress. Overall, the patients described the importance of motivation to change, as well as working with professionals who understood them and focused on all aspects of their recovery, not just physical (Tierney, 2008). Some of the benefits of this study are that the sample included participants from a range of stages in their recovery who had a variety of therapeutic interventions, as well as the inclusion of a male participant. One major limitation concerns the methodology, in that the authors recruited and interviewed participants until “saturation” was reached, which they reported was after 10 interviews. Saturation refers to a point which new descriptions or themes do not emerge from the data; however, it is not applicable to phenomenological studies (Hays & Singh, 2012). The study design was more reflective of a phenomenology, in which saturation is not a goal. This raises a concern regarding the level of rigor in data analysis, and caution should be taken when interpreting findings.

In another retrospective study, Federici and Kaplan (2008) explored the experiences of relapse and recovery in 15 female patients with Anorexia Nervosa. Participants included those who were discharged from either inpatient or intensive outpatient treatment for eating disorders, and the average time since discharge was 14 months. They performed semi-structured interviews

to help shed light on how patients understood and conceptualized their ability to maintain change after being discharged from treatment. The participants were conceptually grouped into two categories: weight-recovered (i.e., those who maintained their weight after discharge) and weight-relapsed (i.e., those who lost weight after discharge). Six categories, or themes emerged from the interviews for all participants that they believed played a role in either losing or maintaining their weight: their desire to change, recovery as a process, how they perceived treatment, supportive relationships, awareness of and ability to tolerate one's negative emotions, and self-validation. They concluded that patients with AN may have unique needs post-treatment and could require additional interventions after discharge to support long-term change and prevent relapse (Federici & Kaplan, 2008). Understanding the recovery process in greater depth could contribute to the development or enhancement of relapse prevention programs. One major limitation of this study is that the only strategy for trustworthiness was bracketing of bias by the researchers. They did not triangulate the interview data with other sources or perform member-checking. Future qualitative research on recovery from AN should include greater attempts at rigor and trustworthiness. Furthermore, given the retrospective nature of the previously outlined studies, future phenomenological research on recovery from AN may wish to interview participants who are nearing the end of their treatment process, which might reflect different descriptions than those captured several months or years after treatment.

Unlike the retrospective studies outlined above, some phenomenological studies have explored the experiences of women diagnosed with AN who were in a treatment facility at the time of the study. Nordbø et al. (2006) interviewed 18 adult females diagnosed with AN, 14 of whom were receiving outpatient treatment and 4 of whom were inpatient. They were interested in the meaning that patients with AN attributed to their anorectic eating behaviors. Eight

different constructs were identified throughout the interviews that highlighted the psychological meaning patients attributed to their anorectic behavior. The method of this study was described as a phenomenology, but they applied elements of grounded theory to data collection and analysis. They described conflicting aims of data analysis: precise and accurate descriptions of participant perceptions, while reaching saturation of data. While the authors outlined a thorough approach to analyzing the data, they did not include strategies of trustworthiness. These limitations should be considered when interpreting the findings of this study, and future research on the meaning of anorectic behavior to patients with AN may be warranted.

In a recent study, Smith and colleagues (2016) explored the perspectives of adults who were receiving inpatient treatment specifically for anorexia. They interviewed 21 women diagnosed with anorexia who were at various stages of treatment at the facility, ranging from two weeks to 28 weeks admission lengths. The findings highlighted five major themes related to how patients perceived their experience, including shifts in personal control, transitioning into and out of the facility, self-discovery and recovery as a process, sharing the experience with peers, and the importance of having supportive relationships with clinical staff (Smith et al., 2014). The study offered valuable insights into the experiences of adult women with anorexia receiving inpatient specialist treatment for anorexia, as many studies have focused on adolescents in the past, and it was the first study of its kind (Smith et al., 2014). It also presented several methodological strengths, including rigor and trustworthiness of data analysis; however, one limitation was the heterogenous sample (i.e., amount of time patients were hospitalized, subtypes of anorexia, and ethnicity). While a heterogenous sample supports a more general understanding of how patients experience specialist treatment for anorexia, there may be variation among participants based on how long they have been in recovery.

The previously outlined phenomenological studies of people with AN offer several insights. First, due to the complex nature of AN, it is very important not to explore AN solely from a quantitative perspective (Espíndola & Blay, 2009). Many of the studies were retrospective in nature, asking the participants to reflect upon their experiences of treatment or recovery from months or years prior. Future research may continue to focus on the perceptions of those who are in the midst of recovery or when they have just completed treatment, in an effort to capture a more vivid and current account of their experiences. The current study addressed this by exploring the experiences of women who were nearing the end of their treatment in a partial hospitalization program. Next, none of the studies asked participants about their experiences of undergoing a specific therapeutic intervention. The present study addressed this gap in literature by exploring the meaning that women attribute to the body image/mirror exposure therapy intervention as part of their recovery process.

Exploring the Experiences of Anorexia using IPA

Interpretative phenomenological analysis (IPA) has been employed as a methodology for exploring phenomena in depth and will be further discussed below. Several studies have used IPA to gain a deeper understanding of the experiences of people who have anorexia nervosa (AN) and the meaning they attribute to some aspect of their recovery. IPA is a suitable approach for studying AN because people with AN find great value in working with those who deeply understand their experiences (Fox & Diab, 2015). This section will outline studies that employed an IPA approach in exploring the perceptions of people who have AN, lending support to the use of IPA for the current study. The following research studies will be summarized and discussed with a critical lens, noting methodological limitations that the current study may address.

Many IPA studies of females with anorexia are retrospective in nature, prompting participants to reflect on treatment they had received in the past. For example, Offord, Turner, and Cooper (2006) interviewed seven female participants who had received treatment as adolescents in an inpatient setting in the previous two to five years. All of the participants were White, British nationals, and ages 16 to 23. Four higher-order themes emerged from the descriptions, including feeling removed from the outside world, being viewed as *another anorexic* instead of as an individual person, feeling powerless within their recoveries, and the importance of relationships with peers both outside and inside the hospital facility. Because of its retrospective nature, a major limitation of the study is that participant reflections may not be as accurate as they might have been, had the interviews occurred soon after they were discharged from treatment; however, an advantage to this delay is that the reflections might be more balanced after having adjusted from being discharged (Offord, Turner, & Cooper, 2006). Future research studies may wish to explore participants' perceptions of treatment more promptly after discharge to address the potential limitation of recall bias.

In another retrospective study, Jenkins and Ogden (2012) interviewed 15 adult women who had received treatment for AN in the past. All interviews were performed over the telephone for reasons of convenience, pragmatism, and preference of the participant. Data was analyzed using an IPA approach, and themes were grouped into the following three areas: being anorexic, the process of change, and being recovered. The authors also noted a transcendental notion of dichotomy throughout those areas (e.g., a rational versus irrational side to themselves), and participants described how recovery was most likely when therapy did not exaggerate those dichotomies but rather helped to resolve them (Jenkins & Ogden, 2012). One of the strengths of this study was the trustworthy process of data analysis, including references to researcher

reflexivity and peer debriefing; however, there were a few limitations. First, participants were at various stages of their recovery, which could contribute to recall bias and heterogeneity of experience. It is important for samples to be as homogenous as possible in IPA because of the idiographic nature of the method. Also, interviews were facilitated exclusively over the phone, which limited the opportunity for detailed field notes describing nonverbal cues from the participants. Further, there was no indication of other methods of data triangulation to encourage further depth of analysis. In order to capture an adequate level of depth and rigor for IPA, it is important to include other data sources to offer greater and more detailed descriptions of the participants' experiences. Future research studies may include alternate data sources to strengthen findings, as well as purposively selecting a sample of participants who are at similar stages of recovery from anorexia.

Some IPA studies have explored the perceptions of females with anorexia during their hospital treatment. For example, Spivack and Willig (2010) explored adolescent inpatient experiences on a specialist unit for the treatment of eating disorders. They interviewed eight females who were nearing the end of their treatment about their perspectives. One of the major themes that emerged from the narratives was the description of a split self, including an *Anorectic self* and a *non-Anorectic self*, highlighting the internal struggle between the two (Spivack & Willig, 2010, pp. 9). For those whose *non-Anorectic self* was more dominant, they viewed their treatment experiences as more positive, and they felt less ambivalent. Another theme was that of feeling controlled and viewing the staff members and rules of the unit as punitive, which is similar to the perceptions outlined in other phenomenological studies of inpatient experiences (Fox & Diab, 2015; Offord et al., 2006). Further, participants expressed perceptions of distance from life outside the clinic, describing their experiences inside the clinic

as more safe and secure instead of uncertain and fearful. Finally, they concluded that the experience of a *split self* might have been prompted by admission to the facility, when patients began confronting their internal battle.

In a similar study, Colton and Pistrang (2004) explored the experiences of 19 female adolescents with Anorexia Nervosa, ages 12 to 17 who were receiving inpatient treatment at a specialized eating disorder unit. Using interpretative phenomenological analysis, they performed semi-structured interviews to capture how participants experienced inpatient treatment for AN. Participants also completed a readiness for change questionnaire specifically designed for disordered eating at the end of their interview as a form of triangulation. Five themes emerged from the data. The participants explained that they when they perceived treatment to be supportive and not punishing, they were more likely to be collaborative. Respondents described mixed feelings about their inpatient treatment experience, both positive and negative, which is a similar finding to other phenomenological studies about inpatient experiences of ED (Fox & Diab, 2015; Offord et al., 2006). An overall theme throughout participant descriptions was that their own readiness and desire to recover was very important (Colton & Pistrang, 2004). The previously outlined studies offered valuable insights about the perceptions of adolescent females receiving inpatient treatment for anorexia; however, further research is necessary to explore the perceptions of adult females with anorexia receiving inpatient treatment.

Sternheim and colleagues (2010) explored the meaning of uncertainty in females with anorexia at various stages of recovery. They facilitated three focus groups of women diagnosed with AN who were receiving treatment at inpatient, rehabilitation, day care settings that lasted between 30 and 45 minutes, employing a semi-structured and non-directive interview method, and analyzed data using the IPA approach. Five super-ordinate themes regarding uncertainty

were identified: experience, external sources, internal sources, need for control, and coping. The authors inferred that the topic of uncertainty was meaningful to the participants and inferred its relation to underlying obsessional and anxious traits often seen in patients with AN. Participants were also able to see the positive aspects of uncertainty, although they felt mostly negatively about it, which is resonant of the ambivalence patients with AN have described in other studies about their experiences. Further, the authors noted some differences in perceptions between groups, based on the treatment setting of participants. Future research may wish to explore those differences in greater depth with individual interviews, as the level of depth in focus groups when using IPA is uncertain (Tomkins & Eatough, 2010).

In a recent IPA study, Fox and Diab (2015) interviewed six women with chronic anorexia (cAN) lasting at least six years, who were receiving inpatient treatment and had participated in at least two or more different therapies for AN. The in-depth interviews consisted of six expansive questions followed up with prompts regarding their lived experiences with AN, treatment, and interpersonal relationships. Five interrelated themes were elicited, describing the following: how one makes sense of AN, the pessimistic view of cAN by staff members, interpersonal relationships with others who have AN, interpersonal relationships with staff/clinicians, and the internal battle with anorexia. They also described the *anorexic voice* as an entity with which they have a dynamic relationship, fluctuating from being a hated part of their identities to offering comfort and safety. The notion of battling within oneself, or ambivalence, is a consistent theme throughout several phenomenological studies of experiences of eating disorders (e.g., Colton & Pistrang, 2004; Fox et al., 2011; Offord et al., 2006; Serpell & Treasure, 1999). Participants also described the personal value and importance of working with clinicians who deeply understand

their experiences and the internal struggle (Fox & Diab, 2015), lending support to the importance of the therapeutic alliance for patients with anorexia.

In a related study, Sly and colleagues (2014) interviewed eight adult women receiving inpatient treatment for anorexia to explore their perceptions of the therapeutic alliance. Participants described how their relationships with clinicians played a role during their treatment experiences, and four themes emerged. First, they considered the therapeutic alliance to be one of the central aspects of their treatment experience. They also valued playing an active role in their own treatment, feeling more equal with clinicians in that process. Participants also found it meaningful when they could discuss disordered eating behaviors that were considered taboo with therapists. Finally, the participants reflected that their early impressions of the therapeutic staff often set the tone for their ongoing experience while in treatment (Sly et al., 2014). This study displayed several strengths, including methodological rigor and trustworthiness. It also shed light on specific aspects of the therapeutic alliance that patients with anorexia may perceive during their hospitalization. Future research studies may wish to explore the role of the therapeutic alliance more in depth, during a specific treatment intervention.

Exploring the experiences of exposure therapy for AN. There are a few qualitative studies about the use of exposure therapy; however, they were case studies that explored the treatment of posttraumatic stress disorder (Gerardi, Rothbaum, Ressler, Heekin, & Rizzo, 2008; Richards & Rose, 1991; Shearing, Lee, & Clohessy, 2011) and driving phobia (Wald & Taylor, 2000). Further, only two studies qualitatively explored a specific exposure therapy treatment or intervention for patients with AN exclusively. First, Godfrey and colleagues (2015) performed a thematic analysis of video-recorded “family meal” sessions, which is a type of intervention employed within the Maudsley model of family-based treatment for anorexia nervosa. Their goal

was to explore the dynamics of how those sessions might differ based on the type of family meal; the study did not examine the patients' perceptions of the intervention, as that was not the intent (Godfrey et al., 2015). The second study that qualitatively explored a specific exposure therapy for patients with anorexia was the mixed methods evaluation performed by Morgan and colleagues (2014), who examined the BAT-10 body image program including mirror exposure. Aside from the qualitative portion of that study, in which the methodology, findings, and level of rigor were unclear, there are no phenomenological studies on how females with AN experience mirror exposure therapy and how they make meaning of that intervention as part of their recovery from anorexia to date. Therefore, it is necessary to perform a rigorous and in depth qualitative exploration of mirror/body image exposure therapy for females with anorexia to help shed light on how they attribute meaning to that experience as part of their recovery process and inform future outcome studies.

Summary of Previous Research

Anorexia Nervosa is a dangerous and deadly condition, with the highest mortality rate of all mental disorders (Arcelus et al., 2011). Young adult females are particularly at risk for disordered eating, with a prevalence rate of AN that is three times that of males (Rikani et al., 2013). Some of the psychosocial risk factors for AN include weight concerns, personality traits such as perfectionism and negativity, an idealization for thinness, and peer influence (Keel & Forney, 2013). There is a high comorbidity between eating disorders and anxiety disorders, which could be due to biological and behavioral similarities (Strober et al., 2007). Frequently comorbid disorders include obsessive compulsive disorder (Kaye et al., 2004), trauma history (Brewerton, 2007), substance use disorders (Harrop & Marlatt, 2010), generalized anxiety disorder and phobias (Pallister & Waller, 2008).

Anorexia in particular is one of the most difficult eating disorders to treat, due to poor treatment outcomes (Smink et al., 2012). Depending on the severity of the condition, therapeutic treatment ranges from residential to outpatient care (Watson & Bulik, 2013), and it often requires multidisciplinary interventions because of complexity (Choate, 2012). There is a deficit in research on the treatment of AN, which could be attributed to the complexity, rarity, and/or chronic nature of the disorder (Wilson et al., 2007). In 2007, the National Institute of Mental Health initiated a call for proposals of innovative therapies for the treatment AN because of the discouraging recovery rate (Watson & Bulik, 2013), and among the recent therapeutic approaches is exposure therapy.

Exposure therapy has a theoretical basis in cognitive-behavioral therapy (Neukrug, 2015) and it aims to reduce anxiety that is associated with some stimulus (Koskina et al., 2013). It was initially developed for the treatment of posttraumatic stress disorder and has a strong evidence base of the treatment of trauma and other complex diagnoses (Powers et al., 2010). Exposure can be in vivo (i.e., real life), in virtuo (i.e., through virtual reality technologies), or imaginal (Laborda & Miguez, 2015). Regarding the treatment of AN, the feared stimulus is typically food or body image. Although there is a strong rationale for the use of exposure therapy for the treatment of AN (Steinglass et al., 2010), only a handful of studies have examined it, and they mostly focused on food exposure. In an exhaustive review of the literature, only two studies focused on body image or mirror exposure in patients with AN (Key et al., 2002; Morgan et al., 2014). The findings from the pilot study by Key and colleagues (2002) suggested that body image/mirror exposure elicited a strong emotional reaction and contributed to a change in body dissatisfaction for women with AN; however, the results must be interpreted with caution because of the small sample size. In a larger scale study (that built upon the pilot study by Key

and colleagues), Morgan et al. (2014) evaluated a 10-session cognitive-behavioral therapeutic program that includes body-image therapy in patients with AN. This manualized treatment approach shows promise in promoting change in negative values and beliefs that are core features of AN; however, there was no control group for comparison of people without AN. Another limitation is that the exposure was performed in a clinic setting with inpatients, which limits generalizability to people with AN who are not hospitalized. Further, it is unclear whether which aspect of the mirror exposure itself was most helpful or beneficial to the patients.

Several research studies have employed a phenomenological approach to understanding the lived experiences of people with AN, and it is important to explore AN qualitatively as well as quantitatively due to its complex nature (Espíndola & Blay, 2009). Participants ranged from adolescents to adults and were mostly females, and many were interviewed while they were inpatients or in various stages of the recovery process. Some studies were retrospective in nature, asking participants to reflect upon their experiences; however, doing so could contribute to recall bias in their descriptions. Therefore, it may be helpful to interview participants who have more recently received treatment. Methodological concerns were prevalent among the phenomenological studies of AN, including lack of triangulation, minimal strategies for trustworthiness, and level of depth and rigor. There were also issues with design and analysis, in which some studies were described as taking a grounded theory approach and reaching saturation of data, but they were more reflective of phenomenological inquiries in which saturation is not a goal. Caution should be taken when interpreting findings of those studies.

Finally, the mixed methods study mentioned above (Morgan et al., 2014) was the only study that referenced a qualitative exploration of the use of body image/mirror exposure for the treatment of AN. Although the quantitative portion of the pilot study was promising and lent

support to the utility of mirror exposure for AN, the phenomenological inquiry method was completely unclear. The authors noted that they used interpretative phenomenological analysis (IPA) to evaluate participant experiences; however, the method of data collection and analysis outlined was not congruent with IPA. First, there were 55 participants in the study, but IPA aims for a small and homogenous sample because of its idiographic and iterative basis (Smith et al., 2009). Secondly, participant experiences were explored with a structured questionnaire, which does not lend support to achieving depth in understanding. Semi-structured, flexible interviews are most often used in IPA, as it allows for the researcher and participant to explore the meaning of the experience in great depth and detail (Smith et al., 2009). Finally, the findings were not discussed at length; rather, the authors seemed to use the qualitative inquiry as a means of triangulation to the quantitative aspect of their pilot study. Themes were briefly mentioned in the results and discussion of the article, and given the vagueness of methodology, one should interpret the findings cautiously.

Interpretative Phenomenological Analysis

Given the lack of qualitative research on exposure therapy, particularly for women who are diagnosed with Anorexia Nervosa, it is important to design a rigorous and methodologically sound study to further understand this phenomenon. Because the focus is on a particular experience for a very specific group of people, a traditional phenomenological approach might not capture the depth and detail that is intended. The exposure intervention that the participants have undergone is a variation of traditional mirror exposure protocols in that it occurs in a naturalistic setting (i.e., a department store) rather than a clinical setting. Therefore, the idiographic nature of Interpretative Phenomenological Analysis (IPA) is a suitable approach. This section briefly introduces IPA as a method of exploring the experiences of a phenomenon in

great depth, focusing on the meaning people attribute to those experiences. A more detailed discussion of the methodology for the current study will be provided in Chapter Three.

The IPA method got its start in the United Kingdom, first appearing in a paper by Jonathan Smith in 1996 and slowly grew in popularity with its first publication outside the UK until 2002 (Smith, 2011). The vast majority of research employing IPA falls into the general category of health psychology, with illness experience being a dominant topic; however, only a small fraction of those studies focus on eating disorders, with 10 out of the 293 reviewed including “eating disorder” as a key term (Smith, 2011). The underlying philosophies of phenomenology, hermeneutics, and idiography align well within the study of mental health concerns and therapeutic interventions (Smith, 2004).

Rationale for using IPA

As portrayed in the literature review above, several studies have used the IPA approach to explore the perceptions and experiences of women with AN who are recovering from their eating disorder. However, no studies have focused on the meaning of a particular therapeutic intervention in one’s recovery. Also, many of the qualitative studies on AN posed methodological limitations, which the current study sought to address by outlining and carrying out the process in a thorough, rigorous, and detailed manner. It is very important for AN not to be explored solely from a reductionistic perspective due to the complex nature of the experience (Espíndola & Blay, 2009). Further, it is important to strive toward depth in understanding with clients who have AN because they often experience feelings of reduced hope when working with clinicians who lack profound knowledge of their disorder (Fox & Diab, 2015). Finally, because the exposure intervention is novel in its approach to mirror exposure (i.e., in a naturalistic setting), it is necessary to explore the phenomenon qualitatively in order to support future

quantitative/outcome studies on its efficacy. Therefore, in an effort to explore the experience of females with AN undergoing a specific treatment (i.e., mirror exposure in a naturalistic setting), as well as how they make sense of that experience within their recovery, the iterative and inductive approach of IPA is most suitable for the present study.

Research Questions

Based on the literature review and rationale for the present study, the following research questions guided the project:

1. How do women diagnosed with Anorexia Nervosa describe their lived experiences of undergoing a body image/mirror exposure therapy intervention in a naturalistic setting?
2. How do women diagnosed with Anorexia Nervosa make sense of the body image/mirror exposure as part of their recovery?

CHAPTER THREE

METHODOLOGY

The following chapter serves as an outline of research design and methodology, as well as strategies for data collection and analysis for the present study. Descriptive information of research team members, including experience within the topic and methodology, are explained. Efforts to enhance trustworthiness are described, and limitations of the study are detailed.

Research Design

This research study followed a phenomenological research tradition and specifically utilized the approach of interpretative phenomenological analysis (IPA) as outlined by Smith, Flowers, and Larkin (2009). The overarching goal was to document the lived experiences of women in treatment for Anorexia Nervosa who participated in a specific therapeutic exposure protocol and, in particular, how they attributed meaning of that intervention as part of their recovery. The main source of data was semi-structured interviews conducted after the intervention, including primary and follow-up interview. Secondary data sources included de-identified session notes written by the clinicians who facilitated the exposure protocol, as well as reflexive journal entries written by the participants.

Rationale for Using Qualitative Methodology

There have been a considerable amount of quantitative research studies examining the efficacy of some exposure protocol when used in the treatment of eating disorders. Many of these outcome studies examined constructs such as anxiety, body image satisfaction, and negative behaviors related to self-image (e.g., checking, avoidance, dieting, purging, etc.); however, only one study qualitatively explored the lived experiences of those who participated in an exposure therapy protocol for eating disorders (Morgan et al., 2014), and the level of rigor

was uncertain. From a counseling perspective, it is important to strive toward a level of depth in understanding one's experiences, which is challenging to do with quantitative methodologies alone. Although outcome studies have demonstrated improvement in some symptomatology constructs (e.g., anxiety or checking behaviors), they did not examine the meaningfulness of the exposure protocol itself to the participant. Such discovery and depth of understanding the experience is not inherent in quantitative designs. Therefore, the primary researcher strived toward this level of depth and rigor in understanding the lived experiences of women with Anorexia Nervosa who participated in an exposure therapy protocol by employing a qualitative approach. The specific protocol of interest is a novel application of body image/mirror exposure therapy that had not yet been examined qualitatively; therefore, it was important to explore how participants described their experiences throughout the protocol to help understand the meaning of that experience in their recovery from Anorexia.

Research Questions

The following research questions guided the study:

1. How do women diagnosed with Anorexia Nervosa describe their lived experiences of undergoing a body image/mirror exposure therapy intervention in a naturalistic setting?
 - a. Objective: Describe the thoughts, feelings, and behaviors as they are understood by those who participate in the protocol.
2. How do women diagnosed with Anorexia Nervosa make sense of the body image/mirror exposure as part of their recovery?
 - a. Objective: Describe the meaning that participants attribute to the exposure therapy as part of their treatment for Anorexia Nervosa.

Questions and prompts during the primary and follow-up interviews and reflexive journal entries were intended to inform the above research questions.

Interpretative Phenomenological Analysis

The ontology of this research study involved multiple subjective realities of one's experience throughout an exposure therapy protocol designed for persons who participated in an intensive outpatient program for eating disorders. Specifically, the researcher took an interpretative phenomenological analysis (IPA) approach to exploring the lived experience and the particular meaning or significance it takes on the lives of those who participated. The IPA approach is theoretically grounded in hermeneutics, in that the participant reflects on the experience and attempts to make sense of it, while the researcher then interprets those reflections in an effort to understand the experience. IPA assumes that an experience is made up of separate 'parts' in time, which make up a more comprehensive unit of the experience as a whole. A shared meaning links these parts together, and the goal of IPA research is to discover that common meaning as one reflects on the significance of that experience in his or her life (Smith et al., 2009).

Epistemologically, a social constructivism lens guided the exploration of participants' lived experiences, in that knowledge was co-constructed between the participants and the researchers, assuming that this understanding was unlimited because of the subjectivity of personal experience (Hays & Singh, 2012). The primary researcher attempted to bracket her beliefs about this phenomenon (Epoche) and capture the essence of the participants' personal experiences. With regard to rhetoric, the researcher placed great emphasis on participant voice, using quotes and narratives as examples of themes throughout data analysis procedures. The axiology of this study considered both the researcher's values and the participants' values as

having an impact on the data and interpretation. The goal was to explore the participants' perceptions and views of their experience; therefore, the researcher's perspectives and values, as well as those of the participants, were considered as influential as she interpreted their reflections.

Phenomenology. The core approach to the IPA methodology is phenomenological. That is, the intent of the researcher was to explore participants' lived experiences of some phenomenon. In this study, the phenomenon of interest was the exposure therapy protocol, and the participants were women who had been diagnosed with Anorexia Nervosa attending an intensive outpatient program (day treatment) for eating disorders. The researcher sought to elicit thick descriptions from participants about what it was like to participate in the therapeutic protocol and strived to capture the essence of that experience.

Hermeneutics. The variation from traditional phenomenology is that IPA does not focus just on the experience of the exposure but on the participants' interpretation of that experience when reflecting upon it (hermeneutic), as well as the interpretation by the researcher as she reflects upon participant reflections (double hermeneutic). Further, it posits that there is a dynamic relationship between the parts and the whole that could be considered circular, which implies a non-linear approach to data analysis (Smith et al., 2009). In this study, the researcher embraced the *hermeneutic circle* while analyzing data line by line, case by case, and across cases by considering the relationship between these individual parts with the overall experience of participants in their therapeutic journey.

Idiography. The nature of IPA is idiographic, i.e., it is committed to focusing on the particular, rather than the general (Smith et al., 2009). For this reason, the sample was purposefully small, homogenous and carefully selected, focusing on the examination of detail in

depth for a specific group of people. There was no attempt to make general claims about a larger group of people or population (e.g., people with anorexia or those who participate in exposure therapy). The focus of this study was exploring the meaning of an experience for a particular individual as it related to that of the other individuals and the overall phenomenon.

Study Design and Protocol

This study explored the subjective experiences of females with Anorexia Nervosa who completed a body image/mirror exposure therapy in a naturalistic setting, as part of their treatment process. Patients were nearing discharge from a partial hospitalization program, and clinical staff members had deemed them in a state of stability/readiness to engage in the protocol. On the day of the exposure, the clinicians announced that they would be taking them to a local department store, where they must select an item of clothing or outfit to try on. Participants were instructed to choose items of clothing that were challenging for them or that they would not ordinarily choose due to fear and anxiety related to wearing that item. Clinicians facilitated the process and engaged in therapeutic dialogue with the participants as they went through the store and made their selections. After the participants selected articles of clothing or outfits, they went to the fitting room to try on the items. There, they were exposed to their own body image in the mirror, as they wore the clothing items. The clinician remained outside the door of the fitting room, continuing to engage in therapeutic dialogue with the client throughout the process. The process of choosing clothing items and trying them on in the fitting room may have been repeated, depending on the individual needs of the participant. They were encouraged to purchase items of their choosing, but it was not mandatory. After trying on, (optionally) purchasing the clothing and leaving the department store, the exposure protocol was considered complete. Upon returning to the hospital facility, eligible participants were informed of the

research study and offered a flyer with more information, if they were interested in participating. They were reminded that participation was voluntary, not mandatory, and it would not affect their treatment at the facility in any way.

Research Team Members

The research team for this study consisted of two doctoral-level students in education. The primary researcher had over ten years of work experience in the mental health profession serving various clinical populations, as well as over five years of experience working as a clinical researcher. She was a doctoral candidate in Counselor Education and completing her residency for licensure as a professional counselor (LPC) in the state of Virginia. She had an understanding of disordered eating because of her knowledge, training, and experiences in a variety of clinical mental health counseling settings. She was a White female in her 30s of European/Mediterranean descent. The second research team member was a third-year doctoral student who has substantial experience in qualitative research methods. His background and experience is in instructional design, training development, and student development. He was a White male in his 30s of European descent. The primary researcher performed all interviews and transcriptions; the clinicians who were employed by the hospital facilitated the exposure therapy protocols part of their typical duties and therapeutic procedures for the partial hospitalization program. Both research team members were responsible for data analysis to include initial commenting (or initial noting), initial clustering, and thematic development from textural themes into larger, structural themes. They met regularly to discuss data analysis, protocol, and subjectivity. The primary researcher was responsible for the final analyses and interpretations.

Addressing Researcher Bias and Trustworthiness

It is important to address researcher bias in establishing trustworthiness when performing qualitative research, particularly phenomenological studies. The primary researcher has experienced disordered eating in her personal life, and she has also worked therapeutically as a clinician to help persons who have been diagnosed with an eating disorder; therefore, she assumed that these experiences could influence and contribute to her understanding and interpretation of the data. Further, her age, race, and gender are similar to that of the target population (i.e., ages 18-30, female, and White/Caucasian). She embraced this subjectivity and the impact that it could have in guiding the research study, and she addressed her biases by maintaining a reflexive journal throughout data collection and analysis. The primary researcher did not have prolonged engagement with the participants prior to interviewing them.

Strategies for trustworthiness. In a concerted effort to establish trustworthiness the primary researcher collaborated with a research team member and methodologist, who had experience carrying out qualitative research. The interview data was triangulated with reflexive journal entries written by the participants after their initial interview, and follow-up interviews were performed to discuss emerging themes with each individual participant. These methods supported the strategies of transferability and authenticity.

Validity. In the tradition of IPA, member-checking after analysis of multiple cases is not always appropriate and may be counter-productive, and peer validation was employed in this study as a preferable method for validity (Larkin & Thompson, 2012). As suggested by Smith and colleagues (2009), the primary researcher attended to Yardley's (2000) four principles for assessing validity in qualitative research: 1) sensitivity to context, 2) commitment and rigor, 3) transparency and coherence, and 4) impact and importance. The primary researcher showed

sensitivity to context by being knowledgeable and current on the research related to anorexia and exposure therapy, performing thorough and in-depth interviews with skill and dedication, remaining interactional with participants during data collection, and utilizing considerable amounts of participant quotes to support interpretation. She demonstrated commitment and rigor by selecting an appropriate sample, performing follow-up interviews with participants, and attending to both the idiographic and interpretative aspects of data analysis. The primary researcher was transparent and coherent throughout the process by explicitly outlining how participants were chosen and details of the data collection and analysis procedures, as well as by drafting detailed individual case analyses leading into the cross-case analysis and development of superordinate themes to show the path of interpretation clearly for the reader. Finally, the present study offered an important contribution to the field of mental health counseling by exploring a novel therapeutic intervention that had yet to be documented, for a population at risk.

Potential threats to trustworthiness. Although there were several attempts to limit threats to trustworthiness as noted above, it was not possible to completely eliminate them. Some potential threats to trustworthiness may include assumptions and biases of the research team members that may have been outside of their insight and awareness. Also, it is possible that during the phases of initial noting of themes, some might have been missed that could be important to the understanding of participant experiences. Further, even while providing a trusting and safe relationship with the participant, it is possible that she may have felt uncomfortable disclosing fully, due to the sensitive nature of the topic and experience. Finally, there could have been other potential threats to trustworthiness, not outlined here, of which the primary researcher was not aware.

Participants

Participants were recruited from a partial hospitalization (intensive outpatient) program for disordered eating at a private hospital in Northern Virginia, upon approval from the university Institutional Review Board (IRB) at Old Dominion University and the quality control review board at the hospital. Participants were purposively selected for this study via convenience sampling, as the specific version of exposure therapy is only performed at the aforementioned facility. Clinicians at the hospital facility, who had access to patients completing the exposure protocol, offered informational flyers (Appendix E) about this voluntary research study regarding their experiences with the exposure treatment.

Typically, phenomenological studies aim for anywhere from six to 35 participants (Hays & Wood, 2011); however, the nature of IPA is more rigorous, and a sample size of three to six is considered adequate (Smith et al., 2009). Of the IPA studies found in the literature search, which explored the experiences of people with eating disorders, most of them used a sample size smaller than 10 (e.g., Bezance & Holliday, 2014; Fox et al., 2011; Fox & Diab, 2015; Lawson & Wardle, 2013; Mendieta-Tan, Hulbert-Williams, & Nicholls, 2013; Offord et al., 2006; Spivack & Willig, 2010; Sternheim et al., 2010). The researchers made an effort to select a homogenous sample for the purposes of this study, i.e. biologically female, ages ranging 18 to 30 years old, diagnosis of Anorexia Nervosa, enrolled in the intensive outpatient program, and completed of the exposure protocol only once. For the purposes of this study, four participants were recruited. The goal was to establish depth in understanding of the meaning participants made of their experiences and compare themes that were discovered both within and across participants. Finally, because considerable variability in the reported experiences of disordered eating has

been noted based on age (Fox et al., 2011; Fox & Leung, 2009), the sample included late adolescent/early adult participants between the ages of 18 and 30 years old.

Participant #1: “Michelle.” Participant #1 will be referred to by the name “Michelle” throughout the discussion of findings. Michelle is a White/Caucasian female in her early 20s who was enrolled in the partial hospitalization program. It was her first time receiving treatment for anorexia nervosa, and she had completed the exposure protocol two days prior to the interview. On the demographic form, she noted that she was not being treated for any other mental health concern. Michelle participated in the initial, in-person interview, which lasted 60 minutes; however, she declined a follow-up interview, stating that she did not have additional information to offer about the experience. She completed the reflexive journal entry and returned it to the researcher by mail one week after the initial interview. The researcher obtained session notes written by the facilitating clinician about the exposure protocol.

Participant #2: “Jessica.” Participant #2 will be referred to as “Jessica” throughout the report. Jessica is a White/Caucasian female in her early 20s who was discharged from the partial hospitalization program the day before, and she had completed the exposure protocol two days before the interview. She had been hospitalized for anorexia three times in the past. On her demographic form, she wrote that she was also being treated for PTSD and OCD. Jessica participated in the initial interview, which lasted 60 minutes; she also participated in a follow-up phone interview, lasting 20 minutes. She completed the reflexive journal entry, and the researcher obtained session notes written by the clinicians about the exposure protocol.

Participant #3: “Rachel.” Participant #3 will be referred to as “Rachel” throughout the discussion of findings. Rachel is a White/Caucasian female in her early 20s who was discharged from the partial hospitalization program three days prior, and she had completed the exposure

protocol five days before to the interview. She had never been hospitalized for anorexia; however, she had five prior hospitalizations for depression and anxiety. On her demographic form, she noted that she was also being treated for depression and anxiety. Rachel completed the initial in-person interview, lasting 60 minutes, and she also participated in a follow-up phone interview, which lasted 25 minutes. Rachel completed the reflexive journal entry; however, the researcher was not able to obtain session notes for this participant because her medical chart was archived before participant consent was obtained.

Participant #4: “Dana.” Participant #4 will be referred to as “Dana” throughout the report. Dana is a White/Caucasian female in her early 20s who was enrolled in the partial hospitalization program. She had participated in several research studies prior to the present study, and she reported receiving treatment approximately 20 times for anorexia. On the demographic form, she wrote that she was also being treated for anxiety, depression, and PTSD. Dana completed the initial in-person interview, which lasted 60 minutes; she also participated in a follow-up phone interview, lasting 20 minutes. She also completed and returned the reflexive journal entry after the initial interview. The researcher obtained session notes written by the clinicians who facilitated the exposure protocol after consent was obtained.

Additional Measures to Ensure Participant Confidentiality and Safety

Client privacy and safety are of the utmost importance, especially in clinical research endeavors. Regarding safety, the researcher explained the nature of the study and potential risks. Participants reviewed and were required to sign an informed consent document before participating, and the researcher explained the voluntary nature of the study, including withdrawal without penalty. Because of the sensitive nature of the topic, the researcher emphasized the voluntariness of participation.

To protect confidentiality, the informed consent form was the only document that had the participants' names on it, and these were kept in a locked cabinet in the primary researcher's office. Session notes regarding the exposure protocol were de-identified by a clinician at the facility, *i.e.*, all identifying information such as names of people and places were removed. They were placed into an envelope with the participant's code number and sealed before given to the researcher for analysis. All data was assigned a unique code number for matching purposes of interview data, session notes, and journal entries. Only the primary researcher had access to the master key, which matches participant names with code numbers. All electronic data was password-protected, and only de-identified data was included in the audit trail. All data will be destroyed after 5 years upon completion of the study.

Because of the small sample size, the primary took an additional step to ensure a higher level of confidentiality and protect participants' identities. The initial interview dates cited in the findings section have been adjusted. In this way, recruiting staff members at the hospital, who may remember when participants were attending the program, cannot identify who was being interviewed on those dates. However, the date ranges between participants' initial interview, reflexive journal entry, and follow-up interview were honored and reflected an accurate lapse in time between data collections.

Discussion of IRB application and review. The primary researcher obtained approval from the Human Subjects Committee in the Darden College of Education at Old Dominion University prior to commencing recruitment and data collection. Although the nature of this topic is sensitive, the protocol was considered exempt from full IRB review at the university level because all data (interview, session notes, journal entries) were de-identified and assigned a

code number to protect the identity of participants. The hospital's quality control committee also reviewed and approved the methodology of this study.

Gaining entry. The primary researcher established contact with clinicians at the hospital site while attending a seminar about the treatment of eating disorders in January of 2014. She met and discussed potential research collaboration with them after a series of conversations about the particular protocol of exposure therapy that they employ with patients at their hospital who attend a partial hospitalization (intensive outpatient) program for disordered eating. Mutually, the primary researcher and clinicians decided that it was important to understand how patients experience this therapeutic intervention and what meaning they make of it as part of their recovery because it is a novel variation of in vivo, body image exposure in a naturalistic setting. The primary researcher did not have any prior contact with potential participants, and recruitment was advertised by flyers at the site and announcements by clinicians who interacted with the patients after the protocol was complete. The clinicians emphasized that participation in the study was completely voluntary and confidential for those who were interested and that it would not affect what treatment they received in their recovery program, nor would it become a part of their personal treatment records. Interested participants were asked to contact the primary researcher via phone or email to discuss details of the study. Interviews took place in a private, designated office or conference room at the treatment facility, and the participants and researcher mutually agreed upon a time and date for the interviews.

Data Collection Procedures

IPA focuses on detailed and in-depth reflections from participants; therefore, the goal of data collection is to obtain "rich data" (Smith et al., 2009). To support this goal, the chosen methods of data collection offered the greatest opportunity for participants to express

themselves, reflect upon their experiences, and strive toward depth of understanding and interpretation. The primary researcher facilitated semi-structured interviews, which allowed for flexibility throughout the interview process while simultaneously eliciting reflections about the phenomenon of interest. The interviews took place at a location that was mutually decided between the primary researcher and the participant. All data was de-identified by removing names of people, places, and other identifying information, and sources were given a code number for matching purposes.

Informed consent. The researcher explained the nature of the study to prospective participants and provided informed consent, which included a statement about confidentiality, data collection procedures, and voluntariness of participation. There was no incentive for participation in the research study. Due to the sensitive nature of this research topic, the researcher was especially mindful to ensure participants understand that they were free to engage or disengage from the research study at any point. See Appendix A for a copy of the informed consent form.

Individual interviews. Individual interviews served as the primary source of data collection. Demographic information was also collected (Appendix B). Each interview lasted approximately 60 minutes and was conducted in a semi-structured format (see Appendix C for a list of prompts). Follow-up interviews lasted an average of 20 minutes and were conducted over the telephone. Interviews were audio recorded for the purposes of transcription. Audio files were deleted from the audio recording device immediately after transferring to the primary researcher's computer. They were kept in a password-protected electronic file on the primary researcher's computer, which was also password-protected. The primary researcher transcribed and de-identified the interview and returned a copy of the transcript to the participant, if the

participant requested. The same procedure was followed for follow-up interviews; however, they were audio-recorded over the telephone and transcribed/de-identified. In general, interviews are designed to be flexible, elicit thick descriptions, and allow for the participants to express themselves in depth. In this process, the participant is given the opportunity to reflect on the interview experience, offer any questions or thoughts that came up for her during the interview, and amend or edit her responses to most accurately reflect her experience, if so desired.

Secondary data sources. Interview data was triangulated by secondary sources of information, including session notes written by the clinicians who facilitated the exposure protocol and reflexive journal entries written by participants after the interview in response to a prompt (see Appendix D for reflexive journal prompt). Once informed consent was obtained by the participant, a hospital staff member de-identified the session notes regarding the exposure therapy that were taken by the clinician; i.e., the hospital staff member removed all identifying information from the session note, such as names of people and places. Then, the session note was assigned a code number for matching purposes. Only the primary researcher had access to the password-protected document matching the names of individuals with the code numbers; hospital staff members did not have access to interview transcriptions to protect their identity. Once the reflexive journal entries and de-identified case notes were gathered, the research team begin data analysis.

After being interviewed, participants reflected on their discussion with the researcher and wrote a journal entry in response to the following prompt: “After talking about your experiences with the researcher, write about what the experience of the exposure therapy means to you, as it relates to your recovery” (see Appendix D). They were asked to complete the journal entry within one week of the interview and were offered a stamped and addressed envelope to mail the

journal entry to the researcher. Participants were reminded not to write their names or any identifying information on the journal entry or envelope to preserve confidentiality.

Data Analysis

The primary researcher facilitated and transcribed all individual interviews (primary and follow-up). Immediately after each interview, she wrote a reflexive memo regarding her impressions and feelings that were evoked during the interaction with the participant. Her reflexive memos are included in the audit trail as part of the bracketing process to reduce bias in data analysis. After the primary interview was transcribed, the research team analyzed the primary interview, matching session note, and participant reflexive journal entry. Both research team members reviewed the transcript separately and performed initial commenting. Then, they came together and performed initial clustering of themes (i.e., thematic clustering), engaging in analytical discourse about the initial comments and working toward depth of meaning to the individual participant. In IPA research, the process of identifying patterns and arranging similar themes together is referred to as *abstraction* (Smith et al., 2009). The primary researcher audio-recorded each consensus meeting and took notes. Then, she listened to the recording of the consensus meeting and transcribed additional notes to aid in the clustering of initial comments into textural and structural themes. After thorough review and re-review of the transcript, session note, reflexive journal entry, and consensus meeting notes, the primary researcher constructed an individual codebook for that participant. In a method that is both iterative and inductive (Smith, 2007), both members of the research team reflected upon the meaning of descriptive themes, in an effort to move from the particular individual to the shared meaning across individuals, and this led to the development of more comprehensive, structural themes (Smith et al., 2009).

After the first round of each analysis, the primary researcher contacted the participant for a follow-up interview. The purpose of the follow-up interview was to discuss the initial themes that were interpreted in an effort to achieve greater depth of meaning, while engaging in discourse with the participant (double-hermeneutic process). Further, it offered the research an opportunity to clarify questions that came up during analysis or consensus coding of the initial interview, as well as offer participants the opportunity to expand upon or clarify information they shared. Follow-up interviews lasted an average of 20 minutes and were conducted over the phone. Each follow-up interview was transcribed, de-identified, and coded individually by the research team members. Then, the research team met to perform consensus coding on the follow-up interview, while reflecting upon the themes from the initial interview and comparing what emerged from the follow-up interview. As series of related themes were arranged in relation to one another, superordinate themes began to emerge, which is a process referred to as *subsumption* in IPA research (Smith et al., 2009). The primary researcher then revisited the individual codebook for that participant and made revisions as necessary. Finally, the primary researcher went back through all of the data for the participant and re-coded according to the individual codebook, using NVivo qualitative software. The cycle of analysis for each individual took approximately six weeks. See Figure 1 for a visual representation of the data analysis process.

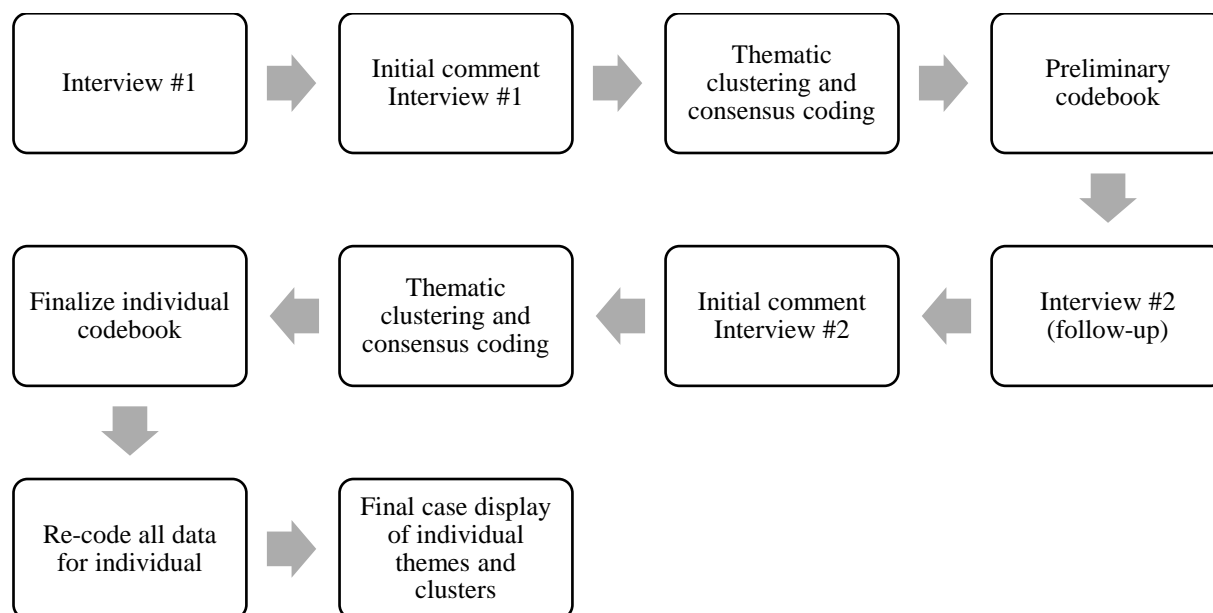


Figure 1. Cycle of analysis for individual cases, which repeats for each participant.

Data was analyzed by the research team one case at a time, and an individual codebook was drafted for each participant. Then, the primary researcher went back through all of the individual participant's data and re-coded according to the individual's final codebook. She drafted a frequency table of themes and thematic clusters for each case, a process called *numeration* in IPA research. This process helped to identify patterns between themes for individual participants (Smith et al., 2009). After all of data for Participant 1 (P1) was analyzed, and the P1 individual codebook was finalized, the research team moved on to the next round of analysis repeating the process Participant 2 (P2), Participant 3 (P3), and Participant 4 (P4).

Cross-case analysis. Until this point, each participant case was examined in depth and individually for emergent themes, employing a “theme within case” approach (Smith et al., 2009). For the final phase of analysis, the primary researcher performed a cross-case analysis of the four participants, while embracing her interpretive role in the process. This led to the emergence of superordinate themes that spoke to the greater picture of how these women

diagnosed with anorexia have attributed meaning to the experience of this particular exposure therapy. They were developed in a double-hermeneutic process of the primary researcher reflecting on the participants' reflections of the meaning of their experiences, as well as employing a cyclical pattern of analyzing themes, moving back and forth from the individual to the shared experience (Smith et al., 2009).

Next, the primary researcher examined the individual participant codebooks and frequency tables, side-by-side. She highlighted themes that were either salient or disconfirmatory. Themes that emerged in at least three cases were considered to be salient. Next, to support the cyclical process of moving from the shared experience to the particular and back to the shared experience, she considered which themes were noted across two participants, as well as themes which were unique to one individual participant. This procedure was performed by hand on paper using color-coded markings and can be referenced within the primary researcher's audit trail.

After considering salient themes, disconfirmatory cases, and unique themes, the primary researcher explored the relationships between those themes by arranging and rearranging them conceptually, a process called *function* in IPA research. This process allows for the examination of how themes relate to each other and enables a deeper interpretation of the overall data (Smith et al., 2009). The result was the emergence of superordinate and subordinate themes regarding the meaning that participants attributed to their experience of the exposure therapy protocol. Finally, employing the "case within theme" approach, the primary researcher outlined superordinate and subordinate themes, offering evidence from each participant to support those themes (Smith et al., 2009). The overall process, from individual to cross-case analysis, lasted approximately ten months.

CHAPTER FOUR

RESULTS

This chapter includes findings and interpretations of themes generated from each of the four participants across all data sources, presented in a case-by-case format. Pseudonyms were used to protect participants' identities. Because the goal of IPA is to understand how one ascribes meaning to a particular experience, I will first introduce each participant and present her codebook individually, outlining definitions for each major theme and subthemes that developed, and I will present descriptive examples (quotes) for each (theme within case; see Smith Flowers, & Larkin, 2009). Participant quotes will be verbatim, with minor editing for readability (*e.g.*, stutter-starts, um, uh, like, etc. that reflect typical speech pattern and are not indicative of sub context). Then, I will summarize each case and offer my reflections and additional interpretations. After discussing all four cases, I will highlight similarities and differences between the participants' experiences and outline the convergent and divergent analyses of themes.

“Michelle”

Michelle is a White female in her early 20s diagnosed with anorexia nervosa. She reported no other mental health concerns in addition to her eating disorder; however, she was prescribed and was taking an antidepressant medication at the time we interviewed. It was Michelle's first time receiving treatment for anorexia, and she had lost an extreme amount of weight due to excessive exercise and not eating enough calories to compensate. She presented in casual attire, was energetic with bright affect and elevated mood. Michelle referred to herself as a “slightly atypical anorexia case,” citing differences in her experience with that of others she knew. Michelle described herself as a professional athlete, noting this as a major part of her

identity. When explaining what made her experience “atypical,” she said that her body image was generally positive and that her weight loss was a “byproduct of the exercise,” not an intentional effort to lose weight because she thought she was too fat. For Michelle, it was more about becoming “the best athlete I could be and pushing myself to the maximum level.”

Several themes and subthemes emerged from the interview with Michelle and her reflexive journal entry (sources). The descriptive themes were then grouped into broader categories, or thematic clusters. The six thematic clusters identified were as follows: 1) exposure protocol, 2) individual, 3) feelings, 4) thoughts, 5) support, and 6) meaning of experience. The order of presentation for themes and clusters does not signify differences in importance; rather, themes are presented in a manner that is consistent with the interview protocol for flow and clarity. See Table 1 for an outline of thematic clusters, emergent themes/subthemes, and numbers of sources and references for emergent themes from Michelle’s interview and reflexive journal entry.

Table 1

Thematic Clusters and Themes Derived from Michelle's Interview and Journal Entry

Cluster	Themes, Subthemes	# Sources	# Refs
<i>Exposure Protocol</i>		1	10
	Expectations as participant	1	7
	Personal role in exposure setting	1	3
<i>Individual</i>		2	22
	My experience of anorexia is different	2	17
	<i>Recovery is personal</i>	2	3
	How I experience the mirror	1	5
<i>Feelings</i>		1	30
	Positive emotional	1	26
	<i>High energy, physical</i>	1	3
	Negative emotional	1	14*
	<i>Denies negative feelings about exposure</i>	1	5
	<i>Guardedness, possible resistance</i>	1	5
<i>Thoughts</i>		1	31
	Comparative thoughts	1	14
	Planning ahead	1	9
	Uncertainty	1	8
<i>Support</i>		1	49
	Positive relationships with peers	1	18
	Role of therapist in exposure	1	31
	<i>Balance between support and autonomy</i>	1	22
	<i>Non-directive</i>	1	8
<i>Meaning of Experience</i>		2	29
	Practical, real-life experience	2	13
	Supportive environment	2	10
	Increased self-awareness	2	6

*Note. Number of references for theme may include references that do not fall into an emergent subtheme; therefore, the total for a theme may be greater than the sum of its subthemes.

Cluster: Exposure Protocol

The thematic cluster of Exposure Protocol included descriptions about procedures surrounding the exposure outing. Two themes emerged: 1) expectations as a participant, and 2) personal role in exposure setting. Each of these themes emerged from Michelle's descriptions about what happened during the exposure, what she was perceived was expected of her as a participant, how she interacted with the other patients and staff during the protocol, including the individual role she fulfilled as a group member.

Expectations as a participant. Michelle mentioned various details about the exposure outing procedure, including what she perceived to be expected of her. She explained that she “had no idea that we were gonna go on [the shopping trip]; [the therapists] just kind of like surprised us.” The therapists explained which clothing store they were going to visit and that they wanted the patients to try on a few things, “preferably garments that are outside our comfort zone.” Then, the staff “encouraged us to buy it if we liked it;” however, it was not a requirement to purchase any items.

They wanted us to pick an outfit... a little bit different than what you would normally wear, and also that was like, pretty, not like form-fitting but something that was like, kind of nice. Not so you're uncomfortable with it, but just being comfortable with showing off your body a little bit more, like wearing clothes that are flattering. (Personal interview, 10/10/2015)

Once they had chosen their garments, they went to the fitting rooms to try on the items they picked. Michelle said that the patients “would try something on and then come out and show [the other patients and staff] and then kind of get their feedback.” It was unclear whether coming out

to get feedback was part of the protocol or if it was a natural happening while shopping with peers. It was described like an unspoken understanding.

Personal role in exposure setting. When reflecting on the interpersonal dynamics throughout the exposure outing, Michelle described offering support and encouragement to the other patients. Michelle denied having negative thoughts or feelings throughout the exposure, and she described her interactions with the other as “kind of like, trying to pump them up a little bit.” At one point, her description of her role seemed to set herself apart from the other patients and more aligned with the therapists: “I think by talking about, like anything, we were distracting them from maybe the nervousness or the anxiety of what they were thinking about the trip.” During our consensus meeting, my research team member and I interpreted her role to be that of a team player or cheerleader, that might be a familiar or comfortable role for her to play as an athlete in a team sport.

Cluster: Individual

As Michelle described, she considered herself to be different from other women who have anorexia. The thematic cluster of Individual included these descriptions of how she experiences anorexia and the exposure in a unique way. Two themes emerged: 1) my anorexia is different, and 2) mirror habits.

My anorexia is different. I asked Michelle about her experience with clothing shopping before and after the exposure therapy, wondering whether she perceived any difference after having participated in the treatment. She said that she was more focused on body image because that topic was discussed so frequently in the treatment program; however, she always enjoyed shopping and has “always liked my body. I’ve always had relatively good body image.” Knowing that body image is a concern for many women with anorexia, (*i.e.*, they believe that

they are too fat and make efforts to lose weight), I probed for deeper understanding and asked her how having a positive body image fit in with anorexia, for her:

For me, my anorexia diagnosis is more of an over-exercising problem than it is body image and food. I'm very competitive, very much a perfectionist, very much a control person, and so I would exercise a lot, kind of run my body down and not intake enough food, which is kind of how I got here. So I never really had much of a body image problem... the hardest part for me hasn't necessarily been putting on the weight, it has been not being able to exercise and having to be stationary all day. (Personal interview, 10/10/2015)

To ensure that I understood her experience, I reflected that for her, body image was not as big of a concern as the exercising, and she responded, "Yeah, I might be a slightly atypical anorexia case, but it still classifies I think nonetheless." Then, to further clarify, I reflected that her losing weight was not because she thought that she was too fat, and she responded, "No, it was just a byproduct of the exercise. My weight loss was a byproduct of my determination to be the best athlete I could be and push myself to the maximum level." Given the above descriptions, it seemed that Michelle believed her experience of anorexia might be different from other women's experiences.

Recovery is personal. Both during the interview and in her reflexive journal entry, Michelle talked about how recovery is personal, and not everyone's treatment should be the same. Toward the end of the interview, Michelle reflected, "That's honestly what I've learned about treatment in general. Everyone's treatment is different, everyone's problems are different. Everyone's body is different. So you can't generalize or compare yourself to another person's treatment. [It's] very much a personal recovery path." In her reflexive journal entry, she

described how helpful it was to her personal recovery to have an experience where she could practice what she learned in therapy in a real-life situation. She wrote:

This makes the experience more meaningful and personalized because you can focus on what works for you individually and what can actually help you once you discharge. Each person's journey through anorexia is different, so group sessions in the treatment center sometimes do not apply to some people as much as others. (Reflexive journal entry, 10/17/2015)

Just as she described her experience of anorexia as different from others' experiences, she considered recovery to be an individual, personal experience as well.

Mirror habits. Part of the exposure protocol involved trying on clothing in a dressing room, which included a full-length mirror. With the understanding that many women who have anorexia perceive their bodies in a critical way, I asked Michelle what it was like for her to try on clothing in the mirror during the exposure. I prompted specifically about whether she found herself spending a greater or smaller amount of time or avoiding the mirror. She began by explaining, "I didn't really find myself avoiding it at all, but I definitely think that, um, I guess when you start to look in the mirror for a long time, then maybe you start to criticize." Michelle continued:

But I didn't really have an issue with that because I didn't look in the mirror too long. I guess that's maybe just like my habit. I don't usually stand in front of mirrors for a very long time. So I kind of just look at it, see how I look, see how I feel, maybe like turn to the side a few times, and then I would go out and show [the other patients] and get their feedback on it too, so you just kinda see how it looks at all angles. But I didn't spend an abnormally long amount of time in the mirror. Um just cuz I didn't want to... I guess

have any negative thoughts creep in. But I didn't really sense that that was going to happen. I just avoided it, just in case and kind of subconsciously, like it wasn't like I was consciously thinking about it. (Personal interview, 10/10/2015)

In her description of how she interacted with the mirror during the exposure, Michelle began by saying that she did not avoid the mirror; however, by the end of her recount, she recognized that she had avoided it after all, albeit subconsciously. Michelle maintained that this was typical for her because "I'm not the type of person to generally stand in front of mirrors for a long time, so I didn't." Her experience with the mirror during the exposure was not much different than usual, for her. She offered, "I have full-length mirrors at home as well, so I'm not, um, uncomfortable with that image." Michelle's description is notably different than many other women with anorexia.

Cluster: Feelings

The researcher prompted Michelle during the interview to reflect upon and describe what feelings came up for her throughout the exposure therapy, including emotional and physical. Three themes emerged during analysis: 1) positive emotions, 2) negative emotions, and 3) high energy.

Positive emotions. The vast majority of feelings that Michelle shared about her experience were positive emotions, including excitement, pride and confidence, safety and comfort, happiness, and having fun. The positive emotion that she cited most frequently was excitement. When the therapists told them that they would be doing the exposure outing, she reflected, "I was actually really, really excited about it. I like going shopping, so I was really looking forward to it." Michelle also said, "I was excited for the opportunity to do something different and do something that I enjoy doing with people that I like." She added, "I think

honestly any time we get to go off the unit, it just like, gets everyone a little excited, in a good way!” On the ride over to the clothing store, she said, “I was just excited for the experience. So I think they (other patients) kind of fed off my excitement a little bit.” Michelle then described her feelings when they arrived at clothing store:

I was just trying to take it all in. Um... I was... (pause) I mean I guess, trying to think of another word besides “excited” but like, I was looking forward to being able to walk around and see the different options that they had. (Personal interview, 10/10/2015)

Along with excitement, Michelle described feeling happy when she heard they were going on the exposure outing, and afterward she reflected, “I was feeling really happy and thrilled because I got overalls, and that was something I’ve always wanted!” She also remembered feeling safe and comfortable while on the outing: “I think the support that was there kind of made me feel safe and made me feel like, even if things did go wrong, I had people there that could help me out.” She noted, “It was nice to feel a bit free, to feel calm and I was looking forward to it.”

Michelle also described feelings of pride and confidence throughout the exposure. She said that she was “proud of myself for getting things that I wouldn’t usually maybe have gotten, and I was proud of myself that I tried on a bathing suit, and really liked it!” Michelle reflected, “I was just proud of myself for being so excited about the trip in general, you know? And just like not really having any negative thoughts, which kind of surprised me.” She remembered having fun on the trip, saying “I was looking forward to being able to see what they had and just kind of have fun,” and that it was “fun to try on different things.” Michelle also talked about physical feelings of high energy and framed them in a positive way. She described, “I felt kind of like a surge of energy, not necessarily like I could feel my heart rate increase, but I kind of felt like jittery.” She clarified that it was a positive feeling: “I was kind of like happy, moving

around a little bit, like dancing and we were joking and laughing and things like that. So I think it was an upbeat thing.” The exposure outing was overall a positive, enjoyable experience for Michelle.

Negative emotions. While reflecting on her experience, Michelle stated several times that she did not experience any negative feelings about the exposure outing. She noted, “I wouldn’t really say that there were any sort of negative emotions, like even just the ‘not knowing,’ it was kinda just like an exciting not-knowing.” During the interview, I prompted Michelle a few times about specific negative feelings that I might have expected to occur during an exposure therapy, such as nervousness, anxiety, or fear about trying on clothing or being exposed to her body image in a mirror. She maintained that “no real issues came up,” “she enjoyed it,” and she “wasn’t nervous about it or anything.”

During consensus coding, I discussed with my research team member the possibility of guardedness or resistance that I sensed throughout my interview with Michelle, which I noted in my reflexive memo. We reviewed the interview transcript again and considered that Michelle might not have trusted me enough to explore her negative feelings. After re-listening to the audio recording and reviewing the transcript again, I decided to code “guardedness, possible resistance” as a subtheme. There were several occasions throughout our interview dynamic that suggested this possibility, including hesitations in speech and a self-discrepancies, where Michelle asserted that she did not feel something negative but described it as such. For example, after she had affirmed numerous times that she did not have any negative feelings during the exposure outing, I asked her how she felt about having to choose an outfit, and she seemed reluctant in describing her concerns about picking a size to try on:

Not being able to exercise is really hard, so I think I did know that there were gonna be changes in my body and changes in how I felt; I didn't really know exactly what size I would be. So I think maybe the uncomfot about like, picking a size was a little bit concerning at times, maybe. But um (pause) it ended up not really being an issue.

(Personal interview, 10/10/2015)

Michelle hesitated and stuttered several times when reflecting about whether she had negative feelings, which I considered to be possible guardedness. When I asked her what it was like to try on clothing in the dressing room and having to look in the mirror, she said "Um, I didn't really have a- any issues with that, so no real issues came up. Um I, I, I enjoyed it. I think it's kinda fun to like try on dresses and you know." At that moment, I wondered if she were avoiding the mirror to avoid self-critical thoughts and negative feelings, so I asked Michelle if she found herself avoiding looking at the mirror too much. In her response (outlined above in the section, "Mirror habits") she began by denying mirror avoidance, but concluded by admitting that she avoided the mirror in case negative thoughts were to arise.

Throughout the interview, there were three instances where Michelle described a negative feeling about the exposure, with little hesitation or resistance. The first instance was when she described that she "felt a little bit guilty about spending money, but at the same time, I was like well, it's for therapy, so [lightly laughing]" and when I asked her to clarify, she said that she does not usually feel guilty about spending money, but because her parents were paying for her therapy, she did not want to disappoint them. However, she reflected that they were happy with what she bought and "it was completely OK." The second instance was when she described how disorganized the clothing store was:

There was so many options that were there, and a lot of it was kind of unorganized, so that part was a little overwhelming because you got there and you were like, OK I need to pick out all these outfits but there were so many clothes, and it's all over the place.

(Personal interview, 10/10/2015)

The third negative feeling that Michelle mentioned was related to perfectionism, in that she wanted to be make sure she saw everything before choosing her outfits. She said, "I kinda had a fear of like, missing something that I really wanted to try on, or something like that. I definitely had to take a few laps around." Circling the store several times to make sure that she did not miss anything was Michelle's way of coping with her fear.

Overall, the negative feelings that Michelle described about the exposure trip had little to do with her self-esteem and body image, although the nature of this particular exposure therapy was intended to address such feelings. It is uncertain whether she had these feelings and denied them during the interview, or if she genuinely did not experience anxiety or fear in relation to trying on clothing and seeing her image in the dressing room mirror. In Chapter 5, I will offer considerations about the goals of this type of exposure protocol (*i.e.*, body image or mirror exposure) and the utility of screening for participants for which it may be most helpful.

Cluster: Thoughts

The thematic cluster of Thoughts comprised of descriptions about what went through Michelle's mind throughout the exposure outing and the reflections she shared during the interview. Four themes emerged: 1) uncertainty, 2) comparative thoughts, 3) self-awareness, and 4) planning ahead.

Comparative thoughts. Michelle had already participated in two other types of exposure therapy outings during her recovery program (food exposures: grocery shopping and dining out

at a restaurant). While reflecting on her experiences, Michelle compared her thoughts and feelings between exposures, noting how they were more or less helpful in her personal recovery. She shared, “some of the previous exposures, like going out to the restaurant, I remember being more anxious about it.” Related to the theme of uncertainty, Michelle noted that the restaurant outing was “the hardest exposure therapy, and probably the most beneficial one for me” because she could not know for sure what was going into the food being prepared, that she would then consume:

I think that does provoke a little bit of anxiety because I don't know what they're putting in the food. I would like to make it myself, I would like to know what they're putting in there. Like, I don't know how healthy it [would be], you know thoughts that would come up, and just learning to let go and be OK with... not knowing. And just kind of going with the flow and being flexible. That's what they always talk about here, being flexible and releasing control. (Personal interview, 10/10/2015)

She reflected that the restaurant outing was most helpful “for me personally, as far as just like overcoming some negative thoughts.” Michelle also valued how practical and applicable to real-life some of the exposure outings were for her. She described the grocery store outing as “very real-life applicable because you have to go shop for your groceries at some point, and you're gonna need to know what to buy and how much and what each thing could count for in your meal plan.” She concluded that “honestly all of them have been very helpful, but I would say the grocery store one was most, like real-life applicable, along with the shopping one.”

Along with comparing exposure outings, Michelle also compared her personal experience with how she perceived the other patients' experiences on the outing. Throughout the interview, she talked about how this particular outing did not provoke negative feelings such as

anxiety for her personally; however, she described that “the other people that I went with were not as excited as I was” because “they were just a little bit more anxious.” She noted that one of them was more anxious because “she doesn’t like spending a lot of money and she also doesn’t really like shopping in general,” and the other patient was “more hesitant about the unknown, kind of like maybe this won’t be fun, maybe I won’t like how I look, maybe I won’t find anything I like.” This theme relates to how Michelle viewed herself as different from others (“atypical anorexia case”) and that her experience of the outing and her recovery from anorexia overall is personal and individual, which is further described in the cluster below.

Planning ahead. Michelle described herself as a perfectionist and that she thought it was an issue related to control for her. In general, she preferred to have a game plan in mind and set personal goals for herself, there were several examples of how she planned ahead, prepared and set goals for herself throughout the exposure outing. For example, Michelle considered what might be most practical for her to try on while shopping: “I was also thinking, what do I need in my closet? Like trying to think of things I could try on, some different things that I might need or might be looking for.” Michelle developed a procedure for herself for the outing, which may have helped her to feel more secure in the lack of structure:

Yeah, well I had to make like, three or four laps around, just to make sure that I saw everything. Cuz after your first time through, you’re just looking at what immediately catches your eye. And then the second time through you start looking a little more closely. And the third time you start really digging and sorting through, and then the fourth time through you’re like OK, let me just see if I missed anything, and maybe perusing a little bit more closely... I was trying to maximize my options, cuz I kinda had

a fear of like, missing something that I really wanted to try on. (Personal interview, 10/10/2015)

She also mentioned that she had set a goal and planned to push herself out of her comfort zone, without needing a gentle push from the therapists during the outing.

Although Michelle denied having negative or self-critical thoughts throughout the exposure, she was prepared to cope with them either way: “Those thoughts actually never really came up, but I had the counter in my head, like if they did come up, that’s what I would say [to myself].” Related to the theme of uncertainty, Michelle offered an example of how she would counter negative thoughts that might have come up:

I just didn’t really know how I would react, if I didn’t fit into certain sizes. But then I would try to tell myself if that did happen, just counter the negative thoughts by saying sizes are all different from store to store, so you can’t compare that to what you were previously because it doesn’t mean anything, you know? There’s no like real “small” standard across the board, or like “medium” standard. (Personal interview, 10/10/2015)

Although she described her plan and personal goals for going out of her comfort zone, Michelle also contradicted herself in this regard. She reflected, “I think what I mainly ended up doing was just went for things that immediately caught my eye as something I was interested in.” She mentioned how she “always wanted a pair of overalls,” and as she was walking through the store, she “turned the corner and I saw overalls... and ended up going straight for them because it was something that she wasn’t expecting that they were gonna have, but something she always wanted.” Michelle had gone against her plan of going outside of her comfort zone when she encountered a pleasant surprise. It is uncertain whether she went for overalls to avoid pushing herself outside of her comfort zone, or whether it was a natural circumstance.

Uncertainty. During the interview, the theme of uncertainty emerged when I asked about her thoughts during the exposure outing. There were several instances where she mentioned that she did not know what to expect, for example: “I didn’t really even know anything about it, like even coming into the hospital that day. I had no idea that we were gonna go on it. They kind of just like surprised us.” She clarified that the surprise of the aspect was not a source of anxiety, but it was more of not knowing what options they would have at the store. Related to the theme of planning ahead, Michelle felt uncertain about how the exposure outing would be carried out:

I didn’t really know exactly how it was going to work, what the schedule was going to be like, what the game plan was going to be, if we were just going to be allowed to go in there and pick out anything or, you know, if there was gonna be more structure to it.

(Personal interview, 10/10/2015)

Although Michelle expressed a positive body image and denied negative feelings during the exposure, she disclosed some concerns and uncertainty about what size of clothing she would get when trying on items. “not being able to exercise is really hard, so I think I did know that there was gonna be changes in my body and changes in how I felt; I didn’t really know exactly what size I would be.” She reflected, “I just didn’t really know how I would react, if I didn’t fit into certain sizes.” Michelle also described some challenge and uncertainty in choosing what clothing to try on “because there were so many options and things were all over the place, it was hard to really choose exactly what I wanted.”

Cluster: Support

During analysis, several themes emerged about the support that Michelle received throughout the exposure from both her peers (i.e., other patients on the outing) and the therapists. The thematic cluster of Support included two themes: 1) positive relationships with peers, and 2)

role of therapist in exposure. Three subthemes emerged during analysis, related to the role of the therapist: 1) balance between support and autonomy, 2) non-directive, and 3) facilitating the process.

Positive relationships with peers. Michelle often referenced her peers when describing her experience of exposure outing, reflecting how supportive they were. She talked about how fun it was to “do something that I enjoy doing with people that I like,” noting that it would have been less exciting and fun if they had not been together. Michelle said, “It was nice to be able to connect with them. I felt like I could connect with them on a more personal level in this environment than in the group [at the hospital].” During the interview, she had mentioned feeling comfortable and safe on the outing, and I asked her what contributed to her feelings of safety. She said, “Maybe just the fact that I knew that I was with a good group of people.” Michelle also wrote in her reflexive journal entry that she “loved shopping with my friends,” noting how enjoyable and helpful the exposure outing was to her.

When reflecting on her interactions with peers during the exposure outing, Michelle talked about how her peers offered genuine encouragement and helped to minimize negative thoughts and feelings. She said, “I liked the group that I went with, it was some of my close friends that are in the treatment center as well, so I think that kind of helped minimized my anxieties.” Michelle also talked about how positive and encouraging her peers were while trying on clothing:

Because when you're with a group and you come out after trying something on, everyone's like “Oh my gosh, you look so good! That's awesome!” and you're like, “Yeah, this does look really good!” and you like, feel really good about yourself, you know? (Personal interview, 10/10/2015)

She went on to clarify that her peers were not only saying positive things about every single outfit, noting, “I could tell they were being genuine about it.” She described how her peers would point out something about the garment itself, if it did not seem to fit properly, keeping the critical focus on the clothing and not on her body:

I remember when I tried on this maxi dress, and I really loved the pattern of it. But they had like really weird seams in the shoulder area. And I was like “these seams just seem kinda weird.” And they were like “yeah, yeah they do. They like pucker a little bit,” and we were kinda talking about that. But they said it like in a way where it was like, maybe that’s just the way that that particular garment fit on you, but that’s fine. There’s nothing bad about that. Not everything is going to fit your body type absolutely perfectly. And maybe something’s wrong with the garment. (Personal interview, 10/10/2015)

Michelle said that it might have been different if she were shopping alone because then her inner critic might come out and start nit-picking. The support of her peers and the positive relationships she had with them were meaningful to Michelle.

Role of therapist in exposure. When describing the role of the therapist during the exposure outing, three subthemes emerged. The therapists offered a balance between support and autonomy, they were non-directive, and they facilitated the process. There were two therapists that facilitated the exposure outing. Michelle noted that the two therapists were different in their approaches to intervention:

One of them was like, really active in picking things out. She was almost like our personal shopper. She would go around and find garments and be like “oh my, do you like this dress?” And then I was like “yeah, I do, I’ll try it on!” type of thing. But then the other therapist was a little bit less interactive. She would wander, provide support if

you needed, but also if you were lingering in one area for a really long time, or one specific garment, like I didn't know if I should get this, I don't know what size I should get, like if you were ruminating over certain thoughts for a long period of time, she would help you be more decisive. She was kinda there to provide support and to help us out a little bit, if she could tell that we were struggling. (Personal interview, 10/10/2015)

Michelle noted that personally, she preferred the approach of the second therapist because she appreciated the balance between independence and having support there, if she needed it. She later suggested that generally, she would prefer the therapists not to be active in offering suggestions of what to try on because she had set goals to push herself and did not think it was necessary.

Balance between support and autonomy. Michelle most frequently described the balance of support and autonomy when reflecting on how the therapists interacted with her and the other patients on the outing. She said, "We had independence, but at the same time, we had support as well. So it was a good balance." Michelle reflected that she felt supported and that she was in a safe environment so that if she felt anxious or had negative thoughts, the therapists were there to help her. She also mentioned that she never felt like she was being monitored: "I just felt kind of the freedom to be how I normally would, you know, without feeling like I was being judged." Michelle appreciated the freedom to be on her own but have a supportive presence nearby in case she needed, as a safety net.

Non-directive. Related to the balance between support and autonomy, the role of the therapist during the exposure was non-directive. Although Michelle described how the therapists would facilitate the process to "move things along" at times, most of the therapists' interactions did not involve firm instructions or strict procedures. When searching for outfits to try on, she

said that they mostly “followed us around” and helped them carry clothing items. Michelle described, “It’s not like they were forcing you to try on anything you didn’t want to try on.” When patients were trying on clothing items in the dressing room, the therapists waited outside the dressing rooms and did not speak during that time: “They didn’t really talk to us at all, other than when we came out in our outfits in front of everyone.” Overall, the therapists did not provide directions to the patients during the exposure; rather, it was semi-structured in nature.

Cluster: Meaning of Experience

The thematic cluster of Meaning of Experience comprised of three themes: 1) practical, real-life experience 2) improved self-awareness, 3) supportive environment. Each of these themes emerged from descriptions Michelle offered about how she attributed meaning to the exposure therapy as part of her recovery from anorexia. Reflections were drawn from the interview and the reflexive journal entry, which prompted about the meaning of the exposure outing experience.

Practical, real-life experience. The most salient theme regarding how Michelle attributed meaning to the exposure outing experience was her belief that it was a practical experience that she could apply to real-life situations. She reflected:

I just feel like, this was more like applicable to your daily life, you know? Like, you’re going to be in situations where you’re gonna be trying on clothes and walking around a store and having to choose things to try on, and having to be comfortable in your body, and things like that. You’re going to have to purchase clothes by yourself, at some point in your life, you know? Whereas, you won’t always have to sit around in a group and share your feelings. So it seemed like something more that I could take with me when I leave. (Personal interview, 10/10/2015)

Michelle believed that one of the most meaningful aspects of the exposure outing was that it was different from the usual therapies of individual and group sessions in the treatment facility. She described the exposure outing as a bridge between learning skills in therapy and using them in real-life:

I think [the exposure outings] really help just kind of 1) break the monotony of everything, and 2) help you feel like you're more prepared and give you the ability to practice the things that you just *talk about* in sessions. So I probably would have felt like I was maybe missing something, that piece of the treatment. It was the bridge. (Personal interview, 10/10/2015)

For Michelle, it was important that what she did in therapy be practical and applicable to her life outside of the treatment center. In her reflexive journal entry, she wrote, “with exposure therapy like the shopping trip, I was able to apply these concepts we learn about into a real life situation.” It was really meaningful to Michelle that her therapeutic experiences be practical and applicable to real-life situations.

Supportive environment. Another meaningful aspect of the exposure outing for Michelle was the supportive environment, including her peers and the therapists. She described the exposure as “a very low-key environment, but it didn't feel like I was being monitored. It just felt like a nice shopping outing with friends.” The exposure outing was memorable for her, especially because of the group of peers that went with her. When I asked Michelle what stuck out most for her during the whole experience, she reflected:

I think just the fun times that I had with the other patients that went as well. Just a fun-loving kind of like light atmosphere throughout the whole thing. We would talk about

good memories that came from it. And just the support that we gave each other. Kind of had like a bond and a unity between all of us. (Personal interview, 10/10/2015)

In her reflexive journal entry, Michelle wrote “I loved shopping with my friends and the therapists because it felt like a very safe environment, and it was very enjoyable but helpful as well.” For Michelle, having a group of people with whom she had positive relationships was a meaningful aspect of the exposure outing.

Increased self-awareness. When reflecting on the exposure outing and what it meant as part of her recovery, Michelle mentioned that her self-awareness increased. During the interview, she said that she has “always had relatively good body image” and that she did not consider her experience of clothing shopping while on the outing to be much different than clothing shopping for her in general. However, Michelle said that she felt more aware of her thoughts about body image:

There were more thoughts of like, “oh, how, how will this fit me?” and the sizes and things like that, how would the style fit me? And I think I was just a little bit more hypersensitive to that, just because of the environment that I’m in. I mean pretty much every day, they’re like “body image, body image, body image.” You know? Like um, like distorted thoughts, that’s just like what’s pumped into your brain like every single day. So I think, now I was probably a little bit more aware of those like body image thoughts, but overall, the experiences were very similar. Both very enjoyable. (Personal interview, 10/10/2015)

In her reflexive journal entry, Michelle wrote: “I learned a lot about myself through this process, for example how it helps me to shop with friends and family and how I can stop negative thoughts by thinking about positive physical and personality characteristics.” Michelle believed

that she has become more self-aware and has practiced how to cope with negative thoughts, if she has them while shopping for clothing in the future.

Case Summary and Researcher Interpretations: Michelle

Michelle described herself as “atypical” in regard to her experience of anorexia, acknowledging that her journey and recovery was different from others. She asserted that her body image had always been relatively positive, which is unlike many women with anorexia, who fear gaining weight because they perceive themselves to be too fat. It was curious to me that she was selected to participate in an exposure therapy intervention, of which the primary stimuli were related to body image and the anxiety surrounding trying on clothing at a store and seeing oneself in the dressing room mirror. She denied experiencing negative thoughts or feelings throughout the exposure, particularly in regard to body image, which seemed counterintuitive to the premise of an exposure intervention (*i.e.*, one works to decrease sensitivity to a stimulus that typically evokes fear or anxiety). I perceived some resistance from Michelle during the interview when I prompted her about negative feelings throughout the exposure. It is possible, however, that she did not experience negative feelings, or she may have had little awareness of them at the time.

Michelle was excited about the opportunity to get off the unit and go shopping for clothing, and she set personal goals to accomplish during the exposure outing. She had a game plan for the outing, and her reflections resembled that of being part of a team and playing a part of a shared outcome. When she realized that the other patients were anxious, she recalled trying to help minimize their anxieties, distract them and pump them up. This interpretation of her experience may align well with her identity as an athlete, which is a familiar role for Michelle.

Although the shopping exposure outing did not have an impact on body image or self-esteem for Michelle, she did perceive it to be a meaningful part of her recovery in other ways. The most important aspect of the experience for Michelle was its practicality, in that she was able to take the knowledge and skills she learned in therapy and apply them in a realistic setting. The importance of practicality aligns well with her identity as an athlete, where she learns exercise drills and game strategies and then needs to practice them before competition. Another related aspect of the exposure outing that was meaningful to Michelle was the supportive environment, where she had peers and therapists whom she trusted. She felt safe because they were there in the case that she needed support, so she was afforded as much independence and autonomy that she needed as an individual.

Recovery from anorexia is a personal and unique journey. Michelle recalled that the restaurant exposure was more beneficial to her because she is most anxious about controlling what she eats (i.e., how healthy it is in relation to her athletic career). She was not concerned about her body image, what size of clothing she wore, and if she appeared fat; rather, Michelle described her concerns to be related to control, perfectionism, and being the best athlete that she could be. Michelle's extreme weight loss was a byproduct of her efforts to maximize her athletic performance. Although the shopping exposure outing was meaningful in certain ways for Michelle, it might not have been as useful as a personal recovery tool because it did not evoke anxiety in the manner that is intended with exposure therapy.

“Jessica”

Jessica is a White female in her early 20s, diagnosed with anorexia nervosa, who has been hospitalized three times prior to our interview. She reported that she was also receiving treatment for Post-traumatic Stress Disorder and Obsessive-Compulsive Disorder, for which she

was prescribed and taking psychotropic medications. Jessica described her diagnosis as “anorexia type II, although I’ve never really had bingeing behavior. I’ve mostly had restricting/purging behavior.” She expressed negative body image and fear of gaining weight or becoming fat. During the interview, she presented in casual attire with bright affect, energetic and somewhat fidgety at times. Jessica seemed to fidget more when discussing her body and self-image.

Several themes and subthemes emerged from the initial interview, reflexive journal entry, and follow-up interview (sources) with Jessica. Descriptive themes were grouped into five thematic clusters, as follows: 1) Anxiety, 2) Expectations, 3) Self-awareness, 4) Supportive Environment, and 5) Impact of Exposure. The clusters, themes, and subthemes are presented in an order that offers flow and clarity, rather than representing differences in importance. See Table 2 for an outline of the emergent themes/subthemes, thematic clusters, and number of sources and references from Jessica’s two interviews and reflexive journal entry.

Table 2

Thematic Clusters and Themes Derived from Jessica's Interviews and Journal Entry

Cluster	Themes, Subthemes	# Sources	# Refs
<i>Anxiety</i>		3	41
	Averse to clothing shopping in general	3	13
	Experienced symptoms throughout exposure	2	10
	Coping strategies	2	18*
	<i>Avoidance</i>	2	10
	<i>Limiting choices</i>	2	4
<i>Expectations</i>		3	15
	Presumptions about exposure outing	3	8
	What patients are supposed to do	1	7
<i>Self-Awareness</i>		3	55
	Lens of anorexia	3	40
	<i>Distorted, negative body image</i>	2	24
	<i>Shame and embarrassment</i>	3	16
	Shift in critical perspective	3	15
<i>Supportive Environment</i>		3	73
	Positive relationships with peers	3	28*
	<i>Inspired by their courage</i>	3	9
	<i>Helped keep self-critic in check</i>	2	8
	Therapist interactions	2	29*
	<i>Gentle push and encouragement</i>	2	12
	<i>Nonjudgment regarding size</i>	1	10
	Safety and trust	2	16
	<i>Shared experience of anorexia</i>	1	7
<i>Impact of Exposure</i>		3	49
	Gained confidence	3	17
	Improved self-awareness, perspective	2	14
	Positive and memorable	3	6
	Felt more connected	2	6
	Normal, real-world experience	2	6

*Note. Number of references for theme may include references that do not fall into an emergent subtheme; therefore, the total for a theme may be greater than the sum of its subthemes.

Cluster: Anxiety

The thematic cluster of Anxiety included descriptions about nervousness, fear, and averseness regarding her experience during the shopping exposure, as well as how Jessica managed those feelings. Four themes emerged: 1) averse to clothing shopping in general, 2) feared this particular exposure the most, 3) experienced symptoms throughout exposure, and 4) coping strategies. Two subthemes emerged within the theme of coping strategies: 1) avoidance, and 2) limiting choices. Jessica's descriptions included anxious feelings that she experienced before and during the exposure outing.

Averse to clothing shopping in general. Jessica mentioned numerous times that she generally did not enjoy shopping for clothing and that it was a stressful experience for her personally. During the initial interview, she recalled the ride over to the clothing store with her peers and the therapists: "I was just really, [light laughter] really nervous and thinking of everything else I'd rather do instead!" In her journal entry, she reflected,

I had developed a strong aversion to even trying to go clothing shopping... Even getting out of the cab when we got there, I was pleading to go to a different store (not for clothes) or even trying to just apply for a job there instead of shopping. (Personal communication, 06/08/2014)

During the follow-up interview, I asked Jessica what in particular about clothing shopping makes her averse. She explained:

Just the mentality that I had when my eating disorder stuff has been at its worst was just that I never wanted to go there. I didn't want any kind of external validation, positive or negative, coming from clothing size, coming from whatever else (Personal interview, 07/01/2014).

Jessica reported that she had been on other exposure outings with the recovery program; however, it was the shopping exposure that she feared most of all. She reflected:

When they pulled us out, right before, I definitely was nervous because I struggle a lot with body image, especially since I've been here and in the recovery process, and um, gaining weight and just like that's been amplifying all of the body image issues I'd already had (Personal interview, 06/01/2014).

Because clothing shopping was a fearful activity for Jessica, this particular exposure therapy had the potential to address her anxieties about the process.

Experienced symptoms throughout exposure. Jessica described symptoms of anxiety throughout the exposure protocol, from when the patients were first informed that they would be going and all during the outing. Jessica remembered rating her anxiety level as “moderate to high” before leaving for the clothing store. She recalled having physical symptoms of anxiety as well:

I definitely had like butterflies in my stomach [smiles, laughs], definitely um, going in. Going in, just like um, tense, um tense-ness. Cuz I could feel it like in my shoulders, just associated with the anxiety, just even like walking around the store (Personal interview, 06/01/2014)

Jessica was worrying about what she would pick to try on and how she would be comfortable trying on clothing and showing her peers. During the interview, she described how her anxiety manifested physically:

I did have like a weird like posture. I was like really nervous stepping out [of the dressing room]. I would peek out of the room and I would almost like draw [my] leg up, like I was trying to hide from them looking at me. It was like a desperate last ditch effort, even

though I knew they were gonna see me anyway. Um, so a lot of anxiety with that
(Personal interview, 06/01/2014).

Jessica also had nervous thoughts about the exposure. She recalled having anxious thoughts related to her body image, gaining weight, and whether she would find clothing that she felt comfortable trying on in front of other people. In her reflexive journal entry, she wrote about how her anxiety increased when trying on clothing to show her peers: “It’s one thing for me to have to deal with hating myself in the mirror when I try on new clothes, but to have to show other people?” The fitting room part of the exposure evoked the most anxiety for Jessica, mostly because of confronting her body image and then showing the outfits to her peers. She did mention, however, that although she felt anxious throughout the exposure, her anxiety subsided somewhat as time went on.

Coping strategies. Jessica managed her feelings of anxiety in various ways throughout the exposure protocol. A few times, she made reference to “countering her negative thoughts” (also known as *reframing* in cognitive therapy), which is a strategy she learned while at the recovery program. Jessica mentioned that she planned to employ this strategy while on the shopping outing as necessary, to cope with her anxiety about trying on clothing and confronting her body image issues. However, while describing how she dealt with anxiety throughout the exposure, two subthemes emerged: 1) avoidance, and 2) limiting choices.

Avoidance. For Jessica, the most stressful point in time during the outing was trying on clothing in the fitting room. Given her averseness to clothing shopping, she admittedly would have rather avoided the outing altogether than go through it. Throughout the protocol, there were several instances in which she practiced avoidance in an effort to manage her anxiety. For example, she recalled not allowing herself to be exposed to her full body image in the dressing

room mirror: “I wouldn’t let myself be like completely naked in front of it. If I was trying on a shirt, I’d make sure I already had my pants on, or vice versa. I couldn’t, um, do the whole-body thing.” Jessica reflected that the fitting room portion of the exposure outing was fast-paced, making it easier for her to avoid confronting her body image. She recalled, “We really didn’t spend too much time in the fitting room. It really was rapid fire, trying on, and then coming back out and seeing each other. Which was better, good!” The group dynamic between Jessica and her peers contributed to the fast pace, ultimately helping her to avoid obsessing in the mirror.

During the follow-up interview, Jessica reflected on a shopping experience she had after being discharged from the hospital program. She remembered employing a similar strategy while trying on clothing to cope with her anxiety:

I found a couple of things, and I tried them on, and I guess similar to when we did the excursion, I didn’t spend too much time on it. I’d put them on, and if it doesn’t feel great, and I’m not gonna wear it all the time, then I didn’t bother with it. And I went to the next thing, and call it a day (Personal interview, 07/01/2014).

Maintaining a fast pace and avoiding spending too much time looking in the mirror was helpful in keeping her anxiety at a manageable level, and Jessica carried this coping strategy forward after the exposure outing.

Limiting choices. During the initial interview, Jessica talked about how shopping can be overwhelming because there are so many options available. She mentioned that she likes to shop in the clearance section because “sometimes there’s not as much size flexibility, like it’s just one size in that,” which reduces her number of options and thus makes her choices easier. During the follow-up interview, I asked Jessica to elaborate on how limiting the number of choices helps reduce her anxiety. She reflected:

I think it's helpful if there's a way to limit choices, whether it's already limited or I put restrictions on it, looking at cost or something else. I think it reduces the stress a little bit, where I don't feel as overwhelmed with the choices (Personal interview, 07/01/2014).

Jessica elaborated further about her budget-conscious spending. She said, "There's also suggestion that it's related to image and self-worth," but she did not believe that was true for her. Jessica thought that having a limit on how much she spends makes the choices more limited and thus easier for her.

Cluster: Expectations

When reflecting on the shopping exposure, Jessica expressed some assumptions about the experience and anticipated how things would likely go during the outing. She had been on other exposure outings during her recovery program, but this was her first clothing shopping exposure. While describing her thoughts about this particular outing, two themes emerged: 1) presumptions about clothing shopping, and 2) what patients were supposed to do.

Presumptions about clothing shopping. Related to the theme of averseness to clothing shopping in general, Jessica anticipated how things would go on this particular exposure outing. She reflected on her thought process at the beginning of the exposure:

Going in, I just had this assumption that I was like, "nothing was going to fit me anyway." Because I had been able to find thing that might fit in one part, but then they are like too tight in other area. Or it fits in one area, and then it's too baggy elsewhere. Like I just don't fit any size. And so I'd go in, and that's kinda what started. I'd look at stuff and [think] like "It's not gonna fit me, why even bother?" (Personal interview, 06/01/2014).

Jessica believed that no clothing item she found or tried on would fit her, and she anticipated that she would become upset and frustrated. She attributed these presumptions to previous experiences of clothing shopping on her own during the recovery process. In her reflexive journal entry, she wrote:

Due to having gained weight since beginning treatment, I had already attempted to go shopping on my own prior to the group trip, and it historically hadn't gone well. I'd been self-conscious, disgusted, upset, and typically, just too frustrated to have any success at all. (Personal communication, 06/08/2014)

Jessica expected that just like before, she would end up frustrated when trying on clothing during the shopping exposure because nothing would fit her. When I asked her about what it was like trying on clothing in the fitting room, Jessica began to affirm her expectations that nothing would fit. She reflected:

It's hard to put on anything, and my first inclination is, "See, I was right, I said it wasn't gonna fit!" Cuz that's how I looked at everything coming in. It wasn't gonna work. And a lot of just comparing myself to where I had been and having difficulty accepting that (Personal interview, 06/01/2014).

When describing her expectations of trying on clothing in the fitting room, Jessica believed that it would be a similar, negative experience as it had before. However, related to the theme below about what patients are supposed to do on the exposure outing, the process of showing her peers the clothing she tried on altered her expectations.

What patients are supposed to do. When I first asked Jessica about the procedures of the exposure outing, she described some general expectations of what the patients would do while shopping for clothing. Some expectations were verbalized by the therapists, and others

expectations seemed to be unspoken or perceived. Prior to leaving for the exposure outing, Jessica said that the therapists discussed expectations with them, such as selecting at least a few items to try on while shopping, and to select clothing items that were somewhat outside of their comfort zones. The staff also said that the patients were not required to purchase clothing items, if they did not want. While shopping, Jessica recalled selecting clothing items: “There was definitely like a gentle push from one of the staff with us to kinda look at other things that maybe I wouldn’t have otherwise tried on.” Jessica said that she appreciated this expectation as the main purpose of the exposure.

When talking about the experience of trying on clothing in the fitting room, Jessica described some perceived expectations, along with those verbalized by the staff. She recalled, “And then all went back to the fitting room together and tried stuff on. And then I realized that they wanted us to come out every time we tried something on and get feedback.” This was not a verbalized expectation of the outing; rather, it was unspoken and seemed to be a phenomenon of the group dynamic. Jessica perceived this process to be helpful because it kept her from obsessing in the fitting room:

I kind of got like, snapped out of it because one of the girls was coming out of her dressing room with something on, and I realized that was the expectation. We were supposed to like, go out and see each other. And so it snapped me out of it. I didn’t have as much time as I usually spent looking and obsessing about things (Personal interview, 06/01/2014)

Because Jessica perceived the peer feedback process to be an expectation, she spent less time in the fitting room, where she anticipated the most negative experiences of confronting her body image would happen. This dynamic, facilitated by Jessica’s coping strategy of avoidance,

contributed to her experience being less negative than she had expected it to be because she did not have as much time to criticize herself in the mirror.

Cluster: Self-Awareness

Jessica expressed keen self-awareness and insight when reflecting on her experience of the clothing shopping exposure. The thematic cluster of self-awareness comprised of two themes: 1) lens of anorexia, and 2) shift in critical perspective. Each of these themes emerged from the reflections that Jessica provided about her internal thought processes and reactions to the exposure outing.

Lens of anorexia. The most salient theme for Jessica, throughout both interviews as well as her journal entry, was about how she perceived herself through the self-critical lens of anorexia. This theme comprised of two subthemes: 1) distorted, negative body image, and 2) shame and embarrassment. The particular exposure therapy Jessica experienced involved confronting her body image in a fitting room mirror, which is generally an anxiety-evoking practice for Jessica because she is very critical of herself. When I asked what it was like to try on clothing in the fitting room, Jessica reflected, “It’s been the same struggle I’ve had when I’ve been trying to go shopping, since I’ve been here and since being in this recovery phase of this world [chuckles]. It’s been um... definitely like 100% critical.” She described obsessing about her perceived flaws and not feeling comfortable with how she appears, all of which she was keenly aware.

Distorted, negative body image. Body image distortion is prevalent in women with anorexia, and the descriptions Jessica offered were congruent with this notion. During the interview, she reflected, “That’s something I struggle with. And rationally, I do have a distorted body image, that what I see isn’t an accurate reflection of how I actually look.” Jessica was

aware that what she perceived about herself in the mirror may not be an accurate reflection of how she appears to others objectively.

Jessica recognized that her distorted body image also applied to the size of clothing that she chose to try on and how that affected her experience. She described frustration in choosing a clothing item that would have fit her before she restored weight:

I still am kinda figuring out how to go shopping in the new size that I am. Because the clothes that I'll like pick up and think will fit me are what my mind recognizes *used* to fit me. And so I get really frustrated in the fitting room when it's like, very wrong (Personal interview, 06/01/2014)

Jessica had a difficult time reconciling the difference in her body size from before to after the weight restoration process and chooses clothing that is vastly different from the size she actually wears. Her body image distortion makes it challenging for her to choose clothing to try on in an appropriate size, whether it is too small or too large in comparison with her body. Jessica recalled, "That is a hard adjustment because I used to go in with different sizes, and even when I accept some size difference now, I still sometimes undershoot it. And sometimes overshoot it. Goes both ways." In her reflexive journal entry, Jessica noted that not knowing her current size was one of her two main concerns about going on the exposure outing.

Shame and embarrassment. Jessica expressed shame and embarrassment in relation to clothing shopping and how she views herself. She noted that in general, she prefers to hide her body in conservative clothing, particularly darker colors. Jessica described her comfort zone: "Almost always darker colors, nothing at all that would be overly flattering, or nothing that would show certain parts. Just a little more conservative things, I've just been more comfortable

in.” She offered examples of how she preferred longer sleeves down to at least her elbows and baggy pants.

During the interview, Jessica reflected, “It’s so much easier for me to hide in like, sweatshirts and sweatpants.” Wearing clothing that was form-fitting or showed much skin made her feel self-conscious and insecure. Jessica was also aware that clothing size played a role in her feelings of shame. She described her thought process in finding the right size:

If I go a size up is gonna be too big, or I can’t possibly go a size up cuz I don’t wanna own something that’s like *that size*. I’ve never owned that size of something before, so I’m just not gonna get anything. Which has been big problem in my head because I’ll try and go shopping because I need clothes, but I’m so reluctant to get anything that’s a certain size and then just leave with nothing. And then, I’m in the same predicament and just more frustrated (Personal interview, 06/01/2014).

Jessica was aware that she had gained weight in the restoration process, but she felt ashamed to try on clothing in a larger size than she was prior to recovery.

The second biggest concern for Jessica regarding the exposure outing was having to shop for clothing with other people, and her concern was related to feeling embarrassed. In her reflexive journal entry, she wrote:

It’s one thing for me to have to deal with hating myself in the mirror when I try on new clothes, but to have to show other people? I was not looking forward to that, no matter how much I liked and trusted them (Personal communication, 06/10/2014).

Jessica said that she felt nervous about being in the group setting because she was self-conscious and worried about being judged by others based on her body appearance. She was keenly aware

of how critically she viewed herself, the distortion in her body image, and her feelings of shame and embarrassment, which were the main reasons she was anxious about the exposure outing.

Shift in critical perspective. Jessica did not experience self-critical thoughts throughout the entire protocol. She described a shift in her critical perspective during the exposure. During the initial interview, Jessica recalled that she was surprised how much fun she had on the exposure outing, and she said, “It was really refreshing, I’ve never felt that I could try something and actually like it or be comfortable in it.” The exposure outing started out as she expected, with anxiety and embarrassment; however, it ended with a shift in Jessica’s perspective from negative and critical to a more positive, confident outlook.

Jessica attributed much of this shift to the group dynamic and receiving feedback from her peers and therapists when trying on clothing. In her reflexive journal entry, she described how positive feedback from her peers helped to replace her self-criticism. She wrote, “[It] was actually really encouraging: just to have each other’s feedback on things, which was always positive! It was awesome to replace my incessant negative self-talk with their positive feedback.” The positive feedback from her peers and the staff challenged her inner critic and contributed to the shift in her perspective.

During the follow-up interview, Jessica elaborated further about her critical perspective, expressing awareness that it may not be accurate. She reflected:

When we were [at the clothing store], I had those thoughts like it’s horrible, this looks terrible on me. But then, it was so incredibly, so strongly challenged and countered by what [clinician] and [other two patients] were saying. I’m so sure something’s gonna be negative, thinking bad about myself. But then being aware that other people were

showing the opposite, like a very positive reaction. It's proof that maybe my inner dialogue isn't really all that accurate. (Personal interview, 07/01/2014)

The positive feedback that Jessica heard from her peers and the therapists directly contradicted her own negative, critical thoughts, which challenged her to practice a more positive outlook of herself. The shift in her critical perspective was facilitated by the supportive environment, which is outlined in the following cluster.

Cluster: Supportive Environment

Numerous themes emerged during analysis regarding the support that Jessica perceived from her peers and therapists that were with her during the exposure outing. The thematic cluster of Supportive Environment had the most references of all clusters in Jessica's case, indicating that she spoke about perceived support most frequently. Three themes comprise this cluster: 1) positive relationships with peers, 2) therapist interactions, and 3) safety and trust.

Positive relationships with peers. Jessica had already established relationships with the other two patients who were on the exposure outing, and she considered them to be her friends while in the recovery program. Every reference Jessica made about her peers was positive, describing how they encouraged her when trying on clothing, provided positive feedback, and helped to boost her confidence in trying new things. During the initial interview, she recalled how much fun she had shopping:

One of the girls was like making funny faces and joking about stuff and totally lightened the mood to the point that I was excited to try on the next thing and get feedback. So it ended up being way more fun than I thought it was going to be! (Personal interview, 06/01/2014)

Initially, Jessica was anxious about shopping with other people because she feared their judgment in addition to her own self-criticism; however, having already established positive relationships with her peers on the outing, she was able to enjoy herself and accept their encouraging feedback. The process of trying on clothing with peers, whom she considered friends, helped her to gain confidence that she could try on clothing items outside of her comfort zone. She reflected,

I just remember their feedback [and] I was like “alright, well I guess maybe I can do this!” So now I have a pink colored tank top, and I got this shirt there too [participant motioned to the shirt she was wearing], and I got a dress the next day [laughs] so it was like, whoa! (Personal interview, 06/01/2014)

Jessica felt a boost in her confidence as a result of her peers’ interactions, which encouraged her to try on clothing items that provoke anxiety in her. In her reflexive journal entry, she reiterated, “Their positive reactions boosted my confidence enough to then consider trying on dresses, which I would have definitely not even considered on my own.” The encouragement from her peers was especially helpful for Jessica during the exposure, and it proved to her that trying on clothing (particularly with other people) could be a positive experience.

Inspired by their courage. When referencing her peers, Jessica often spoke about how bravely her peers were while shopping on the exposure outing. During the initial interview, she recalled how one of her peers jumped right in: “We got into the store, and of the three of us girls, one of them started right away looking at different things to try on, which I respected. I was like, that’s awesome that she can do that!” Jessica remembered how their confidence in picking out clothing to try was inspiring to her. She reflected, “I admired their boldness in whatever they were trying on and their confidence in how they came out, and kind of wanted to emulate that.”

Jessica reiterated in her reflexive journal entry how one of her peers in particular was very confident, which inspired her to act more confidently as well: “[Peer] was more gutsy and just started to go for it and look around, which inspired me, and I also started walking around and eventually started picking up a few things.” During the follow-up interview, Jessica mentioned how seeing her peers act confidently prompted her to find her own confidence as well. She reflected, “Thinking about that trip, especially it being with the other girls [that] were there, and how they were able to find their own little confidence streak, I was like maybe I can do it too!” Both in watching her peers and interacting with them on the exposure outing, Jessica felt inspired and more confident to try on clothing herself, making her experience more positive.

Helped keep self-critic in check. The positive and encouraging interactions with her peers helped Jessica to keep her self-criticism at bay. As previously noted, one of the reasons that Jessica typically avoids clothing shopping is because she becomes anxious and begins obsessing about her body image in the mirror and criticizing herself. During the initial interview, she reflected, “All my negative thoughts were being replaced with all four of them, their positive feedback, like ‘that’s so cute, you should really get it!’ And it seemed real, not just like they felt they had to say it.” Receiving feedback from her peers about how the clothing items fit helped Jessica to redirect her inner critic.

Jessica also found it helpful that her peers offered feedback when a clothing item did not fit well. She recalled, “It was always about the fabric. It wasn’t about me whenever it was anything that wasn’t working. But it was never overly critical, it was just kind of an honest assessment of things, which made me trust [them] better.” In her reflexive journal entry, she reiterated, “Even if an item didn’t look great, it was always about that piece of clothing, rather than my body.” Jessica was able to internalize how her peers critiqued the clothing items because

she believed that her peers' perceptions were more honest than her own: "The biggest difference, as opposed to when I'm by myself, is the fact that we were stepping out and looking... we were each other's mirrors instead of like, the mirror inside the fitting room." Jessica was able to keep her self-critic in check with the help of her peers, who modeled appropriate self-talk, offered her positive encouragement, and were not criticizing her body.

Therapist interactions. When talking about the therapists who were facilitating the exposure, Jessica described a balance of support and autonomy. She noted, "There were two of them, three of us. So they were just kind of like floating around, and like checking in." Jessica described that the exposure outing felt natural and not directive or clinical. During the initial interview, she reflected: "I think that helped. It wasn't like, these are the rules and expectations. Like it wasn't, you have X amount of time, and you only have this amount to do it. It really felt like a casual outing." Jessica noted that she did not feel pressure from the therapists, and she perceived that to be helpful.

Gentle push and encouragement. Along with support, Jessica described how the therapists would gently challenge the patients throughout the exposure process. She did not feel forced to select items or purchase; rather, she considered their encouragement to be helpful. During the initial interview, Jessica explained that conservative clothing in darker colors was in her comfort zone and that it would be difficult for her to wear brighter colors or items that were form-fitting. She recalled how the therapists would encourage her to try something different:

[Clinician] came over and was like, "What's going on, what are you looking at?" I was looking for navy pants because I could use them for work. And she was like "alright, that's great! But I see that you're holding a navy shirt and some navy pants and a black shirt. [Jessica laughed] Maybe pick something else... have you thought about trying..."

and that's kind of where the dresses came into play, or the rompers. Just because I hadn't been comfortable in that. And so that kinda became the push. (Personal interview, 06/01/2014).

Because she did not feel pressured and perceived support from the therapists, Jessica felt comfortable and safe enough with their supportive presence to do something that she would not have done on her own.

Nonjudgment regarding size. Related to the Lens of Anorexia theme, Jessica felt self-conscious about what size clothing she would wear, and she felt ashamed that she has gained weight during recovery. It was helpful that the therapists did not call attention to what size of clothing she needed to try on. Jessica reflected on when she felt anxious and frustrated in the fitting room because of the clothing sizes, and how the therapists offered her support:

The staff made a point of, they would go get a different size. I felt embarrassed by it in general, just cuz I would like to know my own size on things, but they made it not even an issue at all. And it helped make me feel better about things. Cuz when I'm by myself, I get frustrated when I get the wrong size. I don't feel like trying on anything else (Personal interview, 06/01/2014).

The therapists did not call attention to what size she needed or was trying, and they did not make judgments about size at all. Jessica recalled another example of how the therapists helped her feel more comfortable by not judging her size:

At one time, there was a dress I did kind of like, but it was too small, but I felt comfortable enough to be like, "yeah, it doesn't really zip up all the way." And, there was no judgment. There wasn't any laughter or anything like that. It was just like "Cool, let's try a different size." Like there wasn't any judgment. And that was... considering all the

judgment that I had on myself, it was refreshing to not have any judgment from them.

(Personal interview, 06/01/2014)

The therapists offered encouragement and support for Jessica to select whatever would fit her comfortably, rather than expressing any judgment about her size, which alleviated much of her anxiety about trying on clothing in the fitting room.

Safety and trust. Throughout the interview, while discussing her relationships with peers and interactions with the therapists, Jessica described feelings of safety and trust that contributed to the supportive environment of the exposure outing. She had already established positive relationships with the other patients because they were in the recovery program together. During the initial interview, Jessica reflected on how having people she trusted helped her to process her anxiety. She recalled, “Two other girls who I’m already friends with here and comfortable with, [and] the staff members that were going, I trusted and liked. So, that helped abate the anxiety a little bit.” Jessica believed that it was important to go through the exposure with people she already trusted:

When they do the excursions here, it’s people who have been in the partial program for like a little bit of time already. And so it’s people who you’ve like already kind of trusted or got to know within the community here. And so I just think that it helps to get off the unit and still bring those friendships and relationships with us, and it helps to like help us through whatever we’re doing (Personal interview, 06/01/2014).

Jessica also felt that she could trust her peers when they offered her positive feedback because she had already established relationships with them. She reflected, “It was all positive feedback. And it seemed genuine, too. It wasn’t just like, we were supposed to say nice things. It was like genuine.” Related to the shift in critical perspective theme, Jessica was able to and confront her

negative self-image because she was receiving positive feedback from people she believed to be trustworthy and honest.

Shared experience of anorexia. Part of what contributed to Jessica's feelings of safety and trust with her peers was that they understood what it was like to have anorexia. She offered an example of a previous shopping experience with a friend who did not have an eating disorder:

The friend I was with, I just don't think I was as comfortable with, and she didn't have a similar experience and any kind of eating disorder... I just don't think could relate. I just assumed it meant that I was gonna always want to go shopping with myself. But I think being with a group of people who were especially sensitive, but also aware of it and could relate to it [was helpful]. (Personal interview, 06/01/2014).

Jessica reflected that although she and her peers may have unique journeys through recovery, it was helpful to be with people who understood what she was going through.

During the initial interview, there was a moment when Jessica realized how her self-critical perspective shifted, and how that was facilitated by the shared experience of anorexia she had with her peers. She reflected:

We all have some similar experiences or some shared thought processes, I could imagine that they will look in the mirror and think something different or flawed about themselves, but I didn't see that when I looked at them. I saw that they looked awesome in what they were wearing. So, it's a way of countering myself, if I can see them and think they look awesome in these new clothes, it's very real that maybe they looked at me and also thought that I looked good in whatever clothes I was wearing (Personal interview, 06/01/2014).

Because Jessica trusted her peers' perspectives, through their established relationships and shared experiences of recovery from anorexia, she was able to accept their feedback and challenge her own self-critic in a way that she may not have with someone who did not have anorexia.

Cluster: Impact of Exposure

The thematic cluster of Impact of Exposure comprised of five themes: 1) gained confidence, 2) improved self-awareness, perspective, 3) positive and memorable, 4) felt more connected, and 5) normal, real-world experience. Themes emerged from the descriptions that Jessica offered about how the exposure outing affected her recovery from anorexia and the meaning she attributed to that experience. Reflections were drawn from the initial interview, reflexive journal entry, and follow-up interview.

Gained confidence. The most salient theme regarding the impact of the exposure outing for Jessica was that she gained confidence that she did not have before the experience. She described the exposure as “a surprising confidence boost.” During the initial interview, Jessica reflected, “That trip like *legit* gave me so much more confidence that I had not anticipated. I see it as a really good shift of just accepting where I’m at now and being OK with that.” In her reflexive journal entry, she reiterated:

I couldn't believe how much better I felt about myself. Even though I decided not to get a dress on the trip, I was inspired enough to actually go out the next day and try on some other clothes, and surprised myself by buying a dress! I still can't believe how much the confidence I gained on that one trip has carried forward and translated into other aspects of my life, too (Personal interview, 06/08/2014).

The exposure outing was meaningful to Jessica because she gained the confidence to go clothing shopping, try on items outside her comfort zone, and purchase an item that she would have never done before the experience.

During the follow-up interview, Jessica recalled how going through the process with the support and encouragement of her peers helped her realize that she could have a positive clothing shopping experience on her own. She reflected, “I can think back to what they were saying, and how encouraging they were that I could just imagine that they were still there, even when I was by myself.” Jessica gained the confidence she needed to attempt clothing shopping again and have a positive experience.

Improved self-awareness, perspective. Related to the theme of shift in critical perspective, Jessica noted how her self-awareness and perspective improved as a result of her experience on the exposure outing. During the initial interview, she reflected:

To be able to have this experience and be able to challenge all of the thoughts I had about it, and in such a positive light, and actually for the first time in a while feel good about the changes that have happened in the recovery process. And realize that it’s a good thing, and that it’s a healthy, positive thing, and it’s not actually the end of the world that I’ve gained weight, is definitely a very, very motivating and impactful thing (Personal interview, 06/01/2014).

Jessica realized how her perspective had improved as a result of the experience, which was a meaningful aspect of her recovery.

Jessica also referred to the exposure as a “positive reality check,” noting how she was able to see that her perspective could improve during recovery. Jessica described, “It’s just a different shift. I think it’s [being] able to see that things really do change. It highlighted how

things already have changed.” Prior to the exposure, she would assume that shopping for clothing would be a negative experience; however, after the exposure, Jessica was able to reflect on her perspective and improve her self-awareness related to her body image while clothing shopping.

Positive and memorable. When reflecting on the exposure outing, Jessica considered it to be a positive experience. She noted, “It was definitely way more fun. Like that was probably the best shopping experience I’ve ever had in my life!” Jessica did not expect that the shopping exposure outing would be such a positive experience, as it had typically resulted negatively in the past for her.

Jessica also considered the exposure outing to be memorable, and she often reflects on her experience when reminded by the clothing she purchased. During the initial interview, she reflected,

And I love even just looking back at the clothes I got, and remembering the experience.

Because I feel such a strong attachment to those clothes because I’m like, “it was awesome!” I was pleasantly surprised by how much that trip helped. (Personal interview, 06/01/2014)

Jessica also wrote in her reflexive journal entry about how looking at those clothing items reminds her of the positive experience she had. She noted:

So now, mixed in with all my other dark & looser clothing, I have a pink tank top, a dress, and a pair of awesome pants. Every time I wear them, I remember the encouraging comments and feedback from that day.” (Personal interview, 06/01/2014)

The clothing items that Jessica purchased served as meaningful mementos that reminded her of the positive experience she had shopping for clothing. During the follow-up interview, Jessica

described how doing things that are fearful, and associating something positive with those fearful things, is helpful in recovering from anorexia:

One thing that they always talked about was the importance of creating positive experiences. I feel like being on the excursion in general, being in a group of people, and I think that helped, I was with people that I already knew and got along well with, and respected, and just being able to look back on that and have that be a positive experience, so relate it to clothes shopping. (Personal interview, 07/01/2014)

Jessica reflected on the “importance of creating positive experiences” as part of her recovery, and she considered the exposure outing to be an impactful and meaningful positive experience with something she generally considers to be fearful.

Felt more connected. Related to the theme of positive relationships with peers, Jessica described how she felt more connected with her peers after the exposure outing experience. During the initial interview, I asked Jessica how her recovery might have been different had she not gone on the exposure outing. She described:

I think I would’ve felt a lot more isolated. A lot more in my own world. I’ve made some amazing connections and relationships with friends here, other peers, but I still always kinda felt isolated, kinda felt lonely. Because everyone’s journey is different, and everyone’s experience going into it and during it are different. (Personal interview, 06/01/2014)

Jessica believed that going through the exposure outing with her peers established a more meaningful connection with them, which helped her to feel less isolated. She reflected, “Being with a group of people, and having it be such a supportive and such a positive experience, just made me feel a lot more human and a lot more connected.” During the follow-up interview,

Jessica further said that having the shared experience helped build relationships with her peers: “I’m still in touch with those girls, too. So I think that’s another thing that helps, that we have that shared experience... we still talk about it, actually!” For Jessica, going on the outing with her peers, and feeling more connected with them in the process, was a meaningful aspect of the experience.

Normal, real-world experience. Jessica talked about how the exposure outing felt like a normal shopping experience. She believed that this helped her to feel less judged by people around her. In the initial interview, Jessica described:

It really felt like a casual outing. I mean we were definitely aware that we were in a program and we were with counselors, but I don’t even think it was necessarily that obvious to the people that worked there... it just seemed like it was a group of people. It didn’t have a clinical feel to it. It didn’t have a treatment program feel to it. (Personal interview, 06/01/2014)

Although Jessica was aware that she was shopping with her peers and staff from the treatment program, it was not apparent to people at the clothing store. She continued:

And I think that helped a lot because it was a good distraction too. Like I wasn’t there thinking and obsessing about the fact that I was only there because I had an eating disorder. Like, I was there cuz I was looking for new clothes! (Personal interview, 06/01/2014)

Because the shopping experience was normalized, it helped Jessica to feel less self-conscious and not worry about being judged by others, making it more meaningful and impactful for her.

Case Summary and Researcher Interpretations: Jessica

Jessica was averse to clothing shopping in general, and the thought of shopping for clothing with her peers evoked even more anxiety for her. Her main concerns were related to her body image, having gained weight in recovery treatment, not knowing what size she would wear, and having to try on clothing for other people to see. Jessica preferred to “hide” in conservative clothing that does not show her figure. She would avoid looking at herself in the mirror completely or for extended periods of time to manage her anxiety. Jessica experienced anxiety from the moment the staff told her they were going on the shopping outing and throughout the exposure, which increased when it was time to try on clothing and subsided as she received positive and nonjudgmental feedback from her peers and therapists. In hearing her perspective about clothing shopping and her negative body image, my opinion was that this type of exposure intervention seemed appropriate for Jessica because the stimuli (*i.e.*, selecting clothing items and trying them on in the fitting room) evoked anxiety, in which the therapists could intervene and help Jessica to process.

According to Jessica, there was minimal therapeutic processing during the exposure outing, although she recalled processing with the therapists both before and after the exposure. When reflecting on her experience, she described how her anxiety subsided over time throughout the exposure. From her perspective, hearing positive feedback from her peers, whom she trusted and had already established relationships, helped her to feel more confident in trying on clothing. Jessica also mentioned that the therapists were nonjudgmental about the size of clothing she tried on, which helped her to feel less self-conscious, and they challenged her gently to try on items outside her comfort zone. This supportive environment played an important role in Jessica’s positive experience.

Jessica was very self-aware and offered insights about her thought processes throughout the experience, including her negative body image and feelings of shame and embarrassment. Related to the supportive environment, Jessica recognized a shift in her critical perspective related to the process of receiving feedback from her peers. Jessica reflected that her peers served as her mirror instead of the reflection she saw in the actual mirror during the fitting room process. Because she trusted their opinions, and she was able to offer them genuinely positive feedback, Jessica realized that it was possible for her to look good, regardless of what size the label said or if it revealed a perceived flaw. She was able to accept that a change in her self-image was possible.

The shopping exposure was a meaningful and impactful experience for Jessica. She gained confidence in herself to try on new clothing items outside of her comfort zone, and she realized that shopping for clothing could be a positive experience. Jessica also improved her perspective and self-awareness, describing a shift in her critical self-image that was facilitated by feedback from her peers and nonjudgmental therapists. She considered the exposure to be a positive and memorable experience in which she felt more connected, and she is reminded of what she gained from the experience when she wears one of the clothing items she purchased while on the outing. Further, because the exposure outing was normalized and occurred in a real-world setting, Jessica believed that it was more impactful and attributed greater meaning to the experience. She was able to carry some of the things she learned while recovering in the hospital with her as she recovered after being discharged from the program.

“Rachel”

Rachel is a White female in her early 20s diagnosed with anorexia nervosa. She specified that she had “restricting type” anorexia. Rachel reported that she had been hospitalized several

times in the past for other mental health concerns including depression and anxiety, for which she was prescribed and taking psychotropic medications; however, she had never been hospitalized for an eating disorder. Rachel expressed negative body image and anxiety about having gained weight in recovery. She presented to the initial interview well kempt, with her hair styled and wearing cosmetics, and she had bright affect. Rachel appeared nervous at first, but not more than may be expected when meeting someone for the first time. She fidgeted occasionally when talking about aspects of the exposure outing that provoked anxiety for her.

Several themes and subthemes emerged from the initial interview, reflexive journal entry, and follow-up interview (sources) with Rachel. Themes were grouped into five thematic clusters: 1) self-awareness, 2) supportive factors, 3) barriers, 4) meaning of exposure, and 5) suggestions. Themes are presented in an order that does not signify degree of importance; rather, they are discussed in a manner that promotes flow and clarity. See Table 3 for an outline of thematic clusters, emergent themes/subthemes, and number of sources and references for each theme from Rachel's interviews and reflexive journal entry.

Table 3

Thematic Clusters and Themes Derived from Rachel's Interviews and Journal Entry

Cluster	Themes, Subthemes	# Sources	# Refs
<i>Self-awareness</i>		1	67
	Anxiety	1	20
	<i>Avoidance and distraction</i>	1	5
	Body image	1	32*
	<i>Triggers for negative body image</i>	1	19
	<i>Influence of mood on experience</i>	1	11
	Personal goals	1	16
<i>Supportive Factors</i>		2	34
	Positive relationships with peers	2	14
	Role of therapists in exposure	1	20*
	<i>Participated in shopping</i>	1	8
	<i>More like friends than clinicians</i>	1	7
<i>Barriers</i>		2	39
	Unstructured exposure protocol	2	22
	<i>Unclear purpose and goals</i>	2	13
	<i>Minimal guidance</i>	1	9
	Not her individual therapists	1	6
	Lack of support during transition	1	12
<i>Meaning of Experience</i>		3	25
	Enjoyable experience	3	8
	Real-world practice is important	2	5
	Memorable, but not impactful	3	12
<i>Suggestions</i>		3	30
	Go on more exposure outings	3	7
	Processing of emotions during exposure	2	14
	More structure and intentionality	2	9

*Note. Number of references for theme may include references that do not fall into an emergent subtheme; therefore, the total for a theme may be greater than the sum of its subthemes.

Cluster: Self-awareness

Throughout the initial interview, Rachel expressed profound insight into her thoughts and feelings surrounding the exposure therapy experience. The thematic cluster Self-awareness

comprised of three themes: 1) anxiety, 2) body image, and 3) personal goals. Each of these themes included descriptions about what contributed to her anxiety and how she managed her feelings, thoughts about her body image and what influenced her thoughts, and her personal goals for the exposure outing.

Anxiety. During the initial interview, Rachel reflected on how her anxiety fluctuated throughout the exposure protocol, with certain aspects of the exposure evoking more anxiety than other parts. She said that the exposure outing was a surprise to her and the other patients, as the therapists told them that they were going very shortly before they left. Rachel remembered feeling increasingly anxious on the ride to the clothing store:

My heart started racing a little bit. I got a little jittery and my legs started shaking, just one sign that I am very anxious. Something that I can't really control very much. Once we got into the car, I was like okay, we are really doing this. Like it's not a joke, it's not a lie. We're definitely going shopping. (Personal interview, 03/01/2015)

The reality of the situation evoked some anxiety for Rachel; however, she recalled that it was a manageable level of anxiety for her. She speculated that someone who struggled with clothing shopping may have felt more anxious about the outing than she did: "it makes me stressed and anxious, but I can still manage it... for me it wasn't like the end of the world." Rachel shared that in general, she likes shopping for clothing; however, particular aspects of clothing shopping evoked more anxiety for her. Before arriving at the clothing store, she recalled that she was "worried about trying on jeans in front of other people," as well as confronting her body image after going through treatment and restoring weight.

Rachel reflected that throughout the exposure outing, she was less anxious than she had anticipated. She described, "It definitely was not as anxiety provoking as I was expecting. I

thought I would be really nervous, but I wasn't nervous until the end." Rachel noted that her anxiety peaked toward the end of the exposure, after trying on jeans in the fitting room. Trying on the jeans was a trigger for negative body image, which will be discussed further below.

Avoidance and distraction. Rachel remembered trying to distract herself from feeling anxious while on the exposure outing. She recalled engaging in small talk on the car ride to the clothing store: "Once I got in the car with just the one therapist, I was like okay, now I'm getting anxious. So, I could definitely feel it, but we were just talking, small talk you know, trying to distract myself." Similar to distraction, Rachel also found herself avoiding the mirror when trying on clothing to divert her anxiety. During the initial interview, she reflected:

I definitely avoided the mirror. I didn't focus on my body in the mirror as much as I would have, or as much as did in other circumstances. I kind of was just like, okay I'm going to try these on. Once I had the clothes on, then I would look in the mirror as I was getting ready and dressed, like I purposely avoided the mirror because I knew that would be rough for me and be hard. (Personal interview, 03/01/2015)

Rachel was aware that she avoided the mirror while trying on clothing during the exposure outing, in an effort to manage her anxiety about her body image.

Body image. The most salient theme throughout the initial interview with Rachel was body image. This theme comprised of two subthemes, which emerged from the reflections Rachel offered about her body image: 1) triggers for negative body image, and 2) influence of mood on experience. Rachel often reflected on how she perceived her body during recovery, noting that clothing shopping would likely be the most challenging exposure outing for her because she had gained weight; however, she was able to view her current body size rationally:

I know in my head that I'm not the size that I was before, and so it wasn't like, oh I can definitely fit into this size! And it doesn't fit. I wasn't like that. I knew rationally I wasn't that size anymore, that I would have to go up a size or two. (Personal interview, 03/01/2015)

Rachel was able to see that she had gained some weight and that her clothing size changed somewhat, but she considered her perceptions of her current size to be accurate. She recalled, "It wasn't like I was, oh I'm like eight different sizes, and I have no idea which one. I could kind of pin point where I was, and I was pretty accurate in that assessment." Although Rachel later described how gaining weight was a trigger for negative body image (described in subtheme below), she was able to accurately perceive the size of her body in relation to clothing size.

Triggers for negative body image. Rachel was aware of what triggered negative thoughts and feelings about her body image, as well as how she managed those reactions. The greatest trigger of negative body image for Rachel was shopping for jeans, which was exacerbated by her weight gain during recovery. She recalled:

Once I got to the jeans section, that's when the body image thoughts were coming in. I knew from my time in treatment that had I gained weight obviously, and that I was not the size that I even was before my relapse. So that's when the body image definitely went downhill a little bit just because I was feeling a lot bigger than I wanted to. (Personal interview, 03/01/2015)

When I prompted her regarding what triggered her the most about trying on jeans, Rachel clarified, "I think with jeans it's just like, you can tell what size you are from the jeans, from another person's perspective or something. I think that's just what triggers me a little more, like makes it harder." For Rachel, having to wear a larger size in jeans triggered negative thoughts

and feelings about having gained weight during the recovery process because it would be more noticeable.

Rachel considered how size may change more drastically with jeans than for other clothing items such as shirts, and that is what made trying on jeans a stronger trigger. She described, “[With shirts] there aren’t as many sizes. There’s a big range of people who fit in an extra small shirt and a small shirt, and a medium. But with jeans *you know* you went up in size.” Although Rachel knew rationally that she would wear a size or two larger in jeans after gaining weight during treatment, it was challenging to accept her body image after gaining weight in recovery, and trying on jeans during the exposure outing was a reminder of that.

Influence of mood on experience. In addition to her external triggers for negative body image, Rachel also recognized that an internal influence (*i.e.*, her mood) affected her experience. She described how being in a bad mood affected her behaviors:

When I’m already in a bad mood and I just feel gross and repulsive, I would end up focusing on the mirror more, and almost would like perpetuate my bad mood... you make these poor decisions that are gonna make your bad mood worse. (Personal interview, 03/01/2015)

Rachel realized that her mood while clothing shopping could influence her experience because she would find herself fixating on her flaws in the mirror. She also considered how being in a positive mood affected her experience:

I think when I am in a good mood I’m likely to be more rational and not make the poor decision of staring at the mirror. I think that’s why I was able in exposure therapy to not get into a bad mood because I was already in a pretty good mood for shopping, so I was

making a decision of avoiding the mirror I guess, and not focusing on it as much as I would in other circumstances. (Personal interview, 03/01/2015)

Because her mood was generally positive while on the exposure outing, Rachel was more aware of her triggers and made a conscious decision to avoid them.

Another aspect of the exposure outing that contributed to Rachel's mood was being with her peers. During the initial interview, she described how knowing that her peers were likely anxious encouraged her to mask her feelings. Rachel recalled, "You kind of put on a show, like a face for people, trying not to be anxious in front of them, when it's two other girls who are probably just as anxious as you are." She described how being with her peers and the therapists diverted her bad mood while trying on jeans in the fitting room:

Usually I kind of shut down, and I just feel drained and exhausted and tired and I'm just like sad, but again, that didn't happen here. I think because I was with other girls who were having fun, and the therapists were having fun and everyone was having a good time, I didn't feel like I wanted to ruin that. (Personal interview, 03/01/2015)

Trying on jeans during the exposure triggered Rachel to feel upset; however, she chose not to dwell in her negative body image because she was with a group of people who appeared to be having fun, and she was already in a good mood. Although it is uncertain whether being with the group was helpful to Rachel, it seemed to influence her mood and experience of body image.

Personal goals. Rachel set goals for herself to accomplish during the exposure outing, and the main goal was to find a pair of jeans, specifically jeggings, that fit her. She wanted to take advantage of the opportunity to purchase something that she needed, while challenging herself in the unfamiliar situation of shopping in front of other people. Rachel described:

I was like okay, I can kill two birds with one stone here. I'm going to do an exposure therapy, and I can purchase a pair of jeans hopefully, if I find a pair that fits. But, I was kind of excited. I was like, maybe this is a good experiment for me. Can I do it in front of other people, like other girls? Usually I just go with my boyfriend, but this was different.

(Personal interview, 03/01/2015)

Rachel was determined to find a pair of jeggings while shopping on the exposure outing; however, she was disappointed to find that the store did not have any pairs in her size range. As a result, Rachel decided to try on regular denim jeans instead, even though she does not like to wear regular denim because they make her uncomfortable. She recalled, "I was really bummed. So, I ended up trying on two pairs of like regular denim jeans, which was just a mistake all around." Related to the influence of mood on her experience, Rachel's disappointment affected her decision to try on clothing that she knew would not be a positive experience for her. Because she was unable to shop for jeggings, Rachel was unable to achieve her personal goals on the exposure outing. She described:

It was just an unfortunate situation because I'm curious how it would have gone if they had jeggings in a size that would have fit me. I didn't feel like I got the full experience of the exposure therapy just because I didn't get to try on jeans that I wanted. (Personal interview, 03/01/2015)

In an effort to recover her mood, Rachel decided to try on a few shirts, which typically do not trigger negative body image for her in the way jeans do. She reflected, "I think one of the things with shirts is that I haven't changed sizes very much, if any. Just depending on the store. I'm still the size that I was before my relapse, like the past five years." Aware that she was unable to meet her personal goal, Rachel resolved that she was content with the shirts that she purchased. She

said, “I was just like okay, I’m okay. Didn’t like my jeans, but I found shirts that I like that I think look good on me and like, maybe they do look good on me, and like, there you go.” Rachel resolved with herself that she felt okay about the exposure experience because she found shirts that she liked, even though she did not believe she got the full experience of challenging herself in trying on the clothing items she intended.

Cluster: Supportive Factors

In describing her experience during the initial and follow-up interviews, Rachel reflected on several aspects of the exposure outing that contributed to a positive experience for her. Two main themes emerged from Rachel’s descriptions: 1) positive peer relationships, and 2) role of the therapist in exposure. These themes comprise of aspects surrounding the exposure outing that Rachel perceived to be helpful.

Positive relationships with peers. During the initial interview, Rachel mentioned that when it comes to her recovery, she generally feels greater support from her peers than clinicians. She described, “I’ve always found that other patients have been more comforting to me than my therapist and clinicians. So that’s something that is typical for me.” When reflecting on the exposure outing, Rachel considered that situation to be no different than usual. She remembered feeling excited to go shopping with her friends from therapy, noting that “Maybe this would work out better, and they will be there to support me and everything.” Rachel felt hopeful that the shopping experience would go well because she would be with her friends.

Going on the exposure outing with her peers contributed to a positive experience for Rachel. During the initial interview, she reflected on how being with friends improved her mood during the exposure outing. Rachel recalled, “They were in a good mood and that helped me increase my mood the whole time that we were there. It was elevated more than it would have

been with other people, I think.” She noted that their positive moods helped to lift her mood also, contributing to a more positive experience.

As previously mentioned, Rachel anticipated that she would receive emotional support from her peers while on the exposure outing. There was one moment in particular that Rachel described during the initial interview, in which she received support from a friend. She remembered experiencing negative body image and anxiety, which was triggered by trying on denim jeans. On the way back from the clothing store, one of her friends noticed her struggling:

I was just fixating on my body and how it felt in the jeans and how those felt on me, and she could tell. I think she might have seen me touch my stomach or something and she was like, “It’s okay. You’re going to be okay.” (Personal interview, 03/01/2015)

Rachel further explained that her peer offering emotional support was comforting because she knew that her peer was also struggling with negative body image during the trip. She reflected, “That was comforting just because I know that she was struggling at some point during this trip, even if she didn’t exactly show it... so the fact that she was trying to help me was really nice.” For Rachel, receiving emotional support from her peers who were also struggling seemed to be a meaningful aspect of the exposure outing.

During the follow-up interview, Rachel agreed that the being with her peers made the experience more meaningful. She described, “If I was with girls that I wasn’t very close with or didn’t feel comfortable with, it would have been a completely different experience for sure.” It is interesting to note that, when describing the emotional support during the exposure outing, Rachel did not mention specific interactions with the therapists. The role of the therapists, including how Rachel perceived support from them, is described in the following section.

Role of therapist in exposure. Rachel said that there were two therapists on the exposure outing and three patients, including herself. She noted that neither of the therapists were her individual therapist, but she was somewhat familiar with them because they had facilitated group therapy sessions, in which she participated at the recovery program. Rachel believed that one of the therapists happened to be the individual therapist for one of her peers on the outing, but she was not sure if the assignment of therapists and peers was intentional.

While reflecting on the exposure outing, Rachel described, “It didn’t feel like we were in therapy at all. It just felt like we were all friends hanging out shopping together, which was nice.” Rachel considered the naturalistic feeling of her experience in a positive regard. When I prompted about how therapists facilitated the exposure outing, she described them to be mostly non-directive. Rachel did recall the therapists keeping time: “We were looking, they were just kind of like, okay we have about 10 more minutes before we go try stuff on, so just keep looking.” From her descriptions, the therapists’ interventions throughout the exposure outing seemed unstructured, with minimal emotional support. Rachel perceived this dynamic as both supportive, in that the shopping experience felt natural, and as a barrier, which will be discussed further in the following cluster.

Participated in shopping. Rachel shared that the therapists who facilitated the exposure outing were shopping for clothing as well, alongside the patients. During the initial interview, she described, “The therapists were shopping too. They were looking for clothes and trying on clothes with us.” Rachel considered this parallel process to be helpful because it relieved pressure and focus from the patients trying on clothing. She reflected:

It was kind of nice. I would say if they weren’t trying on stuff, and they were just waiting for us to come out of the dressing room, then it would have [been] a lot more pressure on

us to feel good or feel okay. But since they were out of their comfort zones too and trying on things, it was more refreshing and more... relaxing. (Personal interview, 03/01/2015)

Although it was not clear from her descriptions whether the therapists were uncomfortable with the clothing items they were trying on, or if that was her perception of the circumstances, Rachel considered their participation in the exposure outing to be helpful. She added, “It was a lot better I think, than if they were just there being a therapist, you know. But they were shopping for themselves. It was good that it wasn’t just us purchasing things.” Rachel felt more comfortable and supported because there was less focus on her and the other patients trying on clothing.

More like friends than clinicians. Rachel also described that the therapists acted more like friends than clinicians during the exposure outing, which she considered to be helpful at times. She mentioned an instance with one of the therapists: “We were both looking for jeggings, and she was trying to help me through that point, but more like a friend helping me shop as opposed to a therapist.” Rachel reflected that they did not discuss how she was feeling about the process of shopping for jeans or her concerns about sizes; rather, the therapist helped Rachel to look for them in a similar way that a friend would help her.

Embracing my bias (i.e., my understanding of how exposure therapy protocols are carried out), I prompted Rachel about the procedures of this particular exposure outing. I had anticipated hearing that the clinicians had engaged in therapeutic processing with the patients throughout the protocol; however, I was surprised to hear that this aspect seemed to be missing from Rachel’s experience. Probing further, I asked Rachel about whether she had set goals with the therapists prior to the exposure outing, such as what items of clothing made them feel anxious that they wanted to try on, Rachel explained:

No, we didn't have a plan. We did fill out a paper before we went that asked, what is your anxiety level? What would make you feel anxious? And then, if you are feeling anxious, what can they do to help? Which I didn't feel like the therapists ever were like, *therapists* when we were there. They didn't ever really try to comfort us or anything like that, which maybe was good. Maybe it was more like friends shopping. What was more therapeutic, I'm not really sure. (Personal interview, 03/01/2015).

I was surprised to hear Rachel describe the therapists' interactions as similar to that of friend, as my primary expectation of how the clinicians would interact during exposure therapy included processing of emotions, particularly anxiety. Rachel considered that this interpersonal dynamic might have been helpful to her, in some way. She described the experience as "very natural."

Toward the end of the initial interview, I asked about the most helpful things that the clinicians did during the exposure outing, Rachel reflected:

I think that was the most helpful, that they kind of acted like us and were just like "Yep, we are going shopping too. We're going to look for our own stuff. Like, we're not going to focus on your guys or what you are trying on or how you feel. If you need us, we're here, but do things on your own" was the vibe that I kind of got. (Personal interview, 03/01/2015)

For Rachel, having a parallel experience with the therapists, who interacted with the patients more like friends than clinicians, was perceived as supportive. At the same time, however, there were some aspects of this dynamic that served as a barrier to support for Rachel, which be discussed in the following cluster. Toward the end of the interview, Rachel offered suggestions about how additional support might have been provided by the therapists during the exposure

outing, including more processing of emotions during the exposure, which will be discussed in the final cluster, Suggestions.

Cluster: Barriers

Throughout the initial and follow-up interviews, Rachel noted several aspects about both the exposure outing and the recovery program that served as barriers to therapeutic support. Three themes regarding barriers emerged: 1) unstructured exposure protocol, 2) not her individual therapists, and 3) lack of support during transition. The first two themes concerned the exposure outing itself, and the third theme was about her experience transitioning out of the recovery program to outpatient.

Unstructured exposure protocol. Rachel described the procedures of the exposure outing to be non-directive, with few expectations outlined in advance. She reflected, “I didn’t even know what was happening until we went, basically.” Rachel recalled that the therapists did not instruct the patients on what to do before or during the process. She noted, “We didn’t have any goals for what we were gonna do once we got there, or anything like that. They [therapists] were just like, go shopping.” During the initial and follow-up interviews, two subthemes emerged from Rachel’s descriptions: 1) unclear purpose and goals, and 2) minimal guidance.

Unclear purpose and goals. Rachel perceived the purpose of the exposure outing as more exploratory than intentional. During the initial interview, she reflected:

I knew the purpose of it was to kind of see how you are in that sort of environment and what sort of feelings it provokes and things like that. But other than that, I didn’t know much before we went on it. (Personal interview, 03/01/2015)

As Rachel shared the details of her experience, it became evident that the therapists did not discuss the overall purpose of the exposure outing with the patients, nor did they outline

therapeutic goals for the intervention. During the follow-up interview, Rachel reflected on the experience as a whole:

I don't know what the motive is, or the purpose of the trip. Is it just to get you comfortable, or get you to realize you still look good, even while you gained weight?

Like, I don't know what the purpose of it is. (Personal interview, 05/01/2015)

With uncertainty about the general purpose of the exposure outing, Rachel was not sure what she might achieve therapeutically in the process. Rachel recalled that before leaving for the clothing store, the patients completed a worksheet that asked about what would make them feel anxious and what the therapists could do to help; however, she noted that the therapists did not follow up on those aspects during the outing.

From Rachel's descriptions, it seemed that the goals of the exposure were not clarified throughout the process. Once they arrived at the clothing store, Rachel described, "We didn't have a game plan as far as what we were going to try on, or who should look at what." Without specific goals, Rachel directed herself in the moment and ended up trying on clothing items that were safe. She reflected, "I think they wanted us to try on things that are just not typical, but out of the three of us [patients], I think we all just went with the things that we normally would have worn." Because therapeutic objectives were not outlined for the exposure outing ahead of time, the clinicians could not support the therapeutic process of patients trying on specific clothing items that would evoke anxiety.

Minimal guidance. Rachel reported that the therapists offered minimal guidance throughout the exposure protocol, and described the primary guideline of the exposure outing: "It was just kind of like, look at clothes. Try things that maybe would make you feel a little, not uncomfortable, but things that you might be reluctant to try on in other situations." From

Rachel's perspective, the main instruction given by the therapists was for the patients to try on clothing items that they might not try on their own.

During the initial interview, I prompted Rachel about the process of trying on clothing, asking if it were a requirement. Rachel reflected, "I don't know if we had to. I assume that we had to try things on, but everyone found stuff they wanted to try on anyways, so it wasn't like a big deal." When I asked whether it was expected that they showed each other the clothing items that they selected (a process that the previous two participants described), Rachel did not perceive that to be an expectation for every clothing item:

I didn't feel comfortable in [the jeans], and I didn't feel comfortable coming out. But I don't think it was a requirement to put them on and show them. I mean, especially if you're feeling uncomfortable, if it doesn't fit you well. (Personal interview, 03/01/2015)

Given Rachel's descriptions, the therapists did not explain specific guidelines for the exposure outing. It appeared that some expectations were clearly expressed, and some were assumed by the patients. Other concrete guidelines that Rachel recalled included focusing on clothing and not accessories, and patients not being expected to purchase clothing items unless they wanted.

Rachel portrayed the experience as mostly independent. She said that the therapists kept track of time during the outing, prompting the patients about how much time was left to remain at the store; however, the procedures were self-directed by the patients:

We just did everything on our own, to be honest, and the therapists were shopping too. So we were looking, they were just kind of like, okay we have about 10 more minutes before we go try stuff on, so just keep looking. So we were all on our own just looking for clothes. (Personal interview, 03/01/2015)

As previously mentioned, Rachel considered the role of the therapist to be supportive in some aspects (e.g., there was less pressure on the patients, felt like a natural shopping experience), and also a barrier to emotional support because the therapists did not process feelings with the patients while shopping. Reflecting on the fitting room experience and how uncomfortable she felt trying on the jeans, Rachel noted that the therapists did not check in with her about anxiety. She recalled, “They didn’t ask about the jeans or anything. I just said yeah, they didn’t work out, but whatever, it’s fine.” The therapists did not know what particular aspects of clothing shopping would trigger anxiety for Rachel, because therapeutic goals were not outlined with the patients before or during the exposure outing. There was minimal guidance throughout the process regarding what clothing items the patients selected and their emotional reactions, which served as a barrier to support and will be discussed further in the final cluster, Suggestions.

Not her individual therapists. Rachel was familiar with the therapists who took her and the other patients on the exposure outing, as they were group therapy facilitators in her recovery program. They had developed some rapport with each other from those sessions. She reflected on the car ride to the clothing store, when she was alone with one of the therapists:

Being more comfortable with her than the others... I felt like I didn’t have to pretend that I wasn’t nervous or something because it was with [therapist]. Like okay, if I’m going to be anxious, let me be anxious now. (Personal interview, 03/01/2015)

Rachel felt safer showing her anxiety while in the company of the therapist alone; however, the therapist did not notice her signs of anxiety, and they did not process her feelings. She described, “I don’t know this therapist very well, so I don’t think she picked up on the signs. I just don’t think it was acknowledged on her end that I was very anxious.” Rachel believed that her

individual therapist would have recognized her signs, and they would have been able to process her feelings more during the exposure outing. She reflected:

I kind of wish my therapist had gone. I think that would have been more helpful. Just because she does know the signs and we have a history of talking to each other a lot, and we have a relationship. (Personal interview, 03/01/2015)

Although she had a generally positive relationship with the therapists on the outing, Rachel believed that her individual therapist would have offered her greater support. The therapists on the outing did not recognize when she was feeling anxious, and there was minimal therapeutic processing, which served as a barrier to emotional support for Rachel. Processing of emotions will be further discussed in the final cluster, Suggestions.

Lack of support during transition. During the follow-up interview with Rachel, she disclosed that she had relapsed and would be entering a residential treatment program for her eating disorder. She mentioned that she began to struggle within a couple weeks of discharge from the intensive outpatient recovery program, saying that she lacked therapeutic support in the transition process. Rachel described how treatment options vary, depending on your insurance:

It really depends on your insurance and what they're willing to cover because some people left the day program and went to intensive outpatient program, and then other people went straight to outpatient where they just met with their therapist like once a week... and that's what they have done for me. (Personal interview, 05/01/2015)

After finishing the partial hospitalization program, Rachel recalled that she was offered a few transition days from the program, but she believed that there were not enough. She described:

They did give me some transition days which were helpful, but it wasn't like long term enough. I had like four transition days towards the end, but I wish I had more of those

and that I was in the program for longer, or that it was more consistent or something.

Like two weeks after I left, I was already struggling a lot. (Personal interview, 05/01/2015)

Rachel perceived her transition from partial hospitalization to outpatient therapy to be abrupt and not consistent, and she believed that those aspects contributed to her struggle and relapse soon after discharge.

Rachel also mentioned that the therapist she was paired with for aftercare was not the same therapist she was seeing during the partial hospitalization program. She reflected, “I was just paired with a therapist that was not good, so it wasn’t helpful at all.” Rachel was assigned to see a therapist that she did not find to be supportive in her recovery process, which served as a barrier.

I had remembered from the previous interview that Rachel described a very positive relationship with her individual therapist, and I prompted her about why she did not continue seeing the same person during the transition. Rachel explained that it was not an option for her to continue seeing the same therapist. She remembered feeling disconnected once she finished the recovery program, which she considered to be a systemic concern of the facility:

There is no option to stay with them, or there is no continuity between the programs.

Once you leave, you are kind of cut off at that point... it was really unfortunate because a lot of programs have like step downs because like they expect you to go to a lower level of care, but the lowest level care they have is the program that I was in, so there wasn’t anything beneath that. (Personal interview, 05/01/2015)

After leaving the partial hospitalization program, Rachel was not able to continue treatment with the same individual therapist with whom she had developed a relationship during recovery.

Further, she perceived the therapist with whom she was paired to be unhelpful. Finally, her transition from the partial hospitalization program to outpatient therapy was described as abrupt and inconsistent, which seemed to be outside of Rachel's control. These aspects of served as barriers to emotional support for Rachel during her recovery process after discharge.

Cluster: Meaning of Experience

The thematic cluster of Meaning of Experience comprised of three themes: 1) enjoyable experience, 2) real-world practice is important, and 3) memorable but not impactful. Themes emerged from Rachel's descriptions about how she attributed meaning to the exposure therapy experience as part of her recovery program for anorexia. References were drawn from the initial interview, reflexive journal entry, and follow-up interview.

Enjoyable experience. Rachel described the exposure outing in a positive way, saying that she enjoyed the experience. In the initial interview, she recalled how she felt when the therapists told her they were going: "I was excited to go shopping on my last day, and I liked the girls that we were going with, so it was cool." Rachel liked being with her friends from the program, doing something that she considered to be generally fun. She also mentioned that it enjoyable to do something outside of the normal routine of therapy:

I think it was good to have fun and be out of the norm of our program, which is very scheduled. Like, "At this time you are going to do this and this and this!" I think it was kind of nice to do something different and have fun. (Personal interview, 03/01/2015)

Similarly, Rachel described being indoors throughout the day while in partial hospitalization, noting that they did not get outside very often. She said, "You don't see the sun for seven days a week... so it was nice to be out in the sun and enjoy it!" Leaving the facility to go on the exposure outing was an enjoyable break in the routine of therapy for Rachel.

During the follow-up interview, I asked Rachel what she enjoyed the most about the exposure outing. She reflected:

[Being] excited and happy to try something new, and one of the girls I was close with, so I remember hanging out with her. It was fun, and although it was stressful a little bit, overall I enjoyed being with the girls, and that was fun. (Personal interview, 05/01/2015)

For Rachel, doing something different from regular therapy, with her close friends from the program was the most enjoyable. In her reflexive journal entry, she wrote, “Looking back on my time at treatment, the shopping trip was probably the most enjoyable activity I participated in. I really did have a good time with the other patients and therapists.” Rachel considered the exposure outing to be the most enjoyable experience during her treatment program for anorexia.

Real-world practice is important. Rachel considered the importance of having experiences during therapy that are applicable to life outside the treatment facility. During the follow-up interview, she reflected, “I think it was good to do something like... It was a real world experience. It wasn’t a hospital setting, which was nice.” Rachel mentioned during the interviews and reflexive journal entry that she wished that they had done exposure outings more frequently. She reflected on the importance of real-world experiences during treatment:

You’re in this program that’s very structured, and they provide your meals. You don’t just get anything, you chew what’s in front of you. And then you’re just kind of thrown in the real world, which is what happened to me and I kind of had no support after that. So something in the middle would have been nice. I think experiences in the real world would have been helpful in treatment. (Personal interview, 05/01/2015)

Having real-world practice was a meaningful aspect to Rachel in her recovery from anorexia. Further, Rachel believed that having therapeutic experiences outside the facility more often

would have been helpful in her transition out of the program, which will be further discussed in the final cluster, Suggestions.

Memorable but not impactful. Although the exposure outing was memorable and enjoyable, Rachel did not consider it to be an impactful aspect of her recovery. The primary reason she offered was because she only participated once. During the initial interview, Rachel reflected on this aspect:

I don't think that one true instance really impacted my recovery very much. It was still overall a very good experience, and I'm glad I did it. I just don't think in the scheme of my recovery it impacted it very much. (Personal interview, 03/01/2015)

Rachel reiterated in her journal entry that going on the exposure outing one time did not impact her overall recovery from anorexia. She wrote:

I don't think that just one shopping trip was a huge part of my treatment and recovery process. I think, in order for them to be effective, they need to occur more often, to keep testing our ability to function outside of the hospital setting. (Personal communication, 03/08/2015)

For Rachel, it would have been more beneficial if the treatment program had offered more frequent exposure outings because one experience was not impactful. Rachel described the exposure outing as memorable, noting that she thought about her experience while clothing shopping sometimes, as well as when reflecting on her time in the recovery program; however, she did not consider it to have impacted her recovery from anorexia overall.

Cluster: Suggestions

Rachel did not consider the exposure outing experience to be impactful, although she described it as enjoyable and memorable, and she noted several barriers to emotional support

during the recovery process. Throughout our conversations during the initial and follow-up interviews, as well as in her written reflexive journal entry, Rachel offered suggestions that she believed would help make the exposure outings more beneficial as part of her recovery from anorexia. Three themes emerged from her descriptions: 1) go on more exposure outings, 2) processing of emotions during exposure, and 3) more structure and intentionality.

Go on more exposure outings. As mentioned in the previous cluster Meaning of Experience, Rachel believed that the exposure outing was not impactful because she only went one time. During the initial interview, she reflected:

I told them I wish we had done more outings. I had been there for six weeks, and that was the first exposure therapy that we had done. I wish that we had done more of these before I was leaving because I found this very helpful, and I even brought it up to my therapist.

(Personal interview, 03/01/2015)

Rachel's main suggestion throughout both interviews and the reflexive journal entry was for the program to offer more exposure outing experiences. She recalled, "The whole time I was there, they had only done two [exposure outings]. So, I definitely think that's something they need to work on, and something that I think would be very beneficial to the partial patients." Rachel appreciated the practicality of a real-world experience while in the recovery program and suggested that the program offer different kinds of exposure situations. In her reflexive journal entry, she wrote, "I do wish that we were able to do them more often, in a wide range of situations." Related to the theme lack of support during transition (Barriers cluster), having more frequent exposure outings for Rachel to practice real-world skills may have supported her transition process out of the partial hospitalization program, building her confidence to engage in those activities outside of treatment.

Processing of emotions during exposure. Rachel reflected that there was minimal processing of feelings throughout the exposure outing. She was surprised that the clinicians did not facilitate therapeutic processing during the exposure outing because she expected that they would talk about their anxieties. During the initial interview, I disclosed with Rachel that I shared her expectation, saying “I was kind of surprised that there wasn’t any processing going on during the trip.” Rachel responded, “Right. I was definitely expecting that for sure. But we didn’t really talk about it. It was just like, how’s everyone feeling? Good? Good. Alright, let’s go. That’s what it felt like to me.” Rachel recalled brief attention to her anxiety at the end of the exposure outing: “I guess we processed at the end, when we were filling out the sheet afterwards. We rated our anxiety and things like that. But I don’t feel like it was enough.” Rachel believed there was not adequate therapeutic processing of her emotions during the exposure outing, which served as a barrier to emotional support for her.

From Rachel’s descriptions, it seemed that there was not enough time for the clinicians and patients to engage in therapeutic processing throughout the exposure outing. She recalled:

I didn’t feel like we had the time to feel bad or feel anything negative. I felt that wasn’t addressed, really. I think it should be more therapeutic and that we should have processed more during, before or after, everything. The whole thing felt very rushed. (Personal interview, 03/01/2015)

Rachel felt the exposure outing was rushed, leaving minimal time to for her to process anxiety and other feelings with the clinicians. During the follow-up interview, she considered that having more time while on the outing would have allowed her the opportunity to experience her feelings related to the exposure and process them:

I think a longer trip would have been helpful because it felt very rushed. We were in and out in a very short amount of time, and we didn't have much time to think or feel or talk or anything. It was kind of just like, go in, try on these clothes, go check out, sort of thing. (Personal interview, 05/01/2015)

The lack of opportunity for therapeutic processing of emotions served as a barrier to emotional support for Rachel. She reflected, "Processing it more might have been helpful because I didn't feel like we really processed what was happening at all during the therapy. Just having time to talk about it and be like, this is how I felt." As Rachel reflected, she mentioned that having her individual therapist on the exposure outing would have been helpful in this situation. She reflected, "I would have opened up more to her like, alright, can we just take a minute and discuss because I need to process? Because it wasn't my therapist, I didn't feel comfortable saying or doing anything like that." Rachel needed to process her emotions during the exposure but did not feel comfortable confronting the clinicians about feeling rushed while on the outing.

More intentional. In discussing suggestions for improving the exposure therapy, Rachel described frustration in how she perceived that all patients with an eating disorder were treated the same, despite having different experiences. She described:

I hate that people treat it like it's the same disorder. It drives me insane. Even in our partial program, everyone had their own meal plan, but meals were the same for everyone. It's just, a different thing! It drives me crazy. (Personal interview, 03/01/2015).

Rachel believed that her experience of anorexia, restricting type, would be inherently different than the experience of someone who has anorexia binge/purge type, and the approach to therapeutic intervention may not look the same. She recalled that one of her peers in the program did not gain weight, and Rachel believed that clothing shopping might not have had the same

effect on her: “She wasn’t someone who was gaining weight in the program like I was, and trying on clothes. I wear a different size than what I was used to, so that was a little hard.”

During the follow-up interview, Rachel described this circumstance as a trigger and suggested that patients be assigned with others in similar situations for interventions like the exposure outing:

I think putting people who were in similar situations, like for example, one of the girls was saying how she lost weight in the program and said that she realized that she was so much smaller when she went out on the shopping trip, and that was kind of triggering for me, I guess. (Personal interview, 05/01/2015)

Rachel believed that structuring the exposure outings more intentionally, so that patients with similar experiences of anorexia would be grouped together, may have been helpful. Being treated the same as other patients, who have different diagnoses and experiences, was triggering for her.

Case Summary and Researcher Interpretations: Rachel

Rachel disclosed that she was diagnosed with restrictive-type anorexia, in which she did not engage in bingeing/purging behavior. She expressed keen insight into her experience of anorexia and was aware of her personal triggers for negative body image, including how her mood status interacted with the experience. Rachel expressed that she generally enjoyed clothing shopping; however, she anticipated some anxiety related to her body image and having gained weight during the recovery program.

Rachel described how her anxiety fluctuated throughout the exposure protocol, noting how she attempted to distract herself from those feelings. She was mostly nervous about trying on jeans in front of others, with her anxiety peaking immediately after she tried on denim jeans in the fitting room. Rachel set a personal goal to shop for jeggings; however, the store did not

have her size in stock, so she resolved to try on denim jeans instead. This proved to be a mistake because not only did she know that denim jeans would be uncomfortable for her and that she would never wear them, she knew that it would negatively affect her mood. Rachel's rationale for trying on the denim jeans remains unclear. She could have opted not to try on any jeans, or she might have chosen another clothing item that was outside her comfort zone. Rachel mentioned during the initial interview that she did not really follow the guidelines of trying on clothing outside of her comfort zone, and I challenged her interpretation because I believed that denim jeans truly were an item of clothing which made her feel uncomfortable. She agreed with my statement, while noting that the experience would have been much different if she had tried on jeggings instead. It is possible that, as she insightfully explained, her mood was negatively affected by the store not having jeggings in her size, and she in turn made a "poor decision" to try on denim jeans, essentially sabotaging herself and perpetuating her negative mood. Rachel's perception of success on the trip was seemingly out of her control, but she regained her positive mood by trying on shirts that she expected would go well.

From Rachel's perspective, the two main supportive factors during the shopping exposure were being with her peers and therapists. She had established rapport with them during her time in the partial hospitalization program, describing generally positive relationships. Rachel also mentioned that the clinicians were acting more like friends during the outing, as they participated in shopping and trying on clothing in parallel with the patients. Rachel believed that this dynamic was mostly helpful because it normalized the experience for her, and she did not feel any pressure or unwanted attention on herself; however, it also served as a barrier to emotional support, in that the clinicians did not engage in therapeutic processing of negative emotions during the exposure. Also, there was an overall lack of structure to the exposure outing, without

clear purpose and goals, and the therapists who facilitated the outing offered minimal guidance to the patients in the process. Further, although she had rapport with the therapists from group sessions in the program, they were not her individual therapists. Rachel believed that she would have felt more comfortable in confronting her own therapist about the lack of therapeutic processing during the outing, when she was clearly anxious. She was discharged shortly after the exposure outing, and she perceived minimal support during the transition from partial hospitalization to the “real world,” which she believes contributed to her relapse soon after.

Overall, Rachel considered the exposure outing experience to be enjoyable and memorable, but not impactful in relation to her recovery from anorexia because it was only one exposure. She believed real-world experience during therapy to be very important, suggesting that more frequent exposure outings for different concerns be offered to patients. Rachel considered that going on exposure outings more frequently might have supported her transition from partial hospitalization, as that would offer more real-world practicing of skills she learned in the program. She also suggested that there be more structure and intentionality during the exposure outings, as well as more therapeutic processing of anxiety, which would contribute to greater impact and meaning.

“Dana”

Dana is a White female in her early 20s diagnosed with anorexia nervosa, purging type. She was also being treated for anxiety, depression, and PTSD, for which she was taking medication as prescribed by her physician at the time we interviewed. She presented in casual sports-type attire and wearing make-up, although she said that she usually does not wear any. Dana asked if she could have her snack while we met, and she finished eating during the beginning of the interview. She appeared to be somewhat nervous, fidgeting throughout the interview, and she mentioned that she is a nervous person in general. Her tone throughout the interview was witty, and her responses to the interview prompts were generally matter-of-fact. Dana reported on her demographic questionnaire that she had been hospitalized about 20 times for disordered eating and later said, while laughing, “I’ve done this a few hundred times!” She also shared that she has knowledge of psychology and the research process from her studies and experiences participating in other research projects.

Dana participated in both initial and follow-up interviews, and she completed and submitted her reflexive journal entry after the initial interview (sources). Several themes and subthemes emerged and were grouped into the following categories, or thematic clusters: 1) Self-awareness, 2) Exposure Protocol, 3) Supportive Factors, 4) Meaning of Experience, and 5) Suggestions. Themes are presented in a manner that aids flow and clarity, rather than in order of importance. See Table 4 for an outline of thematic clusters, emergent themes/subthemes, and numbers of sources and references from Dana’s interviews and her reflexive journal entry.

Table 4

Thematic Clusters and Themes Derived from Dana's Interviews and Journal Entry

Cluster	Themes, Subthemes	# Sources	# Refs
<i>Self-awareness</i>		2	37
	Body image	2	19*
	<i>Mirror behaviors</i>	2	6
	Personal recovery process	1	18*
	<i>Familiar cycle</i>	1	4
	<i>Status in milieu</i>	1	11
<i>Exposure Protocol</i>		1	21*
	Brief processing before and after	1	8
	Expectations of patients	1	4
	Unstructured	1	6
<i>Supportive Factors</i>		2	35
	Established relationships	1	8
	Role of therapist	1	27*
	<i>Informality</i>	2	15
	<i>Participated in shopping</i>	1	10
<i>Meaning of Experience</i>		3	21
	Real world experiences are helpful	2	7
	Not personally impactful	3	9
	References to second exposure outing	1	5
<i>Suggestions</i>		3	14*
	More planning and preparation	2	3
	Individualizing exposure therapy	2	9

**Note.* Number of references for theme may include references that do not fall into an emergent subtheme; therefore, the total for a theme may be greater than the sum of its subthemes.

Cluster: Self Awareness

Throughout the initial interview, Dana expressed keen insight and self-awareness of her experience of anorexia. The thematic cluster of self-awareness comprised of two themes: 1) body image, and 2) personal recovery process. One subtheme, mirror behaviors, emerged within the theme of body image, and two subthemes emerged within the theme of personal recovery

process: 1) status in milieu, and 2) familiar cycle. These themes emerged from her descriptions about her thought processes and reflections about the exposure outing experience.

Body Image. Dana was aware of her negative body image, and she came to understand that it was distorted after having gone through treatment several times. When it came to trying on clothing during the exposure outing, Dana decided to challenge her body image distortion by selecting items that had number sizes. She described, “I chose to pick a specifically sized item because I struggle with that more than like, small, medium or large. Like numerically sized.” Dana reflected on her thoughts during the process:

The size when I tried on the shorts... I definitely got a couple of the sizes, and the smallest size that I took, I was like, “There is no way I am going to fit in to that.” And then it ended up being the size that fit me, actually. So... definitely like body distortion, dysmorphia stuff. (Personal interview, 05/10/2016)

Although Dana chose a range of sizes that might have fit her at the time, she perceived her body size to be larger than it was in actuality. She was surprised when the smallest size fit her because she had a difficult time accepting that she was smaller than her body image perception.

While describing the process of trying on clothing, Dana shared that she had a history of trauma and that she was distracted during the exposure outing. She perceived her body image to be less distorted as a result of her distraction. She reflected:

I have a trauma history, and I was struggling with some other stuff completely unrelated to the trip or body image. And I think my body image was the least it had been distorted in a really long time because I think all of my mental capacity was taken up by other things that were going on. I felt like my body image was probably truer to real life than it has been... So, it was a weird experience. (Personal interview, 05/10/2016)

Dana believed that because she was distracted by something else during the exposure outing, she was not as focused on her body image as much as she typically might have. She described, “I didn’t hate my body as much as like I normally do, I guess... I was just distracted.” She still remembered thinking that the smaller sized shorts would not fit her, but she did not perceive her body image to be as distorted as she would have expected.

Dana reflected on how she managed her body image distortion during recovery, noting that having an objective measure was helpful. She described that knowing her weight status throughout the weight restoration process helped keep her perspective in check:

It's really helpful for me for [in] countering body dysmorphia and body image stuff.

Because I’m always like, “Oh my god, I’ve gained like 40 pounds!” And they’re like,

“Um, you’ve gained four.” I’m like, okay. So it helps sort of counter the internal

monologue or dialogue. (Personal interview, 05/10/2016)

Using the scale as objective feedback, rather than that of other people’s opinions of her body image, helped Dana to see herself more realistically in the process of recovery.

During the follow-up interview three months later, Dana reflected that her body image was more realistic at that time than it was during any of her recovery processes. I prompted her what might have contributed to her current resolution, and she responded, “I think probably just distance from the weight frustration, maybe is the biggest thing. I think that’s probably the biggest thing.” Dana mentioned that her body image was typically the most distorted during the weight restoration process because that is when her weight fluctuated the most, leaving her little time to adjust. She described, “Being fully weight restored and staying there, just like adjusting versus bouncing back and forth.” For Dana, having distance and time to adjust after the weight restoration process helped her body image distortion the most.

Mirror behaviors. While discussing her body image, Dana considered how she typically approaches the mirror. She reflected, “At home, I tend to look in the mirror more. But at home, I don’t have a full-length mirror. Well, granted my mirror is pretty much full-length in my bathroom, just not an actual full-length mirror.” Dana mentioned that the shopping trip was one of the first times she was exposed to a full-length mirror during that recovery period: “It was one of the first times, I guess. Because I had literally gone partial a day and a half beforehand... So I think that was my first encountering of a full-length mirror, since before I went inpatient.” Dana had been hospitalized prior to entering the partial program, and there were no full-length mirrors on the hospital unit where she could be exposed to her full body image.

When I asked Dana about how she interacted with the mirror while trying on clothing during the exposure, she said, “I definitely looked like, a fair amount. I didn’t avoid it by any means, but I don’t think I stood there and obsessed forever.” To follow up, I prompted her if that was similar or different from how she usually interacted with the mirror. Dana reflected, “It’s a combination, depends on the day. I think sometimes I just completely avoid mirrors. Like when I’m inpatient, I don’t even look at the mirror. Because I’m just like, what’s the point?” Related to her awareness of body image during the weight restoration process, Dana understood that by looking in the mirror while in inpatient, she would see herself through a distorted lens, so she would avoid them.

Personal recovery process. Dana expressed profound awareness about how she personally navigated through the recovery process. She talked about her recovery in a matter-of-fact way. Dana referred to herself as “emotionally disconnected” and “detached” when it came to feelings or emotions, saying, “I don’t do feelings. Part of my issue.” While reflecting on her

personal recovery process from anorexia, two subthemes emerged from her descriptions: 1) familiar cycle, and 2) status in milieu.

Familiar cycle. Dana had been through countless hospitalizations and treatment programs for her eating disorder, and through those experiences, she gained insight into her personal recovery process. She reflected, “I have been doing the whole eating disorder, relapse, recovery thing for a long time, so I’ve sort of been through the upwards swing of everything multiple things, so... that’s pretty familiar.” Dana was very familiar with the cycle of relapse and recovery and how she personally navigated through it because of her previous experiences and level of self-awareness. Because of her familiarity and detachment from her emotions, Dana considered her understanding of this process to be objective. Consequently, knowing what to expect helped her to plan treatment decisions for herself. She reflected:

It also helps in my decisions of when to go partial and when to start transitioning home because I have done this so many times that I sort of know, like weight-wise and behavior-wise and symptom-wise, when I am ready for the next step, before my emotions have gone up. (Personal interview, 05/10/2016)

Dana relied on her understanding from previous experiences to help her navigate through her personal recovery process. Relapse and recovery had become a familiar cycle of which she was keenly aware.

Status in milieu. Through countless hospitalizations and treatment programs, Dana had become an expert patient. She recognized that the other patients may have perceived her as more knowledgeable and wise as a result. Dana reflected, “I think because I have had so much treatment, my peers sort of like, I don’t want to say look up to me for guidance, but in a way [they do] because I’ve done this a few hundred times.” Later, she reflected, “I’ve come to be

like, a mother hen.” Dana saw herself as maintaining a higher position of social status among her peers because of her extensive experience in treatment programs.

Dana also considered how her social status and position of power within the hospital milieu afforded her certain privileges. She offered an example of how she convinced her doctor that she could know her weight status while inpatient:

I’m allowed to know my weight here, which is not normal for this unit. They don’t typically allow it. I sort of used the handbook against them to get the numbers out of them because it says that... (Dana laughing) at doctor’s discretion is disclosure of weight, and my doctor's easily persuaded. (Personal interview, 05/10/2016)

Because she had been through treatment so many times, Dana was aware of hospital policies and procedures, including social norms, and how to navigate through them. Her social status was evident in relationships with her peers, as well as hospital staff.

Dana was observant and would often try to anticipate what was going on and what would happen next. The exposure outing was supposed to be announced unexpectedly by staff members; however, Dana knew about it ahead of time. She reflected:

They tried to keep it that we are unaware that it's going on, but I’m super hyper observant, so I knew that it was going on before they even announced it. They got mad at me for finding out, but that's just my...So, yeah. (Personal interview, 05/10/2016)

Dana went on to describe how she informed her peers about the outing:

I found out two days beforehand and told everyone that was going, but that wasn’t supposed to be the case (laughing). Because I like blocked [the staff] when they were informing people. They're like, “Oh we're going to-” and I'm like, “I know. We’re going

to [clothing store].” And they're like, “How do you know this?” And I’m like, “I already told everyone.” (Personal interview, 05/10/2016)

Dana used her awareness and observations to keep herself one step ahead of others. Then, she shared her knowledge about the exposure outing with her peers, while circumventing the staff, which placed her in a position of privilege and power within the milieu.

Cluster: Exposure Protocol

The thematic cluster of Exposure Protocol comprised of details about the exposure outing procedures. Three themes emerged: 1) brief processing before and after, 2) unstructured, and 3) expectations of patients. Each of these themes emerged from Dana’s descriptions surrounding what happened before, during and after the exposure outing, as well as her perceptions about the structure of the protocol and what was expected of her as a patient during the exposure.

Brief processing before and after. Dana recalled engaging in brief therapeutic processing with the therapists and other patients, both before and after the outing. She described completing worksheets before leaving for the clothing store: “They pull us from right after snack, and then we sit in a room and do pre-sheets before we go.” I prompted Dana about the content of the worksheets, and she recalled:

It's basically just asking what your anxiety level is going into it and what you expect to be difficult about it and challenges that you expect to arise, and what coping skills you can use to alleviate the anxiety in the moment, and how your peers can support you and how the therapists can support you. (Personal interview, 05/10/2016)

Dana said that they completed the worksheets, talked a little bit, and then they left for the clothing store. Similarly, when they returned from the exposure outing, she recalled that they processed briefly after returning from the clothing store: “We came right back and then went into

lunch. So we had like 10 minutes [to process]. We sat in here and processed the trip, and then we went straight into lunch.” I asked Dana how they processed afterward, and she explained:

We did the post-trip sheet, which was on the back of the pre-trip sheet. It asked what your current anxiety level was, what went on, what skills you tried to use, what could be helpful in the future. Questions like that. And then we read through them to the group and sort of talked about it, like a debriefing. (Personal interview, 05/10/2016)

From Dana’s descriptions, the therapeutic processing surrounding the exposure outing comprised of completing worksheets and briefly discussing them in the group setting, before they left and after they returned. Dana did not mention any therapeutic processing while they were shopping at the clothing store or trying on items in the fitting rooms.

Expectations of patients. Dana talked about several aspects of the exposure outing procedures, including what she perceived was expected of her while on the outing. She described, “I knew that we were going to [clothing store] to do a shopping exposure with two of the therapists from here, and that we were requested to try on at least one item.” Dana did not mention any specific instructions about what type of clothing the patients were expected to try on, for example, clothing items that were outside of one’s comfort zone (as mentioned by previous participants). When I prompted whether patients were required to purchase any clothing items, she replied, “We weren’t required to, but we were encouraged.”

Dana described the process of trying on clothing items alongside the other patients, noting that most of the process was unspoken or assumed:

Basically, we had to try stuff on. I think it was just kind of assumed that we had to come out and show people what we were wearing. They never actually said that we had to, but

we all did because I think that's just normal. If you go with friends, you're like, "Oh look, this is cute." (Personal interview, 05/10/2016)

Dana and the other patients expected that they should try on the clothing they picked and show each other the items, as they might do on a normal shopping outing with friends. This expectation was not explicitly outlined by the therapists facilitating the outing, but the patients were instructed to try on at least one clothing item during the exposure outing.

Unstructured. There were few explicit directions for the patients to follow during the exposure protocol, she recalled arriving at the clothing store: "We were just walking around looking at stuff, deciding what was cute and what we wanted to try on, and just kind of walked around for a while, waiting for the other people to show up." The patients engaged in shopping with minimal guidance from the therapists. After they finished trying on clothing, Dana described that they had extra time at the end of the shopping trip before going back to the hospital: "We still had 15 minutes to kill, so we just like, went into the accessory section, looking at stuff randomly, looked around a little bit more, and then like purchased whatever." From Dana's descriptions, it seemed that there was a set amount of time for completing the exposure outing, but the specific objectives were not clear.

Because the patients were offered minimal directives during the exposure outing, it was not surprising when Dana referred to the protocol as unstructured. She reflected:

It was interestingly enough, very unstructured, which I didn't expect because I've done outings and experiential stuff in other programs as well, and it's been a lot more regimented and structured. But I think [hospital] is just really getting their exposures put together. And it's still a work in progress. (Personal interview, 05/10/2016)

Dana had initially expected the exposure outing to be more regimented. However, in contrast with other experiential interventions in which Dana participated, the exposure outing was unstructured. She attributed the lack of structure to the newness of implementing exposure therapy into the treatment program.

Cluster: Supportive Factors

Dana described several aspects of the exposure outing that she found to be helpful, involving her interactions with peers and therapists. The thematic cluster of Supportive Factors included two themes: 1) established positive relationships, and 2) role of therapist. Regarding the role of the therapist, two subthemes emerged: 1) informality, and 2) participated in shopping.

Established positive relationships. Dana described positive relationships with the people she was with on the exposure outing. She mentioned that one of the therapists was “pretty down to earth, so she is fun to be around.” Regarding her peers, Dana said, “We've been together for at least a week or two, all of us so... the three of us talk to each other pretty regularly.” She noted that they had established rapport while attending the partial hospitalization program together.

It was helpful for Dana to have her peers on the exposure outing because they understood what she was going through. She described, “I think going with people that know you and are familiar with your reactions to things is helpful because you can support each other. Sometimes people are able to identify heightened anxiety before you realize it yourself.” Dana recalled how she and her peers offered each other support during the exposure outing:

I noticed one of my peers getting super anxious, and I just talked to her a bit about it. And then, another one of them, we both were looking at the shorts in the same exact size, and

were like, “This isn’t gonna fit,” and it fit for both of us. So, we sort of had the same reaction. (Personal interview, 05/10/2016)

Dana felt supported by her peers on the exposure outing because they shared similar perspectives and were able to recognize each other’s anxiety. Consequently, she felt more confident in challenging herself to try on numerical sizes because she was with her peers, saying “I took advantage of having the support.” Dana considered them to be her friends and said that she felt closer to her peers than the therapists in the program.

Role of therapist. Dana mentioned that there were two therapists and three patients, including herself, who went on the exposure outing. She mentioned that the therapists were facilitators of their group sessions in the partial hospitalization program, but they were not her or the other patients’ individual therapists. Dana talked mostly about one of the therapists, noting that the other left the group for most of the outing to “run an errand” at another store; therefore, the following descriptions pertain to the one therapist with whom Dana interacted for the majority of the exposure outing.

Informality. Dana described her interactions with the therapist as “very informal,” noting that their conversations throughout the exposure outing and were mostly casual and not therapeutic in nature. She mentioned that the therapist also tried on clothing items and showed them to the group for feedback, alongside the patients: “Yeah, and the therapist [tried on clothes] as well. And she was like, ‘Should I buy this?’ And I’m like, ‘Yeah!’ And she wore it yesterday. So it was very like, informal.” Dana recalled that the exposure outing felt like a normal shopping trip with friends. She described:

Initially, one of the other girls and I were in the dressing rooms alone in the being.

Which, it was fine. And then one of the therapists came back and was back there. I mean,

it just sort of felt like I was going to buy clothes with a friend. (Personal interview, 05/10/2016)

Dana valued the informal nature of the shopping trip exposure. In her reflexive journal entry, Dana affirmed, “It was nice to be in the ‘real world’ and outside of the hospital and interacting with the therapists on more of an informal level. Which in the moment might have been more beneficial than the shopping exposure itself.” It was more helpful for Dana to be in a realistic setting, interacting with the therapists as if they were her peers, than the actual exposure to clothing shopping. The meaning she attributed to the exposure outing experience will be discussed further in the next cluster, Meaning of Experience.

Participated in shopping. Related to the informal nature of the exposure outing, Dana found it helpful that the therapist also participated in clothing shopping alongside the patients. She described, “The therapist came in the back and tried on clothes with us, which was helpful just because of how normal she was acting.” Dana perceived this aspect to be supportive because the therapist was behaving normally and not in a formal, clinical manner. However, she was unsure whether the therapist was behaving this way purposefully, to demonstrate normal shopping behavior, or if it were unintentional. Dana reflected:

I think they were modeling normalized behavior. I mean, I would like to assume that's just how they are because they don't have eating disorders, but I wouldn't know for a fact if they were doing that on purpose, or if that's just how they are. (Personal interview, 05/10/2016)

In considering whether the therapist's normalizing behavior were purposeful, Dana offered an example of when the therapist tried on a clothing item that did not fit her well. The therapist came out of the dressing room to show the other patients her reaction. Dana recalled:

[Therapist] was able to identify the negatives in the clothing versus like, my body doesn't fit into this. But, I would like to think that that's normal human behavior without an eating disorder mindset. So, whether that was modeled or not could be argued. I think you would have to ask them. (Personal interview, 05/10/2016)

The further Dana considered the fitting room experience, the more uncertain she was that the therapist was intentionally demonstrating normalized shopping behavior for the patients. She offered another aspect of her example and reflected:

Odds are, it was probably how she normally shops. It just happened to be with us. But I think that if they had been like, "Well, I'm wearing this size." But at the same time... it wasn't like she took the size off to prevent us from seeing. So, I think it was pretty much like, she was just shopping. (Personal interview, 05/10/2016)

After reflecting on several examples from the shopping exposure outing, Dana resolved that the therapist was not intentionally modeling normal behavior for the patients. Rather, she perceived that the therapist was simply shopping for clothing as she would have regularly. Nonetheless, Dana considered the overall feeling of going on a normal shopping trip with friends to be a helpful and supportive aspect of the exposure outing.

Cluster: Meaning of Experience

The thematic cluster of Meaning of Experience comprised of three themes: 1) real world experiences are helpful, 2) not personally impactful, and 3) references to second exposure outing. Themes emerged from discussion about how participating in the exposure outing may or may not have impacted her recovery from anorexia and how she attributed meaning to the experience. References were drawn from the following three sources: initial interview, reflexive journal entry, and follow-up interview.

Real world experiences are helpful. Toward the end of the initial interview, I asked Dana what her big take-away was from the exposure outing experience. She reflected:

I think the biggest thing was realizing how bad my body distortions are. No matter how many times I do, not necessarily shopping exposures, but going to try on clothes at the mall, like in real life, with friends. I'm pretty shocked every time I do it. So I think just re-realizing that again is probably the biggest take-away. (Personal interview, 05/10/2016)

Dana considered her biggest take-away to be confronting her body image distortion, whether it be while shopping with friends or during an exposure outing. I further prompted Dana about what she perceived to be the most meaningful aspect of the experience. She noted, "The time that was taken out of our treatment day to do something that is more real life. But with the additional support." Dana believed that in general, having experiences in a real world setting, with the support of her peers and therapists, is helpful in the recovery process.

Dana also believed that real world experiences are not included enough in recovery programs. She considered her own experiences participating in exposure outings at the recovery program, noting, "I think incorporating stuff like that before transiting home is important. And not enough of it is done most places, especially here." Dana mentioned that she was in the same program a couple years before, and at that time, she had only participated in one exposure outing during her eight-week stay. However, during this hospitalization, she had been on several different exposure outings. "[Now] they have definitely started incorporating them a lot more, which I think is helpful." When I asked what she considered to be the most helpful aspect of having real world experiences, Dana described, "I think it sort of eases you into like the situations that you're going to experience on a daily basis at home, without the partial program to

go back to.” She believed that exposure outings are beneficial in the transition from partial hospitalization to daily living at home.

Although Dana considered the concept of incorporating real world experiences to be important, she did not perceive that particular exposure outing experience to be personally beneficial. In her reflexive journal entry, she wrote: “I think that exposures in general can be extremely helpful, but this specific one was just not the most needed for where I was at in my process.” Dana appreciated the experience for its potential value, but she did not believe it addressed her personal recovery needs at that time; thus the clothing shopping exposure was not personally impactful for Dana, which will be outlined further in the following cluster.

Not personally impactful. Dana did not believe that the particular exposure outing experience impacted her personal recovery from anorexia. During the initial interview, she noted that her recovery would not have been different, had she not participated in the shopping exposure. She reflected, “I honestly don’t think it would have made a difference. I think [exposure outings] have a role, and they are really helpful. But for me, I just don’t think that, at this point.” Dana reiterated this sentiment in her reflexive journal entry. She wrote, “I think that the shopping experience did not play a huge role in my treatment or recovery. However it did not inhibit my process either. For me it was a pretty neutral experience.”

From Dana’s descriptions, it was unclear why she did not perceive this particular experience to be personally impactful, given that she considered those types of experiences to be beneficial in the recovery process overall. During the follow-up interview, I asked Dana what might have made that particular exposure outing more impactful to her. She considered her experiences in other treatment programs in comparison:

I've gone on shopping exposures in other treatment programs that are well-established, and I don't think I found those very helpful either. So I don't think that it's necessarily the program, or what they're doing or not doing, but more so with me. The shopping trips in general aren't the most effective. (Personal interview, 05/10/2016)

Dana explained that there was not a specific aspect of the shopping exposure outing that she did not find beneficial; rather, she did not perceive them to be effective to her, personally. Dana appreciated the concept of exposure outings but did not find them helpful in her experience. She later suggested individualizing the exposure therapy, which will be outlined in the next cluster.

References to second exposure outing. During the follow-up interview with Dana, she mentioned that she went on the shopping trip exposure again, since the time of our initial interview. Of the three participants who completed follow-up interviews, she was the only one who talked about a second shopping trip exposure. I asked Dana if she would like to share anything about her experience, and she responded "I honestly don't remember (laughing). It was like three months ago." Dana mentioned that the protocol was mostly the same as the first time she went and that nothing different stood out for her. She said, "It was the day I discharged, so it was kind of a hectic day to remember." Dana recalled the staff asking if she wanted to go on the shopping trip again to fulfill a minimum quota. She reflected, "I think the reason I went shopping the second time was because there weren't enough people that were eligible to go. Like Dana, you wanna go again? I was like, sure." Although it was her final day in the program, and she did not find the first shopping exposures to be particularly beneficial, Dana participated nonetheless.

Cluster: Suggestions

Dana had been through numerous recovery programs and participated in various therapeutic interventions for anorexia, including different types of exposure therapies. Her vast

experience as a patient served as a basis for comparison with the particular exposure outing of interest. Toward the end of the initial interview, we discussed possible ways to improve the exposure outing so that it might be more beneficial. Two themes emerged: 1) more planning and preparation, and 2) individualizing exposure therapy.

More planning and preparation. In her previous experiences of exposure therapy, Dana had come to expect a structured protocol. She reflected, “I sort of expected it to be more regimented, and it was sort of relief for it not to be that regimented. But there’s probably room for a little bit more.” Dana had mixed feelings about the unstructured nature of the shopping exposure outing and thought that it might have been further refined. She described, “I mean, that’s [hospital program], and their stuff in general was fairly new at that point... so I think that they’re working. I think it’s a work in progress.” Dana believed that the particular hospital was in the early stages of incorporating exposure therapies into their treatment program and therefore did not have a planned structure to their exposure outings.

To improve the experience, Dana suggested better preparation for the outing. She reflected, “I think preparing for it a little better, instead of...I understand they don’t want people panicking ahead of time about it. But I think it might be helpful to know it’s coming.” Perhaps knowing about the exposure outing ahead of time might have afforded the patients and staff more opportunity to set individual goals plan for specific therapeutic interventions that would address each patients’ particular concerns, which led into the following theme within the cluster of Suggestions: individualizing exposure therapy.

Individualizing exposure therapy. As a result of having gone through so many treatments, Dana became increasingly aware of what she needed to navigate successfully through the recovery process, noting, “I think it’s just the level of insight I have into my eating disorder

and the causes of the disorder that I didn't have six years ago." Related to the theme of personal recovery process, Dana recognized the importance of individualizing treatments to meet her needs. She offered the following suggestions: "I think that A) things need to be individualized patient to patient, but I think B) patients need to be taken as they are, each admission, or day even." Given her descriptions, it became apparent that Dana did not believe the shopping exposure addressed her particular concerns at that specific time.

Toward the end of the initial interview, Dana discussed possibilities for exposure therapy experiences that might better suit her individual recovery needs. For example, she believed it would be more helpful to be with her individual therapist for the exposure outing, while in a real world setting. She described her idea:

I think having the one-on-one shopping experience. Like your individual or primary therapist would be ideally, like in a private setting, but in a real store. Like alone in a real store, with your therapist, I think would be probably the most [ideal]. (Personal interview, 05/10/2016)

For Dana, the most ideal condition for a shopping exposure would still be in a real world setting but with more privacy and her individual therapist. In this type of situation, she would be able to address her particular issues with the therapist in an individualized manner.

Dana offered another idea for an effective exposure therapy, incorporating a body tracing activity into the clothing exposure: "If you were to incorporate the body tracing and shopping exposure into one, and you did the body tracing, and then held clothes up to the body tracing. Because you [could] see what your distortion is." Recalling the theme of personal recovery process, Dana found it most helpful to have external, objective references to challenge her body image distortion. Further, her biggest take-away from the exposure outing was confronting her

body image distortion and realizing how she still perceives her body size to be very different from actuality. Hence, Dana's idea seemed to be an ideal way of meeting her recovery needs through exposure therapy.

Dana further reflected her suggestion of individualizing exposure therapy in her journal entry. She wrote:

I think that exposures in general can be extremely helpful, but this specific one was just not the most needed for where I was at in my process. I think that adapting the way the shopping exposures happen could be the "magic" ticket for being more helpful for me and possibly others. (Personal communication, 05/17/2016)

Dana reiterated that although she considered exposure therapy to be beneficial in general, the particular shopping exposure outing was not what she needed at that time, in her personal recovery process. She believed that tailoring the exposure therapy to meet individual needs would be the most helpful.

Case Summary and Researcher Interpretations: Dana

Dana considered herself to be emotionally detached, which came across in the way she described her experience of anorexia and history of treatments. Her accounts were mostly matter-of-fact and included few, if any, references to feelings and emotions. At one point in the interview, Dana mentioned that she was distracted by something unrelated to the exposure outing. She said, "It's actually kind of a funny story because I was struggling. I have a trauma history..." As previously outlined, Dana went on to say that her body image was the least distorted it had been because she was distracted, and her mental capacity was preoccupied with that instead of her reflection. Her choice of words were interesting to me because the phrases

“funny story” and “trauma history” seem paradoxical when paired so closely together. This example seemed to fit her self-description of “emotionally disconnected from myself in general.”

Dana expressed profound insight into her personal recovery process, knowing what to expect physically and cognitively at every stage. She had been through so many treatment programs in the past that recovery became a familiar cycle. Because of her experience as a seasoned patient, she was positioned in an elevated social status in the milieu among both her peers and patients in the program, of which she was also aware. Dana relied on her knowledge and awareness to her advantage in staying ahead of the game, such as when she found out that they were going on the shopping trip before it was announced and when she convinced her doctor that she could know her weight during the restoration process.

At that point in her recovery cycle, when she went on the exposure outing, Dana did not believe that clothing shopping was the type of exposure outing she needed. She did not feel anxious about trying on clothing, saying “I wasn’t very worked up about it.” Dana explained that for her, shopping “Can be [anxiety-provoking], but not lately.” From her descriptions, it became clear that the shopping exposure outing was not intentionally designed to address her specific therapeutic goals. As a result, Dana did not consider the exposure outing to be impactful in her personal recovery from anorexia.

Although the exposure outing experience was not personally impactful for Dana, there were some aspects that she considered to be beneficial. She described having positive relationships with her peers who went on the outing with her, noting that she felt supported by them because they understood each other’s concerns. However, the most salient theme that emerged was the role of the therapist. Dana appreciated the casual nature of the shopping trip and interacting with the therapists more informally. She said it was like shopping with friends,

and she appreciated feeling independent and not “micromanaged,” although she mentioned that a bit more structure may have been beneficial. Dana also found it helpful that the therapist participated in shopping alongside the patients, selecting clothing items and trying them on as a parallel process. Initially, she considered that they might have been “modeling normalized behavior,” but later she was not certain the therapist’s behavior was intentional. Nonetheless, she considered the informality and participation of the therapist to be supportive and a helpful aspect of the outing. Dana primarily suggested that individualizing the exposure therapy to address her individual concerns would help to make the experience more meaningful and impactful.

Convergent and Divergent Analysis

Until this point, each participant case was examined in depth and individually for emergent themes and outlined in the previous sections, employing a “theme within case” approach (Smith, Flowers, & Larkin, 2009). Throughout the process, I have illustrated those themes descriptively by using participant quotes, paraphrasing and summarizing, and I offered my personal reflections at the end of each case display. For the final phase of analysis, while embracing my interpretive role in the process, I performed a cross-case analysis of the four participants. This led to the emergence of superordinate themes that spoke to the greater picture of how these women diagnosed with anorexia have attributed meaning to the experience of this particular exposure therapy. In general, superordinate themes are not necessarily the most frequently referenced, although that may be the case (Biggerstaff & Thompson, 2008). Superordinate themes highlight salient aspects of the experience that resonated as the most meaningful and important across participants. They are developed in a double-hermeneutic process (i.e., the primary researcher reflecting on the participants’ reflections of the meaning of their experiences), as well as employing a cyclical pattern of analyzing themes, moving back and forth from the individual to the shared experience (Smith, Flowers, & Larkin, 2009).

Cross-case Analysis of Themes

My primary intention was to identify superordinate themes related to the meaning participants ascribed to their experiences of this particular exposure therapy. With that goal in mind, I considered several factors in the process of creating the cross-case analysis table. First, I examined the summary tables of each participant side-by-side and highlighted themes and subthemes that were 1) apparent in at least two of the four participants’ descriptions, and 2) served as an exception of interest. In doing so, I noted in the margins which themes were shared

among participants and which were unique to one participant. This procedure was performed by hand on paper using color-coded markings (see audit trail).

Recognizing salient themes. Across all four participants, there were a total of 82 themes and subthemes. Many of those themes overlapped and were merged. That is, the specific names of themes may have been altered slightly from the individual case summary tables to match, when they were describing similar experiences (e.g., “real-life” and “real world” or “recovery is personal” and “personal recovery process”). After merging similar themes, I arranged them categorically so that related themes were grouped together, similar to the process of thematic clustering that was performed for individual participants. As a result, I found that 20 themes were apparent in at least two cases, 10 themes emerged for at least three participants, and five themes were evident in all four participant cases. Moving toward the identification of superordinate themes, I considered those that emerged in at least three cases to be salient at this point in the analytical process. Salient themes included the following: 1) real world experience, 2) unstructured protocol, 3) expectations of participants, 4) supportive environment 5) positive relationships, 6) therapist role, 7) self-awareness, 8) personal recovery process, 9) negative body image, and 10) enjoyable, memorable experience. Table 5 illustrates the initial phase of cross-case analysis, displaying an “x” where themes are indicated for each participant.

Table 5

Initial Phase of Cross-Case Analysis: Themes Apparent in At Least Two Participants' Descriptions

Theme	Michelle	Jessica	Rachel	Dana
Real world experience	X	X	X	X
Unstructured protocol			x	x
Expectations of participants	x	x		x
Supportive environment	X	X	X	X
Positive relationships	X	X	X	X
Therapist role	X	X	X	X
Participated in shopping			x	x
Non-directive	x		x	
Balance between support and autonomy	x	x		
Therapist was informal			x	x
Enjoyable, memorable experience	x	x	x	
Self-awareness	X	X	X	X
Personal recovery process	x		x	x
Interpersonal role within group	x			x
Negative body image*		x	x	x
Mirror interactions	x			x
Anxiety regarding exposure		x	x	
Coping strategies (e.g. avoidance)		x	x	
Not impactful			x	x
Suggestions to improve exposure			x	x

Note. Themes in bold font emerged in all four participant cases. Those marked with an asterisk were salient and apparent in three participants' descriptions but offered a disconfirmatory case.

The themes in Table 5 are organized in a way that demonstrates a hierarchical aspect of their relationship, with indentations denoting that a theme categorically belongs to the one above that is not indented. This arrangement was intentional and attempts to honor the manner in which themes were organized conceptually for individual cases. For example, all four participants described having positive relationships with their peers on the exposure outing (positive relationships), and they also described different ways the therapists interacted with them during the exposure outing (therapist role), both contributing to the supportive environment which they

perceived. For that reason, the themes of positive relationships and therapist role were indented and grouped categorically under the larger theme of supportive environment.

Disconfirmatory cases. Some themes emerged for most participants but not for all of them. Four of the nine salient themes contained disconfirmatory cases: expectations of participants, personal recovery process, negative body image, and enjoyable, memorable experience. An example of a disconfirmatory case is as follows: three participants described having negative body image as part of their experience (Jessica, Rachel, and Dana), but one participant denied negative body image (Michelle). Disconfirmatory cases have potential importance regarding the meaning participants attributed to their experiences, and they will be included within the summary of superordinate themes in the following section.

Unique themes. To support the cyclical process of moving from the shared experience to the particular and back to the shared experience, I also examined unique themes to ensure that I had taken each person's individual perspective into consideration. Unique themes were those that emerged for only one participant and were not able to be merged together with similar themes of other participants. Table 6 displays unique themes for each participant, including some of my own reflections. This information was included to offer examples of the analytic process, noting how those unique themes might be compared with or related to references that were made by other participants in their interviews and journal entries.

Table 6

Unique Themes Indicated in Only One Participant of the Four, With Researcher Reflections

Participant	Unique theme/subtheme	Comparisons and reflections
Michelle	Excited, positive emotions	
	<i>Denies negative feelings</i>	Dana also did not express negative feelings regarding the exposure, but it was not an emergent theme for her
	<i>Guardedness during interview</i>	
	Comparative thoughts	In the individual case analyses, this did not emerge as a theme for the other participants; however, all participants referenced another kind of exposure intervention they participated in or knew about otherwise. This theme could be related to the theme about expectations, or it could develop into another theme.
	Planning ahead	Could be coping strategy, but was not in response to anxiety as it was with others
	Uncertainty	
Jessica	Averse to clothing shopping	Interesting exception; Jessica was the only one who was averse to clothing shopping to begin with, so it seems more applicable as an exposure therapy to her
	Lens of anorexia	
	<i>Shame and embarrassment</i>	
	Inspired by their courage	
	<i>Non-judgment regarding size</i>	
	Safety and trust	Michelle also mentioned this in her journal entry, but it did not emerge as a theme
	<i>Shared experience of anorexia</i>	An exception to personal recovery process; Jessica viewed having others on the trip who had eating disorders to be a supportive factor because of shared understanding
	Gained confidence	
	Felt more connected	Similar to Michelle, supportive environment was meaningful aspect
Rachel	<i>Influence of mood on experience</i>	Her personal way of experiencing anorexia and body image issues; could be related to theme “personal recovery process”
	<i>Unclear purpose and goals</i>	Similar to “non-directive” theme about therapists but she perceived it as a barrier to support
	Lack of support during transition	
	Not her individual therapists	Dana also mentioned this during the initial interview, but it did not emerge as a theme
	Processing of emotions during exposure	Dana talked about brief processing before and after; could be considered similar; Rachel wanted more processing, and Dana did not say if she believed it was adequate, only that it happened.

Dana	More structure and intentionality	Similar to “More planning and preparation” theme (Dana)
	Go on more exposure outings	Dana also mentioned that exposure outings should happen more frequently, although it was not a theme for her individually
	<i>Familiar cycle</i>	
	Brief processing before and after	Rachel suggested that there be more therapeutic processing throughout, and Dana mentioned that there was brief processing but did not offer a suggestion about it
	References to second exposure outing	
More planning and preparation	Similar to “More structure and intentionality” theme (Rachel)	
Individualizing exposure therapy	Related to personal recovery process (also referenced by Michelle)	

After considering the salient themes presented in Table 5, while reflecting on disconfirmatory cases and the unique themes presented in Table 6, I explored the relationships between those themes by arranging and rearranging them conceptually. Then, I considered how themes related to the meaning participants attributed to their experience of the exposure protocol. In this step, I recognized that one of the salient themes identified above (i.e., expectations of participants) was merely describing the exposure protocol and not highlighting the meaning of their experiences; therefore, it was not included as a final superordinate theme. Further, I recognized that another salient theme (i.e., enjoyable, memorable experience) was actually embedded within the theme of supportive environment in that, participants considered the experience to be enjoyable because of their positive relationships with peers and therapists. Figure 2 offers a visual display of how superordinate themes are organized and related to the meaning of participants' experiences of this particular exposure therapy.

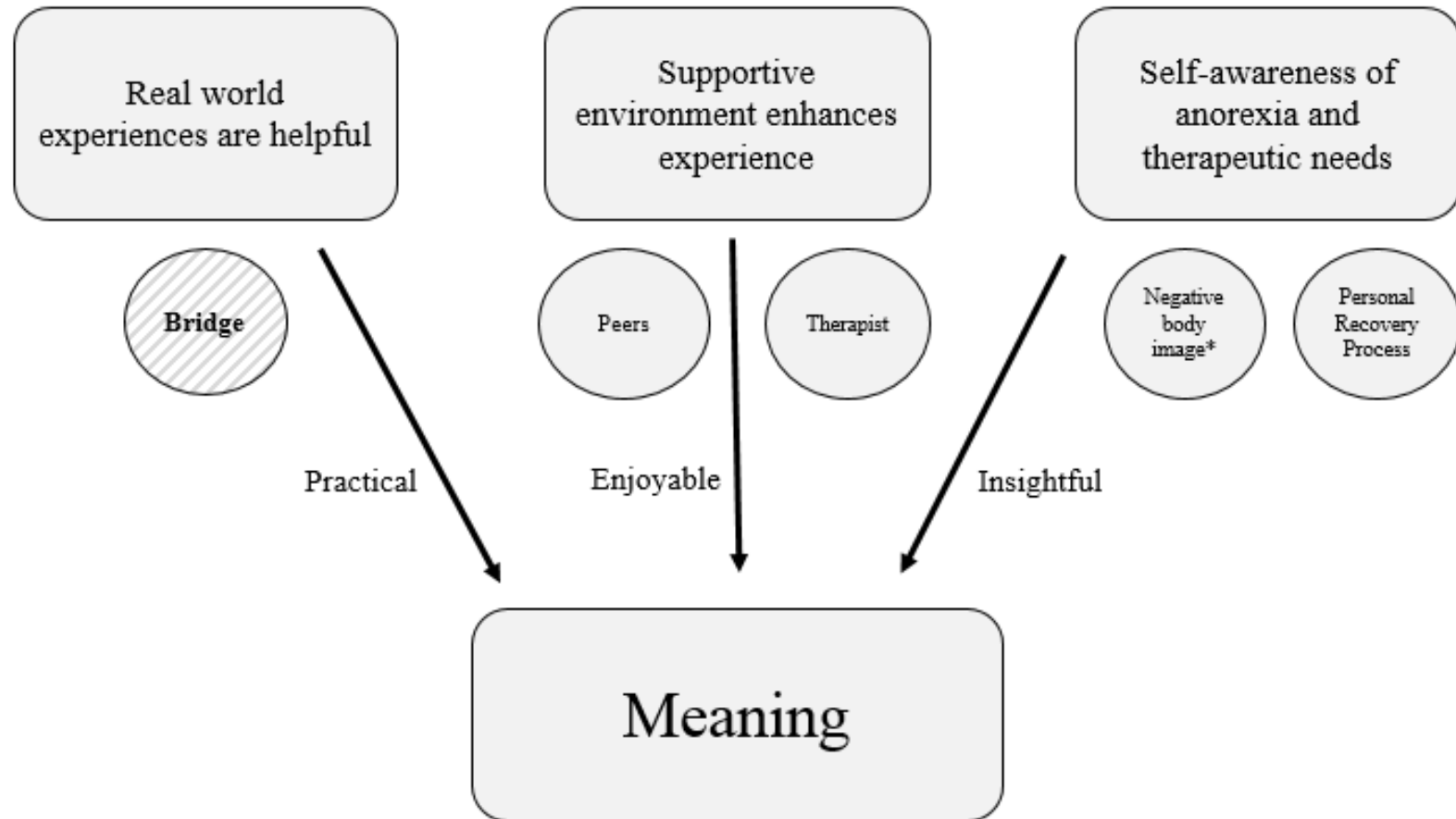


Figure 2. Organization of superordinate and subordinate themes for meaning of exposure therapy experience. Subtheme “bridge,” indicated with stripes, emerged during cross-case analysis; subtheme “negative body image,” indicated with asterisk, presented a disconfirmatory case.

As a result, the following three superordinate themes emerged, related to the meaning participants attributed to their experiences of the exposure therapy: 1) Practical: real-world experiences are helpful (subtheme: Bridge between hospital and home life), 2) Enjoyable: supportive environment enhances experience (subthemes: Positive peer relationships and Role of therapist), and 3) Insightful: self-awareness of anorexia and therapeutic needs (subthemes: Negative body image and Recovery is personal). In this section, I will employ a “case within theme” approach by outlining superordinate themes and offering evidence from each participant to support those themes (Smith, Flowers, & Larkin, 2009). Table 7 summarizes the final structure of superordinate themes and subthemes, notes which participants contributed to each theme, offers examples of indicative quotes, and includes researcher notes.

Table 7

Final Structure of Superordinate Themes Related to the Meaning Participants Attributed to Exposure Therapy Experience

Superordinate Theme	Participants contributing to this theme	Subthemes	Participants contributing to this subtheme	Indicative quotes	Notes
Practical: Real-world experiences are helpful	All participants	Bridge between hospital and home life	All except Jessica	I just feel like, this was more like applicable to your daily life, you know? (Michelle)	Everyone expressed that having the exposure in a real world setting made the experience more meaningful.
				I think it sort of eases you into the situations that you're going to experience on a daily basis at home, without the partial program to go back to. (Dana)	Michelle and Dana talked about how this type of exposure can help with the transition from being in the hospital to living back at home.
Enjoyable: Supportive environment enhances experience	All participants	Positive peer relationships;	All participants;	If I was with girls that I wasn't very close with or didn't feel comfortable with, it would have been a completely different experience for sure. (Rachel)	The role of the therapist was perceived as supportive in different ways. For example, Michelle and Jessica described some therapeutic prompting, while Rachel and Dana perceived therapist interactions as more casual, like friends. But they were all considered supportive.
		Role of therapist	All participants	I never felt pushed too far. I always knew it was a gentle push and encouragement. (Jessica)	
Insightful: Self-awareness of anorexia and therapeutic needs	All participants	Negative body image;	All except Michelle;	I was fixating on my body image and recognizing all the weight that I've gained from the program, and that was just hard for me. (Rachel)	Michelle was a disconfirmatory case for the negative body image subtheme because she expressed that she has "always liked my body" and "always had relatively good body image."
		Recovery is personal	All participants	Everyone's treatment is different, everyone's problems are different. Everyone's body is different. So you can't generalize or compare yourself to another person's treatment. It's very much a personal recovery path. (Michelle)	Jessica believed that everyone's journey is unique and she also valued the shared experience of anorexia and having peers who understood what she was going through during the exposure.

Practical: Real World Experiences Are Helpful

All four participants talked about the “real world” aspect of the exposure outing, in direct connection with the meaning they attributed to their experience. Each of these women perceived value in the fact that the intervention took place outside the hospital setting and in a natural environment. Michelle reflected that one of the most meaningful aspects of the exposure outing was that it was different from the usual therapies of individual and group sessions in the treatment facility:

All of the groups and all of the worksheets, they kind of mesh together. Whereas the exposure trips like this, they’re something different. And, it makes it more impactful and meaningful. I probably got more out of this hour and a half experience than I do in a week of usual groups! (Michelle)

Rachel also believed that incorporating real world experiences into therapy was helpful in preparing her for life outside of the hospital. In her reflexive journal entry, she summarized, “The purpose of treatment, in my opinion, is to get us stable enough to be in the real world, so being able to go shopping as part of treatment was very beneficial.” Jessica said that having experiences outside of the hospital helped her maintain what she learned after discharge:

I feel like the longer I’ve been out in the real world, I feel more distant with what happened within the walls of [the hospital]. But the things that happened outside and that weren’t necessarily on that unit kind of stuck with me because that was in the real world. (Jessica)

Dana mentioned, “I think incorporating stuff like that before transiting home is important. And not enough of it is done most places, especially here.” Rachel echoed this perspective, saying, “I think it’s an effective form of therapy, I really do. And I think that it needs to be done more

often.” Overall, the participants believed that having the exposure outing in a real world setting was meaningful and an important aspect of their recovery.

Bridge between hospital and home life. Although it was not apparent within individual participant cases, this theme emerged while analyzing descriptions of the real world theme across cases. Three participants described the exposure outing like a bridge or transition between hospitalizations and living back at home in the real world. Michelle mentioned that if she had not participated in the exposure outing, she “probably would have felt like I was maybe missing something, that piece of the treatment. It was the bridge.” Rachel reflected on the importance of having real-world experiences during treatment:

You’re in this program that’s very structured, and they provide your meals. You don’t just get anything, you chew what’s in front of you. And then you’re just kind of thrown in the real world, which is what happened to me and I kind of had no support after that. So something in the middle would have been nice. I think more experiences in the real world would have been helpful in treatment. (Rachel)

Dana echoed this perspective, reflecting, “I think it sort of eases you into like the situations that you’re going to experience on a daily basis at home, without the partial program to go back to.”

Jessica was the only participant who did not specifically perceive the exposure outing as a transition piece or bridge from hospital to the real world, although she alluded to it sticking with her for longer because it happened in the real world; therefore, it is unclear whether Jessica was disconfirming this subtheme, or if she also perceived the experience this way, based on her descriptions. For the majority of participants, however, the fact that this particular exposure therapy was performed outside the hospital served as a helpful transition from being in the partial hospitalization program to living back at home.

Enjoyable: Supportive Environment Enhances Experience

Support emerged as a salient theme across all participant cases. Participants discussed supportive interactions with both their peers from the program and the therapists who were facilitating the exposure outing. They discussed various ways in which their peers and the therapists contributed positively to the meaning of their experiences of the exposure outing.

Positive peer relationships. All four participants believed that their experience of the exposure outing was enhanced by the presence of their peers, with whom they had already established positive peer relationships while in the recovery program. They often referred to their peers as “friends” when talking about them. Michelle talked about how they offered her genuine encouragement while on the exposure outing, which helped to minimize negative thoughts and feelings. She said, “I liked the group that I went with, it was some of my close friends that are in the treatment center as well, so I think that kind of helped minimize my anxieties.” Jessica looked to her peers as role models, describing how seeing her peers act confidently inspired confidence within herself during the exposure outing. She reflected, “Thinking about that trip, especially it being with the other girls [that] were there, and how they were able to find their own little confidence streak, I was like maybe I can do it too!” For Rachel, it was typical that she felt the most meaningful support from her peers while in treatment. She described:

I’ve always found that other patients have been more comforting to me than my therapist and clinicians. So that’s something that is typical for me. I usually find more comfort, or I feel like I have more progress in therapy, when I am just talking to them and trying to figure things out and analyzing situations, or even helping them in their problems. That helps me a lot, more than I would have expected. (Rachel)

Similarly, it was helpful for Dana to have her peers on the exposure outing because they understood what she was going through and could offer her support. She described, “I think going with people that know you and are familiar with your reactions to things is helpful because you can support each other.” Although each of the participants described slightly different supportive aspects of having their peers on the exposure outing, they all believed that going through the exposure outing with them added value and meaning to their experience.

Role of therapist. All of the participants perceived the role of the therapist in the exposure outing to be supportive and positively contributed to the meaning of their experiences. Michelle appreciated the balance of autonomy and support that the therapists offered while on the exposure outing. She said, “We had independence, but at the same time, we had support as well. So it was a good balance.” Jessica echoed this perception about balance, reflecting that she did not feel too much pressure from the therapists, while receiving a “gentle push” to try things outside of her comfort zone. She reflected on how the therapists were encouraging and not forceful, even though she did not plan on purchasing items:

It was just for the sake of trying things on, and seeing how they fit, and seeing how I felt in them, and seeing if I liked it. And so much more about being in clothes, as opposed to anything else. Just that comfort level, and that exposure, and being with [Clinician] on a one-on-one basis, picking out things that I would have *never*... one thing you gotta understand, I would have *never* tried on my own. (Jessica)

What was most meaningful for Michelle and Jessica was that they were offered a balance of therapeutic support and independence from the therapists while on the exposure outing; however, Rachel and Dana described a different dynamic. They talked about how the therapists participated in clothing shopping alongside the patients during the exposure, perceiving them to

act more like friends than clinicians. Rachel described, “It didn’t feel like we were in therapy at all. It just felt like we were all friends hanging out shopping together, which was nice.”

Similarly, Dana

described, “The therapist came in the back and tried on clothes with us, which was helpful just because of how normal she was acting.” She valued the informal nature of her interactions the therapists on the exposure outing:

Yeah, but I will say that I sort of liked the informality of it. That was helpful because I’m not the type of person that likes to be micromanaged and over-controlled. So not having a therapist like literally follow us around and be like, “Try this, try this, try this” was nice.

(Dana)

Rachel and Dana described a more informal role of the therapists than Michelle and Jessica, who did not describe the therapists to have participated in clothing shopping along with the patients. In Michelle and Jessica’s descriptions, the role of the therapists seemed more clinical in nature; however, each of these women perceived those different aspects of the therapist’s role to be supportive in their own ways.

Insightful: Self-Awareness of Anorexia and Therapeutic Needs

The theme of self-awareness was apparent throughout the descriptions of all four participants. For Michelle and Jessica, it manifested as an individual theme related to the meaning they attributed to their experience because they both believed that their self-awareness improved as a result of their participation in the exposure outing. For Jessica, Rachel, and Dana, self-awareness represented a cluster of themes related to how they perceived themselves throughout the experience. During cross-case analysis, the following two subthemes emerged

regarding participants' self-awareness of their experiences of anorexia and their individual therapeutic needs: negative body image and personal recovery process.

Negative body image. Three of the four participants talked extensively about negative body image as part of their experiences of anorexia and the exposure outing, but one participant (Michelle) disconfirmed this theme. Jessica described feelings of shame and embarrassment regarding her body image, which contributed to her general aversion to clothing shopping. As a result, she would dress conservatively. Jessica reflected, "It's so much easier for me to hide in like, sweatshirts and sweatpants." Wearing clothing that was form-fitting or showed much skin made Jessica feel self-conscious and insecure.

Rachel described how gaining weight in the recovery process was a trigger for her negative body image. Although she recognized that she would rationally wear a size or two larger in jeans after gaining weight during treatment, Rachel reflected on the struggle of challenging her negative body image and accepting her size:

I was fixating on my body image and recognizing all the weight that I've gained from the program, and that was just hard for me, I guess. It was just a hard adjustment. And I'm still getting used to it, I guess. Like I don't know when I will ever feel okay with it, but definitely still trying to understand and accept it, I guess. (Rachel)

Similarly, Dana expressed how difficult it was for her to challenge her negative body image. She recognized that her own perceptions of how she looked were theoretically different from others' perceptions; however, she still struggled to see herself in a more realistic way:

I still struggle with like... knowing that. Like I know that cognitively, but it's hard for me to sort of wrap my head around like how distorted things are because I don't really trust other peoples like opinions of, "You don't look like that." I'm like, "But I do." (Dana)

As previously noted, Dana described her biggest take-away from the exposure outing to be recognizing how negative her body image distortion was, improving her self-awareness and contributing to the meaning of that experience.

Michelle was an exceptional case regarding negative body image. She described, “I’ve always liked my body. I’ve always had relatively good body image.” Her main concern was about not being able to exercise while in the program. This reflection was notably different from the other participants, who perceived their bodies negatively during the weight restoration process. Although she did not describe negative body image during the exposure outing, the experience was meaningful to Michelle because of her improved self-awareness. In her reflexive journal entry, she wrote: “I learned a lot about myself through this process, for example how it helps me to shop with friends and family and how I can stop negative thoughts by thinking about positive physical and personality characteristics.”

Personal recovery process. All of the participants talked about how their experience of anorexia was unique. For Michelle and Dana, the personal recovery process emerged as its own theme in their individual cases. Michelle started off the interview by referring to herself as a “slightly atypical anorexia case” because she did not experience negative body image as many of her peers did. She wrote in her reflexive journal entry: “Each person’s journey through anorexia is different, so group sessions in the treatment center sometimes do not apply to some people as much as others.” Dana was also familiar with her personal recovery process and how she personally navigated through it. She described:

I have a very objective view on it just because I have done the restoration process so many times, that I sort of know what things are going to look like and what distortions are going to be like throughout where my weight is and the restoration process. (Dana)

For Rachel, personal recovery process did not emerge as its own theme; however, she did emphasize that not all eating disorder experiences are the same. She reflected:

I hate that people treat (bulimia) like it's the same disorder. It drives me insane. Like even in our partial program, like we never knew who had what diagnoses or what, but we were all treated the same and all had the same meal plan. It's just, a different thing! It drives me crazy. (Rachel)

Similarly, Dana considered how the exposure therapy did not align with her individual therapeutic needs at that point in her personal recovery process; however, she still participated in the exposure twice while in the program. She reflected,

I think that exposures in general can be extremely helpful, but this specific one was just not the most needed for where I was at in my process. I think that adapting the way the shopping exposures happen could be the "magic" ticket for being more helpful for me and possibly others. (Dana)

Although she perceived the exposure outing to be meaningful in some aspects, Dana suggested that individualizing the exposure therapy to meet individual therapeutic needs would enhance the value of their experiences.

Jessica's experience of this theme was considered to be potentially disconfirmatory. She did believe that people with anorexia have unique journeys throughout recovery and expressed that perception explicitly. At the same time, she considered it to be most helpful being with people on the exposure outing who had a shared understanding and experience of negative body image. During the initial interview, there was a moment when Jessica realized how her self-critical perspective shifted, and how that was facilitated by the shared experience of anorexia she had with her peers. She reflected: "We all have some similar experiences or some shared thought

processes.” Jessica felt more connected with her peers because of the similarities of their experiences, which made her experience more meaningful.

Notable Mention

Although it did not emerge as a superordinate theme or subtheme, I noticed a pattern during cross-case analysis worth mentioning. Two participants (Michelle and Jessica) perceived the exposure outing experience to have influenced their recovery from anorexia in a positive and impactful way. Michelle believed it was necessary to have an opportunity to practice what she learned during treatment outside in a realistic setting. Jessica gained confidence and experienced a shift in her self-critical perspective that she believed may not otherwise have happened. However, the other two participants (Rachel and Dana) both had individual themes describing that the exposure outing was not an impactful experience as part of their recovery from anorexia. Rachel expressed that she needed more frequent exposure outings to have a greater influence on her personal recovery. Dana appreciated the benefits of exposure outings but did not believe that she needed that particular intervention at that time. Consequently, both Rachel and Dana offered suggestions of how to improve the exposure outing experience, whereas Michelle and Jessica did not discuss recommendations. The common threads between Rachel and Dana’s suggestions were structure and intentionality of the exposure outing. They both also described the therapists as casual and more like friends than clinicians, which was not apparent for the other two participants. Although Rachel and Dana considered the experience to be meaningful in some ways, it is plausible that offering more structure and setting intentional and individualized therapeutic goals for the exposure outing may have been more beneficial.

Summary of Findings

After analyzing participant data and finalizing individual codebooks for each participant in depth, the primary researcher performed a cross-case analysis to review shared and unique themes, as well as disconfirmatory cases of salient themes. This process helped to shed light on themes that may not have been apparent within individual cases but became apparent during comparison. The following superordinate themes and subthemes emerged: 1) 1) real world experiences are helpful, (subtheme: bridge between hospital and home life), 2) supportive environment enhances the experience (subthemes: positive peer relationships; role of therapist), and 3) self-awareness of anorexia and therapeutic needs (subthemes: negative body image; personal recovery process). The most noteworthy disconfirmatory case was for the subtheme of negative body image, in which Michelle denied negative perceptions of her body shape and size and referring to herself as “atypical.” Another notable finding was that the first two participants considered the exposure outing experience to have had an impact on their recovery from anorexia, while the second two participants reflected that the experience was meaningful in certain aspects but it did not impact their recovery overall.

CHAPTER FIVE

DISCUSSION

This chapter begins with an overview of the purpose and methodology of the current research study. Key findings (i.e. superordinate and subordinate themes) are outlined, and connections are made to existing literature on the topic of exposure therapy interventions for women with anorexia nervosa. Implications for clinical research and practice, drawn from the findings of the present study, are also noted. Finally, the chapter concludes with limitations, specific recommendations for enhancing the exposure protocol, and future research directions.

Overview of Purpose of Study and Methodology

The purpose of this study was to explore how women, who were diagnosed with anorexia and enrolled in a partial hospitalization program for disordered eating, described their experiences of participating in an exposure therapy protocol that was performed in a naturalistic setting. There have been numerous phenomenological studies exploring various aspects of the lived experiences of women with anorexia; however, there were very few qualitative studies exploring the experience of undergoing a particular therapeutic intervention (e.g., Godfrey et al., 2015; McIver et al., 2009; Proulx, 2007). Further, none of those studies were focused specifically on women with anorexia. There was only one study that mentioned a qualitative inquiry of body image exposure in women with anorexia (i.e., Morgan et al., 2014), and it posed several methodological limitations. After an extensive review of the literature, I have not found a published research study that explores how women with anorexia describe their experiences of undergoing an exposure therapy intervention in a naturalistic setting. Therefore, the present study aimed to fill this gap in the literature with a rigorous qualitative exploration of this particular experience for a specific group of people.

The first research question of this study sought to understand how women diagnosed with anorexia described their lived experiences of undergoing a body image/mirror exposure therapy that was performed in a naturalistic setting. The second research question explored how those women attributed meaning to their experiences as part of their recovery from anorexia. Employing the in-depth, qualitative approach of interpretative phenomenological analysis (IPA), the research team members examined semi-structured interview transcripts and participants' reflexive journal entries for emergent themes within individual participant cases, and the primary researcher re-analyzed and reported findings for each individual case one at a time (theme in case). Themes and thematic clusters emerged for individual participants, which informed the primary research question. Next, embracing her interpretive role in the analytic process, the primary researcher performed a cross-case analysis to explore the relationships between individual cases and themes, highlighting both salient themes and disconfirmatory cases in a cyclical, double-hermeneutic process. The intention was to identify superordinate themes regarding the meaning that participants attributed to their experiences of the exposure therapy as part of their recovery from anorexia, informing the second research question of this study.

Participants described the procedures of the exposure outing, including explicit and perceived expectations of what would happen during the intervention. They discussed interactions with their peers who were also on the exposure outing, as well as the role of the therapist throughout the experience. The participants also demonstrated self-awareness while reflecting on the experiences, sharing thoughts and feelings about their body image during the exposure. As the researcher prompted them to reflect further, the participants considered how they attributed meaning to their experiences, making sense of how it fit into their personal recovery process. Overall, they perceived that incorporating practical, real world interventions

into treatment was important, they valued the support of their peers and therapists, and they appreciated the self-awareness and insight they experienced on the outing.

Research questions often evolve in the process of performing qualitative inquiries. Different areas for exploration may emerge that were not anticipated at the start of the project, as is the nature of such endeavors. While seeking to understand how participants made sense of their experiences as part of their recovery, my interpretations shifted from descriptive to more evaluative. I recognized the shift during the process of analyzing the final two participant cases, in which they reflected that their experiences were meaningful, but not impactful (which contrasted with the first two participant cases, who said the experience was both meaningful and impactful). It is with this evaluative lens that I discuss the key findings of the study as they relate to existing research and offer recommendations for potential improvement of the particular exposure protocol described in this study.

Comparison of Key Findings with Extant Literature

Three superordinate themes emerged within participants' reflections about the meaning of their experiences during the shopping exposure: 1) real world experiences are helpful, 2) supportive environment enhances the experience, and 3) self-awareness of anorexia and therapeutic needs. In the nature of IPA research, themes often emerge during analysis that were not anticipated in the semi-structure of the interview prompts (Smith et al., 2009); therefore, it was important to revisit the evidence base when exploring the connections of the key findings of this research study. In this section, I will discuss how the main findings of this study resemble or contradict existing research studies about exposure therapy and recovery from anorexia.

Real World Experiences Are Helpful (Practical)

One of the unique aspects of this particular exposure therapy protocol was that it was facilitated outside of the hospital, in a naturalistic setting. All of the participants endorsed the practicality of having therapeutic experiences in a real world setting because they perceived benefits in taking what they learned during treatment and practicing it the way they would after discharge. To the knowledge of this researcher, there are currently no published research studies investigating a body image/mirror exposure therapy that was facilitated outside the hospital setting for women diagnosed with anorexia. Most exposure therapy studies for anorexia have examined food exposure, and there were only two studies that investigated mirror exposure for women with anorexia in particular (i.e., Key et al., 2002; Morgan et al., 2014). The majority of studies about body image exposure combined participants with bulimia and anorexia (e.g., Hildebrandt et al., 2012b; Marco, Perpina, & Botella, 2013; Vocks et al., 2007), did not have a diagnostic criterion other than body image disturbance (e.g., Delinsky & Wilson, 2006; Jansen et al., 2016), or were performed within non-clinical populations (e.g., Leuthcke, McDaniel, & Becker, 2011; Moreno-Dominguez et al., 2012). The present study was the first to qualitatively explore how women with anorexia described and attributed meaning to an exposure therapy performed in a naturalistic setting as part of their treatment for an eating disorder.

Although there was not a specific question in the interview protocol that alluded to real world experience, it was the nature of the phenomenon of interest. Therefore, it seemed logical that this aspect of the experience would present within participant descriptions at some point. The participants in this study reflected on the “real world” aspect of the experience, describing how it was normalized and felt natural, unlike other therapeutic interventions that they had experienced in the partial hospitalization program. In a related IPA study, Offord and colleagues

(2006) explored young adults' views of inpatient treatment for anorexia. They found that participants felt removed from the outside world during hospitalization, which made it more difficult for them to transition and adjust to life in the "real world" after discharge. Clinicians might address this type of concern in patients with anorexia by incorporating real world experiences into treatment programs, such as the exposure outing described in the present study. These findings highlight the importance of continued research on performing therapeutic interventions in a naturalistic setting for patients with anorexia because the real world aspect of the experience was particularly meaningful to participants.

Bridge between hospital and home life. While reflecting on the importance of incorporating real world experiences into recovery from anorexia, most of the participants considered it to be a practical and beneficial transition, or bridge between hospital and home life. In a recent study, Smith and colleagues (2014) found a similar theme regarding the experience of transition, while exploring the perspectives of females with anorexia who undergo specialist inpatient treatment. Some of their participants were concerned about transferring the skills they acquired in the "safety bubble" of the hospital back into their home environment. In a related study, Federici and Kaplan (2008) explored how women with anorexia perceived relapse and recovery after weight restoration. They concluded that patients with anorexia may require additional interventions after discharge to help prevent them from relapse and support long-term change. The findings of the current study align with those conclusions and emphasize the importance of strengthening the transition process from hospital to home life for women with anorexia. Further, the current study methodologically addressed trustworthiness and triangulation of data, which was a limitation of the aforementioned study. Because research on the topic of transitioning from hospital to home is limited (Smith et al., 2014), future studies may choose to

explore the transition process qualitatively to help shed light on additional constructs that contribute to a successful step-down recovery process.

Supportive Environment Enhances Experience (Enjoyable)

Participants in this study valued the support of their peers and therapists during the exposure outing, and they considered the intervention to be a more positive and enjoyable experience because of that supportive presence. Although there was some variation in which particular aspects of those relationships were the most meaningful, the consensus was that going through the experience with people with whom they had already established positive and trusting relationships enhanced their experience. Support is one of the most widely recognized factors that facilitates the process of recovery for patients with anorexia throughout the qualitative literature on patients' perspectives. For example, in an IPA study of blogs written by women with anorexia, participants believed that one of the most helpful aspects in the recovery process was the support of interpersonal relationships, including friends, family members, clinical staff, and partners (Bradley & Simpson, 2014). In a similar IPA study of weblogs written about the experience of recovery from anorexia, therapeutic and social support was an emergent theme and noted as a facilitative factor in the recovery process (Smethurst & Kuss, 2016). Further, Federici and Kaplan (2008) also concluded that a supportive environment during treatment, including peers and therapists, was a helpful aspect of the recovery process. The findings of the current study reflect the evidence base and offer specific examples of how that support may manifest, both from peer interactions and the role of the therapist, during an exposure therapy intervention.

Positive peer relationships. Although there were no specific questions written into the interview about interactions with peers during the exposure, this theme was salient throughout the participants' reflections. This particular exposure intervention was social by nature because

the patients went on the outing as a group. The participants had already begun developing relationships with their peers while attending the partial hospitalization program and felt comfortable with them because of their shared understanding of negative body image.

Results from previous studies exploring the perspectives of patients with anorexia have also highlighted the importance of peer relationships during recovery from anorexia. For example, Smith and colleagues (2014) performed a similar IPA study about women's perspectives of undergoing inpatient treatment for anorexia. One of the major emergent themes was sharing that experience with their peers, including feeling accepted and less isolated, as well as learning positive coping skills from their peers (Smith et al., 2014). The results of the current study offered examples of how women with anorexia may perceive support from their peers while participating in a therapeutic intervention, which could shed light on how peers may play a role during an exposure protocol.

Other related studies have noted that patients with anorexia may experience conflicted feelings of both support and distress toward their peers during recovery. Colton and Pistrang (2004) found that adolescent females with anorexia perceived relationships with their peers as both supportive and distressful, having a major impact on their recovery. They valued their peers' shared understanding of anorexia as helpful and positive, but they also described feelings of competition, comparing their weight and body shape with their peers (Colton & Pistrang, 2004). Offord, Turner, and Cooper (2006) similarly noted that participants considered their peers to be supportive because they understood what they were going through, but they also felt distressed when comparing themselves with their peers. In the present study, feelings of competition and comparison with one's peers did not emerge from participants' reflections. Perhaps age of participants could play a role in feelings of competition, as the participants in the

current study were young adults and not adolescents. Another possibility is that the participants in the current study were reflecting on one intervention experience and not their treatment program as a whole. Future research studies may expand upon the findings of the current study and further explore how the dynamic between peers during a particular intervention might contribute to a more meaningful therapeutic experience to facilitate recovery.

Role of therapist. Within the interview schedule, there was a question directly related to the role of the therapists who facilitated the exposure outing because of the potential importance that the therapeutic alliance may have in the treatment of anorexia (Sly et al., 2014). The question included optional prompts about the participant's interactions with the therapists and what she found to be the most and least helpful things the clinician did during the intervention. All of the participants reflected feelings of support from the therapists during the exposure outing. Sly and colleagues (2014) explored the how women with anorexia perceived the therapeutic alliance while inpatient. They found that patients perceived the therapeutic alliance to be a central aspect of their treatment, and they valued feeling active in the therapeutic process on a more equal field with clinicians (Sly et al., 2014). The findings of the current study support previous research on the importance of the therapeutic alliance in the treatment of anorexia from patients' perspectives.

As with peer relationships, there was some variation in what aspects of the therapist's role they considered to be particularly helpful. The first two participants described a "gentle push" and perceived a balance of therapeutic support and autonomy throughout the outing, while the other two participants described the role of the therapist as informal and casual in nature because they engaged in the clothing shopping alongside the patients. In a case study about exposure and response prevention for eating-related anxiety (AN-EXRP), Glasofer and

colleagues (2016) noted similar helpful aspects of the therapeutic alliance, including a collaborative relationship and the therapist modeling normal behavior. In AN-EXRP, the therapist should purposefully prompt the patient toward anxiety-provoking stimuli and resist the temptation to offer them reassurance or protection (Glasofer et al., 2016). The collaborative relationship was apparent in the first two participant cases, and modeling normal behavior was evident in the final two; however, no individual participant reported experienced both aspects of this dynamic in the current study.

Incidentally, the first two participants perceived the exposure outing to be impactful in their recovery process, but the other two did not believe it was impactful (as noted in Chapter Four). The role of the therapist was notably different between the first two and second two participants' thematic clusters. It is possible that the "gentle push" and collaborative nature of the therapist's role in the first two cases was more helpful than the therapist modeling positive behavior in the second two cases. Another possibility might be that the therapists described in the second two cases were nervous themselves about facilitating an exposure intervention and did not want to distress the patients, thus interacting more casually and not pushing the patients toward anxiety. Turner and colleagues (2014) described a similar dynamic in their study about clinician concerns in delivering cognitive behavioral therapies to patients with eating disorders, noting the possibility of therapists engaging in "safety behaviors" to provide patients reassurance and thus not prompting change (Turner et al, 2014). It is possible that this phenomenon occurred in the final two cases, in which the participants did not perceive the experience to be impactful; however, future research is necessary to explore this dynamic.

Self-awareness of Anorexia and Therapeutic Needs (Insightful)

All of the participants in this study described improvement in some aspect of their self-awareness and personal therapeutic needs in recovering from anorexia. They attributed meaning to the experience based on the insights they gained about themselves, including their body image and personal recovery process. Previous phenomenological studies exploring patients' recovery from anorexia were retrospective, asking the participants to reflect upon their recovery experiences from several months or even years prior to the interview (e.g., Federici & Kaplan, 2008; Lamoureux & Bottorff, 2005)). In the present study, however, the researcher interviewed participants within days of the exposure outing, either just before or right after they were discharged from the partial hospitalization program. This was done in an effort to capture a more vivid account of participants' experiences and avoid recall bias. The timing of this approach may offer insights about the perceptions of female patients with anorexia who are in the process of transitioning from hospitalization to home life, where phenomenological research is lacking.

Negative body image. Negative body image is a primary concern for most women diagnosed with anorexia, who fear becoming fat or gaining weight (APA, 2013). The premise of the particular exposure therapy in this study involved confronting one's concerns of body image that often arise while shopping for clothing. Because negative body image is a strong predictor for relapse in patients with anorexia (Fairburn, Cooper, et al., 2003; Fairburn, Stice, et al., 2003), employing interventions that target body dissatisfaction in an effort to improve body image, such as the exposure outing in the present study, may be helpful in the recovery process.

Previous studies have found that mirror exposure interventions can improve body image in women who experience body dissatisfaction without eating disorder (e.g., Diaz-Ferrer et al., 2015; Jansen et al., 2016) as well as patients with anorexia who express negative body image

(Key et al., 2002; Morgan et al., 2014); however, the exposure therapies in those studies were mostly structured protocols, and the exposure outing described by participants in the current study was unstructured. Further, the therapists in previous studies often prompted patients about their body image anxiety throughout the exposure intervention, whereas the therapists in the current study did not prompt the patients about their body image anxiety while they selected clothing items or tried them on in the dressing room. The naturalistic setting and normalizing aspect of the exposure therapy in the present study offers an alternative way of addressing body image concerns that is different from standardized methods noted in other studies, such as those performed in controlled settings and based on manualized interventions.

Three of the four participants described negative body image to be a central aspect of their experience with anorexia; however, one of the participants (Michelle) was an exception. Michelle considered herself to be different from many others who had anorexia because she did not experience body dissatisfaction; her primary concerns were over-exercising, which she considered part of her identity as a professional athlete. In a recent IPA study, Kolnes and Rodriguez-Morales (2016) explored the meaning women with restrictive anorexia attributed to their experiences of compulsive exercise women. One of the primary themes indicated that compulsive exercise was part of their identity and how they understood themselves (Kolnes & Rodriguez-Morales, 2016), much like how Michelle perceived her own experience of anorexia. The overall intent of the exposure outing was to address negative body image, which Michelle did not experience; nonetheless, she found the experience meaningful for other reasons, including practicality and social support. Although it is unclear whether the other three participants in this study had improved body image after the exposure outing, they each expressed improved insight about their body image and self-awareness through the experience.

Future research endeavors may seek to measure body satisfaction before and after the exposure outing to examine change in self-image.

Personal recovery process. All of the participants in the present study expressed insight about their therapeutic needs during recovery from anorexia. Their perceived individual needs varied from one person to the next, as they had unique concerns related to how they experienced living with anorexia. Each of the women in this study reflected on what they believed was the most helpful to them specifically, employing insight and self-awareness as a tool to support their personal recovery process. This finding resonates with existing qualitative research exploring how women perceive recovery from anorexia. Colton and Pistrang (2004) found that for female adolescents with anorexia, it was important to be viewed and treated by staff as an individual and not “just another anorexic.” Similarly, Offord and colleagues (2006) noted the importance of being treated as a unique individual and that standardized care can be viewed as unhelpful in recovering from anorexia. In a more recent IPA study, Smith and colleagues (2014) explored adult women’s perspectives of receiving inpatient treatment for anorexia. Participants valued being treated as an individual with unique needs and “not a walking eating disorder.” The findings of the present study add to the existing evidence base, further emphasizing the importance of individualizing therapeutic interventions for patients with anorexia not only because of its complexity but also because patients valued their own personal recovery process. Attending to individual needs may contribute to a more meaningful treatment experience for patients recovering from anorexia.

Responding to Limitations

While employing rigorous and in-depth qualitative methodology was a notable strength of this study, there were also inherent limitations to that approach. First, the primary mode of

information gathering was semi-structured interviews, which rely on participants' reflexivity and openness to share the details of their personal experiences. As the primary researcher, I relied on my interviewing techniques acquired throughout previous years of experience in both clinical research and counseling practice to build rapport and prompt for greater depth; however, it was ultimately the participant's decision to disclose about her experiences. It was upon those descriptions, as well as my interpretations, that the findings of this study were based.

Researcher Bias

Unlike traditional phenomenology, in which bracketing is performed in an attempt to set aside biases, IPA assumes that the researcher's role is phenomenological inquiry is by nature interpretative (Smith et al., 2009). That is, the researcher's reflections and interpretations are embraced as part of the analytical process of the IPA method. There were aspects of my personal and professional experience within the topic of eating disorders that may have influenced my interpretations. For example, I have provided therapeutic interventions to individuals with anorexia as a counseling professional. Also, I have had friendships with women who were diagnosed with anorexia in the past. Further, there have been times when I have personally experienced negative body image and disordered eating behaviors, although I was never diagnosed or treated for anorexia. Finally, there may be aspects of my personal bias of which I am not aware that might have influenced my interpretations.

Although researcher bias is considered an integral part of the IPA method, it is important to note this limitation, as well as my attempts to enhance trustworthiness and validity of the research method. Because my understanding of how participants attributed meaning to their experiences was accessed through my subjective lens, I maintained a reflexive journal of my interpretations and considered how they interacted with the emerging findings. Further, I

collaborated with a research team member, who also performed initial commenting and challenged my perspectives during analysis and thematic clustering. The research team member served as an auditor throughout analysis, as suggested by Smith, Flowers, and Larkin (2009), to enhance validity of the study. Finally, I engaged in a follow-up interview with participants to discuss initial comments and preliminary themes before performing the final analyses.

Sampling

Within the idiographic nature of IPA research, the sample size was purposefully small because the researcher must offer in depth and detailed consideration to individual participant cases during analysis; however, it is equally as important to strive for a homogenous samples so that specific conclusions may be drawn about a the experience for a particular group of people (Pietkiewicz & Smith, 2012; Smith et al. 2009). The present study aimed to recruit a homogenous sample by setting inclusion criteria, i.e. anorexia diagnosis, age range of 18 to 30, female, and first time participating in exposure outing; however, there was some unforeseen variation within the sample. One participant reported that she did not have negative body image, while the other three did. One participant had never been hospitalized for disordered eating in the past, and another had recurring hospitalizations (i.e., chronic and persisting anorexia). Also, the comorbidity of other mental health concerns varied from PTSD, OCD, anxiety and depressive disorders. It was important to consider these variations when drawing conclusions about the particular group as a whole. Future studies may incorporate more detailed screening criteria for inclusion in the research study.

Data Collection

There were some limitations regarding data collection that were not expected at the start of the current study. For example, one participant did not engage in a follow-up interview, so I

was not able to discuss my interpretations from analyzing the initial interview and reflexive journal entry with her, as with the other three participants. It is possible that the interpretations of her individual case might not have achieved as much depth as a result; at the same time, her reason for not engaging in the follow-up interview was that she perceived that everything important to her about the experience was discussed in the initial interview and reflexive journal entry. Another unanticipated limitation was the lack of detail provided in the session notes that clinicians wrote about the exposure outing for each patient. Because the descriptions were general, they did not serve as a valid source of triangulation and were dropped from analysis; however, analyzing participants' reflexive journal entries after the initial interview, engaging in a follow-up interview, and having a research team member serve as an auditor were more than adequate measure to address triangulation and trustworthiness for the study. Future research may offer a template or descriptive prompts for clinicians to complete after facilitating the outing, or provide assessments of participants' body satisfaction throughout the exposure protocol (as performed in the study by Trottier et al., 2015) to support triangulation.

A final limitation regarding data collection concerned the follow-up interview method. Three participants engaged in a follow-up interview, and they each preferred meeting over the telephone for convenience. In this modality, I was unable to recognize body language and other nonverbal cues, as I did in the initial interview. It is possible that I might have missed some underlying meanings, although I made attempts to identify those by transcribing hesitations in speech and verbal inflections as accurately as possible for analysis.

Implications for Counseling Practice and Research

The current study is the first to examine this novel application of exposure therapy for women with anorexia, lending several implications for counseling practice and clinical research.

The following section will describe how the results may offer insights to clinicians, agency directors, and supervisors who provide therapeutic interventions to women with anorexia and oversee clinical practices. Then, implications for employing the IPA approach in counseling research will be discussed. The section will conclude with directions for future research studies.

Practical Implications: Clinicians, Agency Directors and Supervisors

Integrating real world experiences into treatment was the most meaningful aspect of the exposure therapy experience for participants in this study. Therefore, clinicians and hospital staff may work to develop experiential interventions that address realistic concerns of their patients with anorexia. This would afford them the opportunity to practice their coping skills in real-world settings, which may support transitioning back to home life and prevent relapse.

Participants also expressed self-awareness and understanding of their therapeutic needs in the recovery process and how those may differ for individual people with anorexia. It is important that clinicians individualize exposure therapy interventions to address goals that are specific to the patient, in an effort to optimize therapeutic benefits.

The findings of the present study lend further support to the importance of supportive relationships in recovery from anorexia. It extends on the current literature in that it highlights the importance of having peer support during a specific treatment intervention that could enhance the experience by making it more meaningful to the patient, and possibly impactful. For example, both peers and therapists could model positive behaviors and coping skills for others who are struggling during an exposure intervention, as well as normalizing the experience to feel less clinical and more applicable to real life. Perhaps the combination of seeing one's peers during an exposure therapy, having positive behaviors to emulate in real time, and a safety net of support when anxiety is overwhelming, could foster a more meaningful experience. Clinicians

and hospital staff may consider grouping patients intentionally during exposure therapy interventions to foster positive interpersonal dynamics to support meaningful therapeutic experiences with patients and their peers.

The current study also sheds light on specific aspects of the exposure therapy that patients found particularly beneficial. Agency directors and clinical supervisors may advise clinicians on how to incorporate those practices into their treatment interventions with patients who have anorexia. Further, they may consider providing ongoing professional development and training to clinicians, to support competence in the delivery of individualized exposure therapy protocols. Because incorporating experiential interventions into treatment programs can be costly of time and resources, it is important that agency directors and supervisors consider how to optimize potential benefit to the patients during those experiences.

The majority of research about exposure therapy for anorexia has included a structured protocol, with the clinician strategically guiding patients toward the anxiety-provoking stimulus in a controlled setting. While this type of intervention has demonstrated promise, the findings of the current study suggest that having less structure could also be beneficial. Patients with anorexia often fear uncertainty of life outside the structured treatment environment (V. Smith et al., 2014; Sternheim et al., 2010), and incorporating the unpredictability of a naturalistic environment, such as the exposure outing in the present study, could support the transition process. The present study was the first to examine an intervention of this kind for women with anorexia, addressing a gap in the literature on exposure therapy for women with anorexia performed in a real world setting.

Research Implications: Employing the IPA Method

There are several research implications of the current study, as it was the first to employ the interpretative phenomenological analysis (IPA) method to explore a novel exposure therapy protocol performed in a naturalistic setting for women with anorexia. As noted by Larkin and Thompson (2011), the IPA approach may be useful in evaluating therapeutic services and interventions for specific groups of people. The findings of the present study offered valuable insight about the meaning participants attributed to their experiences, including what they perceived to be most helpful about the experience and suggestions for improvement of the therapeutic protocol. This study serves as an example of how IPA can be used in clinical research settings to support evidence-based practice when developing novel therapeutic interventions. The findings will be shared with the particular hospital administrators and clinical staff, including suggestions about how to enhance their exposure therapy protocols to elicit greater participant meaning and individualize treatment strategies.

The nature of the IPA method is simultaneously empathic and questioning (Smith et al., 2009), which aligns well with the practice and study of mental health counseling topics. The methodological approach outlined in the current study is an example of how clinical researchers can use IPA to explore complex and understudied phenomena. This study demonstrates how the IPA approach is especially suitable for in-depth exploration of therapeutic treatments for people with anorexia. As previously noted by Espindola & Blay (2009), anorexia is a complex condition, and qualitative investigations are useful in shedding light on constructs that may not be evident in reductionistic approaches. The findings of the current study offered in-depth understanding about which particular aspects of the intervention were meaningful to patients as part of their recovery, which may inform future outcome studies in larger groups.

Future Research Directions

Due to the limited research on body image exposure therapy for women with anorexia, there are numerous avenues for future research endeavors. The present study was the first qualitative exploration of an exposure therapy intervention performed in a real world setting, and the participants found that aspect particularly meaningful in their recovery from anorexia. Therefore, it is important to continue exploring the utility of this type of experiential treatment, both qualitatively and quantitatively, to contribute to the evidence base and support ongoing development of innovative exposure therapies for women with anorexia.

Further, qualitative research is severely lacking on the transition period between hospitalization and outpatient treatment for women recovering from anorexia, as most studies were retrospective in nature. The current study addresses the gap in literature by exploring patient perceptions of an intervention that was offered during the transition period from hospitalization to home life; however, more research is necessary. Future studies may wish to focus on how women with anorexia make sense of therapeutic treatments during this critical period of time, when relapse is more likely to occur.

Previous research studies have not outlined details of a body image exposure intervention for patients with anorexia. In collaboration with the partial hospitalization program, it may be helpful to delineate a protocol that could be replicated, in an effort to assess the efficacy of the exposure intervention on a given outcome measure. Another benefit of designing a more structured protocol is the potential to isolate specific aspects of the intervention, such as peers modeling positive behaviors or therapists offering a gentle push, to explore how those aspects might influence patient experiences. After developing a replicable protocol, future outcome studies may observe anxiety levels at various points during the exposure outing, either by patient

self-report or physiological monitoring, to assess variation throughout the intervention. Another possibility is to measure body image satisfaction before and after the exposure outing to determine if there is any change as a result of the intervention.

Finally, the findings of this study will be distributed to the clinical staff and administrators of the eating disorders treatment program from which the participants were recruited. Insights will be shared about what these patients considered to be the most helpful aspects of the intervention, as well as suggestions for enhancing the experience.

Recommendations will be offered to support improvement of the exposure therapy intervention and promote further research endeavors. The present study is an example of how counseling professionals may employ interpretative phenomenological analysis (IPA) in a treatment setting, as the philosophical underpinnings of this methodology align exceptionally well with mental health counseling. Incorporating IPA research into counseling practice may support evidence-based treatment and foster more meaningful therapeutic interventions for patients with anorexia.

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CHAPTER SIX

MANUSCRIPT

Understanding the Experiences of Women with Anorexia Nervosa who Complete an Exposure
Therapy Protocol in a Naturalistic Setting

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ABSTRACT

Exposure therapy has a growing evidence base for the treatment of anorexia nervosa (AN); however, there are very few studies that explore body image/mirror exposure. Using Interpretative Phenomenological Analysis (IPA), this study explored the experiences of four adult women diagnosed with anorexia who participated in a novel application of body image/mirror exposure therapy in a naturalistic setting. Three superordinate themes emerged: real world experiences are important, supportive environment enhances experience, and self-awareness of therapeutic needs. The findings may support enhancement of the treatment protocol and inform future outcome studies on the efficacy of using body image/mirror exposure for AN.

Keywords: exposure therapy, females, anorexia nervosa

Understanding the Experiences of Women with Anorexia Nervosa who Complete an
Exposure Therapy Protocol in a Naturalistic Setting

INTRODUCTION

Approximately 30 million people in the United States have suffered from an eating disorder at some point in their lives, 20 million women and 10 million men, respectively (Wade, Keski-Rahkonen, & Hudson, 2011). Eating disorders generally affect females more frequently than males (Rikani et al., 2013). Young adult females are particularly at risk for disordered eating, with some estimates of up to 40% reporting experiences of extreme body image concerns, practicing excessive weight-control strategies, and episodes of overeating (Choate, 2012). The typical age of onset for AN is before the mid-20s, which is younger than that of other eating disorders, and adolescence is the peak period of risk (Hudson, Hiripi, Pope, & Kessler, 2007). In particular, the AN is one of the most difficult eating disorders to treat, due to poor recovery outcomes and a high mortality rate (Arcelus, Mitchell, Wales, & Nielsen, 2011; Rikani et al., 2013; Smink, van Hoeken, & Hoek, 2012). Anorexia is a dangerous condition with up to 8% of patients dying due to complications directly related to the illness (Herzog et al., 2000) and about 10% dying within a decade of onset (Sullivan, 2002). Of all the mental disorders, anorexia has the highest mortality rate (Arcelus et al., 2011).

Some of the psychosocial risk factors for AN include an idealization for thinness, weight concerns, personality traits such as perfectionism and negativity, and peer influence (Keel & Forney, 2013). There is a high comorbidity between eating disorders and anxiety disorders (Swinbourne & Touyz, 2007), and oftentimes people with AN or BN are also diagnosed with at least one anxiety disorder (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004). This could be due to biological and behavioral similarities between anxiety and eating disorders (Strober,

Freeman, Lampert, & Diamond, 2007). Frequently comorbid conditions with AN in particular include trauma history (Brewerton, 2007), obsessive compulsive disorder (Kaye et al., 2004), generalized anxiety disorder, and phobias (Pallister & Waller, 2008).

Eating disorders are a complex phenomenon that often requires multidisciplinary interventions (Choate, 2012). There is a high cost for treatment of AN because about half of people diagnosed with AN will require hospitalization and medication, and most of them require some form of outpatient therapy (Agras et al., 2004). There is an unfortunate deficit in empirical research on the treatment of AN, which could be due to the rarity, medical complexity, and/or chronic nature of the disorder (Wilson, Grilo, & Vitousek, 2007), or perhaps it is due to high attrition rates in studies on AN (Agras et al., 2004). Because of the thin evidence base, the National Institute of Mental Health in 2007 initiated a call for proposals of innovative therapeutic applications of treatment for AN (Watson & Bulik, 2013). Some of the approaches have recently been applied for the treatment of AN, including cognitive remediation to improve cognitive flexibility, emotion acceptance behavior therapy, enhanced CBT (CBT-E), and exposure and response prevention (Berg & Wonderlich, 2013), also referred to as exposure therapy.

Exposure therapy, sometimes referred to as prolonged exposure (PE) or exposure and response prevention (ERP), was developed in the mid-1980s by Edna B. Foa with a theoretical basis in cognitive-behavioral therapy (Neukrug, 2015). It is a kind of intervention that aims to reduce one's anxiety and fear that is associated with some stimulus (Koskina, Campbell, & Schmidt, 2013). Exposure therapy assumes that, through learned experiences, the person will come to understand that whatever consequence he or she fears will not in fact occur (Abramowitz, Deacon, & Whiteside, 2011). Exposure therapy can be done in vivo (i.e., live

situations), in *virtuo* (i.e., with the use of virtual reality technology), or *imaginal* such as the use of mental imagery (Laborda & Miguez, 2015).

Exposure therapy has a strong evidence-base for the treatment of trauma and other complex diagnoses such as Post-Traumatic Stress Disorder, or PTSD (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Exposure therapy is noted as a flexible treatment that can be applied across populations in various settings (Rauch, Eftekhari, & Ruzek, 2012), which supports the rationale for applying this intervention to other mental disorders in which fear or anxiety are key features. Generally, there are two kinds of exposure therapy for people with eating disorders: food exposure and body image (mirror) exposure. This is because what typically contributes to distress in people with eating disorders is food/eating, body image, or both. Although there is a strong rationale for the use of exposure therapy for AN (Steinglass et al., 2010), only a few studies have focused on AN exclusively and separately from other eating disorders. Further, the majority of studies that do focus on AN investigate food exposure, not body image/mirror exposure. In an extensive search of the literature, only two studies focused on the use of mirror exposure in patients with AN (i.e., Key et al., 2002; Morgan, Lazarova, Schelhase, & Saeidi, 2014). This is surprising, as body image disturbance is a core feature of AN (American Psychiatric Association, 2013) and one of the most noted predictors of relapse in disordered eating (Fairburn, Cooper, & Shafran, 2003).

As research is extremely limited on the use of mirror exposure therapy for AN, it may be helpful to explore the intervention qualitatively. The majority of phenomenological research on the experiences of eating disorders focuses on females with AN. The interpretative phenomenological analysis (IPA) approach was employed in many of the studies that explored the experiences of women with AN, and what meaning they attribute to some aspect of their

experience (e.g., Fox, Larkin, & Leung, 2011; Spivack & Willig, 2010; Sternheim, Konstantellou, Startup, & Schmidt, 2010). Fox and Diab (2015) concluded that people with AN find great value in working with clinicians who deeply understand their experiences, which supports the rationale for using an IPA approach.

Very few studies qualitatively explored the experience of undergoing a specific therapeutic intervention in people with AN, and none of those studies focused on exposure therapy for AN, which is the phenomenon of interest in the present study. Only one mixed methods study made mention of a qualitative inquiry of participants' experiences of a 10-session body image exposure therapy program (Morgan et al., 2014), and there were some methodological concerns regarding the qualitative portion of the study. Incorporating exposure therapy in a naturalistic setting and personalizing therapy helps it to be more effective (Rikani et al., 2013). Furthermore, no studies have been published that explore body image exposure therapy performed in a naturalistic setting for women with anorexia.

Given the lack of qualitative research on body image/mirror exposure for women who are diagnosed with anorexia nervosa, it was important to design a rigorous and methodologically sound study to further understanding of this phenomenon. Because the focus of the present study is on a particular therapeutic experience for a specific group of people, a traditional phenomenological inquiry might not have captured the desired level of depth and detail. Further, the body image/mirror exposure in the present study was a novel application, in that it occurred in a naturalistic setting (i.e., a department store) rather than a clinical setting. Interpretative Phenomenological Analysis (IPA) can be useful for evaluating therapeutic services for particular groups of people (Larkin & Thompson, 2011). Finally, it was necessary to explore the

intervention in depth in order to support future quantitative/outcome studies on its efficacy; therefore, the idiographic nature of IPA was a suitable approach.

Purpose of the Study

The purpose of this study was to explore the perspectives of women diagnosed with anorexia nervosa who had undergone a novel exposure therapy intervention and how they made sense of that experience. The intent was to fill a gap in the literature, inform future research endeavors, and support potential outcome studies for the use of body image/mirror exposure in patients with anorexia nervosa. The following research questions guided the current study: 1) How do women diagnosed with anorexia nervosa describe their lived experiences of undergoing a body image/mirror exposure therapy intervention, and 2) How do women diagnosed with anorexia nervosa make sense of the body image/mirror exposure as part of their recovery?

METHOD

This research study specifically utilized the approach of interpretative phenomenological analysis (IPA) as outlined by Smith et al. (2009). The overarching goal was to document the lived experiences of women in treatment for anorexia nervosa who participated in a specific therapeutic exposure protocol and, in particular, how they attributed meaning of that intervention as part of their recovery. The main source of data was semi-structured interviews conducted after the intervention, including primary and follow-up interview. Secondary data sources included reflexive journal entries written by the participants.

Context of Exposure Protocol

This study explored the subjective experiences of females with anorexia nervosa who completed a body image/mirror exposure therapy in a naturalistic setting, as part of their treatment process. Patients were nearing discharge from a partial hospitalization program, and

clinical staff members had deemed them in a state of stability/readiness to engage in the protocol. On the day of the exposure, the clinicians announced that they would be taking them to a local department store, where they must select an item of clothing or outfit to try on. Participants were instructed to choose items of clothing that were challenging for them or that they would not ordinarily choose due to fear and anxiety related to wearing that item. After the participants selected articles of clothing or outfits, they went to the fitting room to try on the items. There, they were exposed to their own body image in the mirror. The process of choosing clothing items and trying them on in the fitting room may have been repeated, depending on the individual needs of the participant. After trying on, purchasing the clothing (optional) and leaving the department store, the exposure protocol was considered complete.

Participants and Data Sources

Participants were recruited from a partial hospitalization (intensive outpatient) program for disordered eating. All participants were White females in their early 20s with a primary diagnosis of anorexia nervosa. Participants were purposively selected via convenience sampling, as the specific version of exposure therapy is only performed at the aforementioned facility. Clinicians working at the hospital, who had access to patients, offered informational flyers about this voluntary research study regarding their experiences with the exposure protocol.

Individual interviews served as the primary source of data collection. Demographic information was also collected. Each interview lasted approximately 60 minutes and was conducted in a semi-structured format. Follow-up interviews lasted an average of 20 minutes and were conducted over the telephone. Interview data was triangulated by reflexive journal entries written by participants within one week of the initial interview.

Data Analysis

The primary researcher facilitated and transcribed all individual interviews (primary and follow-up). Next, the research team analyzed the primary interview and participant reflexive journal entry. Both research team members reviewed the transcript separately and performed initial commenting. Then, they came together and performed initial clustering of themes (i.e., thematic clustering), engaging in analytical discourse about the initial comments and working toward depth of meaning to the individual participant. The primary researcher audio-recorded each consensus meeting and took notes. Then, she listened to the recording of the consensus meeting and transcribed additional notes to aid in the clustering of initial comments into textural and structural themes. After thorough review and re-review of the transcript, session note, reflexive journal entry, and consensus meeting notes, the primary researcher constructed an individual codebook for that participant.

After the first round of each analysis, the primary researcher contacted the participant for a follow-up interview to discuss the initial themes that were interpreted in an effort to achieve greater depth of meaning, while engaging in discourse with the participant (double-hermeneutic process). Follow-up interviews lasted an average of 20 minutes and were conducted over the phone. Each follow-up interview was transcribed by the primary researcher coded by both research team members. Then, the research team perform consensus coding on the follow-up interview, while reflecting upon the initial interview themes and comparing what emerged from the follow-up interview. The primary researcher then made revisions to the individual participant codebook, as necessary. Finally, the primary researcher recoded all participant data according to the final individual codebook, using NVivo qualitative software. See Figure 1 for a visual representation of the data analysis process.

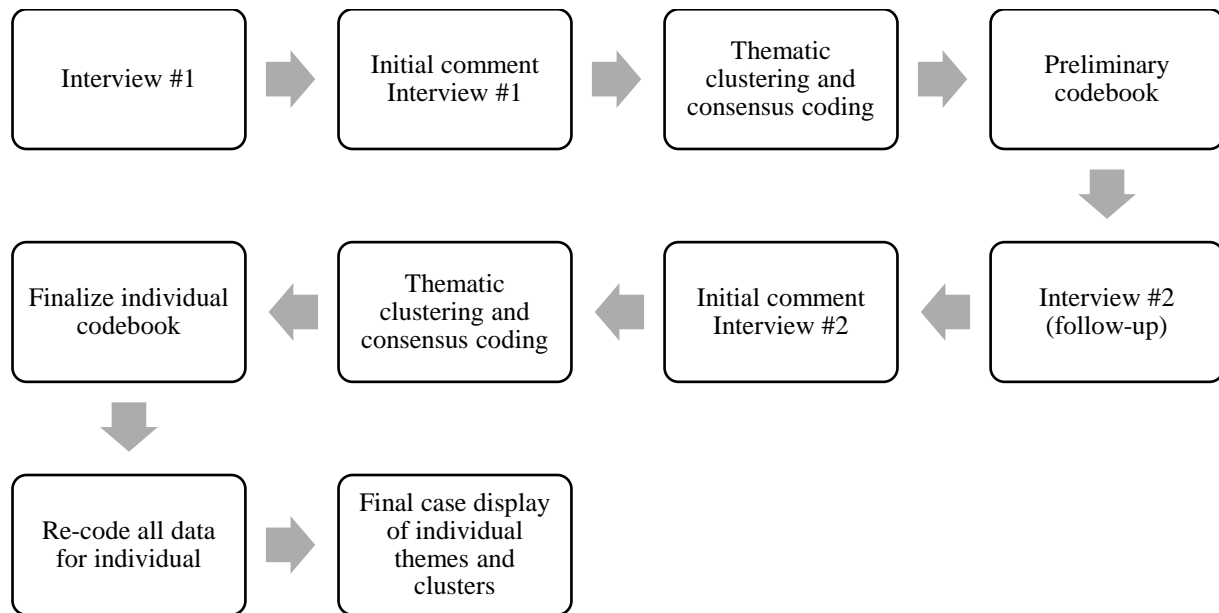


Figure 1. Cycle of analysis for individual cases, which repeats for each participant.

Data was analyzed by the research team one case at a time, and an individual codebook was drafted for each participant. After all of data for Participant 1 (P1) was analyzed, and the P1 individual codebook was finalized, the research team moved on to the next round of analysis repeating the process Participant 2 (P2), Participant 3 (P3), and Participant 4 (P4).

Cross-case analysis. For the final phase of analysis, the primary researcher performed a cross-case analysis of the four participants, while embracing her interpretive role in the process. She examined the individual participant codebooks side-by-side, highlighting themes that were either salient or disconfirmatory. Themes that emerged in at least three cases were considered to be salient. Next, to support the cyclical process of moving from the shared experience to the particular and back to the shared experience, she considered which themes were noted across two participants, as well as themes which were unique to one individual participant. The result was the emergence of superordinate and subordinate themes regarding the meaning that participants

attributed to their experience of the exposure therapy protocol. The overall process, from individual to cross-case analysis, lasted approximately ten months.

FINDINGS

The following three superordinate themes emerged, related to the meaning participants attributed to their experiences of the exposure therapy: 1) Practical: real-world experiences are helpful (subtheme: Bridge between hospital and home life), 2) Enjoyable: supportive environment enhances experience (subthemes: Positive peer relationships and Role of therapist), and 3) Insightful: self-awareness of anorexia and therapeutic needs (subthemes: Negative body image and Recovery is personal). Table 1 summarizes the final structure of superordinate themes and subthemes, notes which participants contributed to each theme, offers examples of indicative quotes, and includes researcher notes.

Practical: Real World Experiences Are Helpful

All four participants talked about the “real world” aspect of the exposure outing, perceiving value in the fact that the intervention took place outside the hospital setting. P1 reflected that one of the most meaningful aspects of the exposure outing was that it was different from the usual therapies of individual and group sessions in the treatment facility:

All of the groups and all of the worksheets, they kind of mesh together. Whereas the exposure trips like this, they’re something different. And, it makes it more impactful and meaningful. I probably got more out of this hour and a half experience than I do in a week of usual groups! (P1)

P3 also believed that incorporating real world experiences into therapy was helpful in preparing her for life outside of the hospital. In her reflexive journal entry, she summarized, “The purpose of treatment, in my opinion, is to get us stable enough to be in the real world, so being able to go

shopping as part of treatment was very beneficial.” P2 said that having experiences outside of the hospital helped her maintain what she learned after discharge:

The longer I’ve been out in the real world, I feel more distant with what happened within the walls of [the hospital]. But the things that happened outside and that weren’t necessarily on that unit kind of stuck with me because that was in the real world. (P2)

P4 mentioned, “I think incorporating stuff like that before transiting home is important. And not enough of it is done most places, especially here.” P3 echoed this perspective, saying, “I think it’s an effective form of therapy, I really do. And I think that it needs to be done more often.”

Bridge between hospital and home life. Three participants described the exposure outing like a bridge or transition between hospitalizations and living back at home in the real world. P1 mentioned that if she had not participated in the exposure outing, she “probably would have felt like I was maybe missing something, that piece of the treatment. It was the bridge.” P3 reflected on the importance of having real-world experiences during treatment:

You’re in this program that’s very structured, and they provide your meals. You don’t just get anything, you chew what’s in front of you. And then you’re just kind of thrown in the real world, which is what happened to me and I kind of had no support after that. So something in the middle would have been nice. I think more experiences in the real world would have been helpful in treatment. (P3)

Table 1

Final Structure of Superordinate Themes Related to the Meaning Participants Attributed to Exposure Therapy Experience

Superordinate Theme	Participants contributing to this theme	Subthemes	Participants contributing to this subtheme	Indicative quotes	Notes
Practical: Real-world experiences are helpful	All participants	Bridge between hospital and home life	All except P2	I just feel like, this was more like applicable to your daily life, you know? (P1)	Everyone expressed that having the exposure in a real world setting made the experience more meaningful.
				I think it sort of eases you into the situations that you're going to experience on a daily basis at home, without the partial program to go back to. (P4)	P1 and P4 talked about how this type of exposure can help with the transition from being in the hospital to living back at home.
Enjoyable: Supportive environment enhances experience	All participants	Positive peer relationships;	All participants;	If I was with girls that I wasn't very close with or didn't feel comfortable with, it would have been a completely different experience for sure. (P3)	The role of the therapist was perceived as supportive in different ways. For example, P1 and P2 described some therapeutic prompting, while P3 and P4 perceived therapist interactions as more casual, like friends. But they were all considered supportive.
		Role of therapist	All participants	I never felt pushed too far. I always knew it was a gentle push and encouragement. (P2)	
Insightful: Self-awareness of anorexia and therapeutic needs	All participants	Negative body image;	All except P1;	I was fixating on my body image and recognizing all the weight that I've gained from the program, and that was just hard for me. (P3)	P1 was a disconfirmatory case for the negative body image subtheme because she expressed that she has "always liked my body" and "always had relatively good body image."
		Recovery is personal	All participants	Everyone's treatment is different, everyone's problems are different. Everyone's body is different. So you can't generalize or compare yourself to another person's treatment. It's very much a personal recovery path. (P1)	P2 believed that everyone's journey is unique and she also valued the shared experience of anorexia and having peers who understood what she was going through during the exposure.

P4 echoed this perspective, reflecting, “I think it sort of eases you into like the situations that you’re going to experience on a daily basis at home, without the partial program to go back to.”

Enjoyable: Supportive Environment Enhances Experience

Support emerged as a salient theme across all participant cases. Participants discussed supportive interactions with both their peers from the program and the therapists who were facilitating the exposure outing. They discussed various ways in which their peers and the therapists contributed positively to the meaning of their experiences of the exposure outing.

Positive peer relationships. All four participants believed that their experience of the exposure outing was enhanced by the presence of their peers, with whom they had already established positive peer relationships while in the recovery program. P1 said, “I liked the group that I went with, it was some of my close friends that are in the treatment center as well, so I think that kind of helped minimized my anxieties.” P2 looked to her peers as role models, reflecting, “Thinking about that trip, especially it being with the other girls [that] were there, and how they were able to find their own little confidence streak, I was like maybe I can do it too!” For P3, it was typical that she felt the most meaningful support from her peers:

I’ve always found that other patients have been more comforting to me than my therapist and clinicians. So that’s something that is typical for me. I usually find more comfort, or I feel like I have more progress in therapy, when I am just talking to them and trying to figure things out and analyzing situations, or even helping them in their problems. (P3)

Similarly, P4 reflected, “I think going with people that know you and are familiar with your reactions to things is helpful because you can support each other.” Each of the participants believed that going through the exposure with their peers added value to their experience.

Role of therapist. All of the participants perceived the role of the therapist in the exposure outing to be supportive and positively contributed to the meaning of their experiences. P1 appreciated the balance of autonomy and support that the therapists offered while on the exposure outing. She said, “We had independence, but at the same time, we had support as well. So it was a good balance.” P2 echoed this perception about balance, reflecting that she did not feel too much pressure from the therapists, while receiving a “gentle push” to try things outside of her comfort zone. P2 reflected on how the therapists were encouraging and not forceful, even though she did not plan on purchasing items:

It was just for the sake of trying things on, and seeing how they fit, and seeing how I felt in them, and seeing if I liked it. And so much more about being in clothes, as opposed to anything else. Just that comfort level, and that exposure, and being with [Clinician] on a one-on-one basis, picking out things that I would have *never* tried on my own. (P2)

What was most meaningful for P1 and P2 was that they were offered a balance of therapeutic support and independence from the therapists while on the exposure outing; however, P3 and P4 described a different dynamic. They talked about how the therapists participated in clothing shopping alongside the patients during the exposure, perceiving them to act more like friends than clinicians. P3 described, “It didn’t feel like we were in therapy at all. It just felt like we were all friends hanging out shopping together, which was nice.” Similarly, P4 described, “The therapist came in the back and tried on clothes with us, which was helpful just because of how normal she was acting.” P4 valued the informal nature of her interactions the therapists:

I sort of liked the informality of it. That was helpful because I’m not the type of person that likes to be micromanaged and over-controlled. So not having a therapist like literally follow us around and be like, “Try this, try this, try this” was nice. (P4)

P3 and P4 described a more informal role of the therapists than P1 and P2, who described the role of the therapists to be more clinical; however, each of these women perceived different aspects of the therapist's role to be supportive.

Insightful: Self-Awareness of Anorexia and Therapeutic Needs

The theme of self-awareness was apparent throughout the descriptions of all four participants, and the following two subthemes emerged regarding participants' self-awareness of their experiences of anorexia and their individual therapeutic needs: negative body image and personal recovery process.

Negative body image. Three of the four participants talked extensively about negative body image as part of their experiences of anorexia and the exposure outing, but one participant (P1) disconfirmed this theme. P2 described feelings of shame and embarrassment regarding her body image, which contributed to her general aversion to clothing shopping, reflecting, "It's so much easier for me to hide in like, sweatshirts and sweatpants." For P3, gaining weight in the recovery process was a trigger for her negative body image:

I was fixating on my body image and recognizing all the weight that I've gained from the program, and that was just hard for me, I guess. It was just a hard adjustment. And I'm still getting used to it, I guess. Like I don't know when I will ever feel okay with it, but definitely still trying to understand and accept it, I guess. (P3)

Similarly, P4 recognized that her own perceptions of how she looked were theoretically different from others' perceptions; however, she still struggled to see herself in a more realistic way:

I still struggle with like... knowing that. Like I know that cognitively, but it's hard for me to sort of wrap my head around like how distorted things are because I don't really trust other peoples like opinions of, "You don't look like that." I'm like, "But I do." (P4)

P4 described her biggest take-away from the exposure outing to be recognizing how negative her body image distortion was, improving her self-awareness.

P1 was an exceptional case regarding negative body image. She described, “I’ve always liked my body. I’ve always had relatively good body image.” This reflection was notably different from the other participants, who perceived their bodies negatively during the weight restoration process. The experience was meaningful to P1 because of her improved self-awareness. In her reflexive journal entry, she wrote: “I learned a lot about myself through this process, for example how it helps me to shop with friends and family and how I can stop negative thoughts by thinking about positive physical and personality characteristics.”

Personal recovery process. Three of the four participants talked about how their experience of anorexia was unique, with the exception of P2. For P1 and P4, the personal recovery process emerged as its own theme in their individual cases. P1 wrote in her reflexive journal entry: “Each person’s journey through anorexia is different, so group sessions in the treatment center sometimes do not apply to some people as much as others.” P4 was also familiar with her personal recovery process and how she personally navigated through it:

I have a very objective view on it just because I have done the restoration process so many times, that I sort of know what things are going to look like and what distortions are going to be like throughout where my weight is and the restoration process. (P4)

P3 emphasized that not all eating disorder experiences are the same, alluding to the importance of individualizing treatment. She reflected:

I hate that people treat (bulimia) like it’s the same disorder. It drives me insane. Like even in our partial program, like we never knew who had what diagnoses or what, but we were all treated the same and all had the same meal plan. It’s just, a different thing! (P3)

Similarly, P4 considered how the exposure therapy did not align with her individual therapeutic needs at that point in her personal recovery process; however, she still participated in the exposure twice while in the program. She reflected,

I think that exposures in general can be extremely helpful, but this specific one was just not the most needed for where I was at in my process. I think that adapting the way the shopping exposures happen could be the "magic" ticket for being more helpful for me and possibly others. (P4)

Although she perceived the exposure outing to be meaningful in some aspects, P4 suggested that individualizing the exposure therapy to meet individual therapeutic needs would enhance the value of their experiences.

DISCUSSION

One of the unique aspects of this particular exposure therapy protocol was that it was facilitated outside of the hospital, in a naturalistic setting. All of the participants endorsed the practicality of having therapeutic experiences in a real world setting because they perceived benefits in taking what they learned during treatment and practicing it the way they would after discharge. To the knowledge of this researcher, there are currently no published research studies investigating a body image/mirror exposure therapy that was facilitated outside the hospital setting for women diagnosed with anorexia. The present study was the first to qualitatively explore how women with anorexia described and attributed meaning to an exposure therapy performed in a naturalistic setting as part of their treatment.

Offord and colleagues (2006) noted that patients may feel removed from the outside world during hospitalization, making it more difficult for them to transition and adjust to life in the “real world” after discharge. Clinicians might address this type of concern in patients with

anorexia by incorporating real world experiences into treatment programs, such as the exposure outing described in the present study. These findings highlight the importance of continued research on performing therapeutic interventions in a naturalistic setting for patients with anorexia because the real world aspect of the experience was particularly meaningful to participants. Most of the participants considered the exposure therapy to be a practical and beneficial transition, or bridge between hospital and home life.

In a recent study, Smith and colleagues (2014) found a similar theme regarding the experience of transition, while exploring the perspectives of females with anorexia who undergo specialist inpatient treatment. Some of their participants were concerned about transferring the skills they acquired in the “safety bubble” of the hospital back into their home environment. Federici and Kaplan (2008) also noted that patients with anorexia may require additional interventions after discharge to help prevent them from relapse and support long-term change. The findings of the current study align with those conclusions and emphasize the importance of strengthening the transition process from hospital to home life for women with anorexia.

Participants in this study valued the support of their peers and therapists during the exposure outing, and they considered the intervention to be a more positive and enjoyable experience because of that supportive presence. Support is one of the most widely recognized factors that facilitates the process of recovery for patients with anorexia throughout the qualitative literature on patients’ perspectives (e.g., Bradley & Simpson, 2014; Federici & Kaplan, 2008). This particular exposure intervention was social by nature because the patients went on the outing as a group. Results from previous studies exploring the perspectives of patients with anorexia have also highlighted the importance of peer relationships during recovery from anorexia (e.g., Smith 2014). Conversely, some studies have noted that patients with

anorexia may experience conflicted feelings of both support and distress toward their peers during recovery (Colton & Pistrang 2004; Offord et al., 2006). In the present study, feelings of competition and comparison with one's peers did not emerge from participants' reflections. Perhaps the age of participants could play a role in feelings of competition, as the participants in the current study were young adults and not adolescents. Another possibility is that the participants in the current study were reflecting on one intervention experience and not their treatment program as a whole. Future research studies may expand upon the findings of the current study and further explore how the dynamic between peers during a particular intervention might contribute to a more meaningful therapeutic experience to facilitate recovery.

The therapeutic alliance has noted importance in the treatment of anorexia (Sly et al., 2014). In the current study, all of the participants reflected feeling supported in some way by the therapists during the exposure, supporting previous research. The first two participants described a "gentle push" and perceived a balance of therapeutic support and autonomy throughout the outing, while the other two participants described the role of the therapist as informal and casual in nature because they engaged in the clothing shopping alongside the patients. Glasofer and colleagues (2016) noted similar helpful aspects of the therapeutic alliance, including both a collaborative relationship and the therapist modeling normal behavior. The collaborative relationship was apparent in the first two participant cases, and modeling normal behavior was evident in the final two; however, no individual participant reported experienced both aspects of this dynamic in the current study.

All of the participants in this study described improvement in some aspect of their self-awareness and personal therapeutic needs in recovering from anorexia. Previous qualitative studies exploring patients' recovery from anorexia were retrospective, asking the participants to

reflect upon their recovery experiences from several months or even years prior to the interview (e.g., Federici & Kaplan, 2008; Lamoureux & Bottorff, 2005). In the present study, however, the researcher interviewed participants within days of the exposure outing, either just before or right after they were discharged from the partial hospitalization program, in an effort to capture a more vivid account of participants' experiences and avoid recall bias. The timing of this approach may offer insights about the perceptions of female patients with anorexia who are in the process of transitioning from hospitalization to home life, where phenomenological research is lacking.

The premise of the particular exposure therapy in this study involved confronting one's concerns of body image that often arise while shopping for clothing. Because negative body image is a strong predictor for relapse in patients with anorexia (Fairburn et al., 2003), employing interventions that target body dissatisfaction in an effort to improve body image, such as the exposure outing in the present study, may be helpful in the recovery process. Previous studies have found that mirror exposure interventions can improve body image in women who experience body dissatisfaction without eating disorder (e.g., Diaz-Ferrer et al., 2015; Jansen et al., 2016) as well as patients with anorexia who express negative body image (Key et al., 2002; Morgan et al., 2014); however, the exposure therapies in those studies were mostly structured protocols, and the exposure outing described by participants in the current study was unstructured. Further, the therapists in previous studies often prompted patients about their body image anxiety throughout the exposure intervention, whereas the therapists in the current study did not prompt the patients about their body image anxiety while they selected clothing items or tried them on in the dressing room. The naturalistic setting and normalizing aspect of the exposure therapy in the present study offers an alternative way of addressing body image

concerns that is different from standardized methods noted in other studies, such as those performed in controlled settings and based on manualized interventions.

All of the participants in the present study expressed insight about their individual therapeutic needs during a personal recovery process from anorexia. This finding resonates with existing qualitative research exploring how women perceive recovery from anorexia (Colton & Pistrang, 2004; Offord et al., 2006). In a more recent IPA study, Smith and colleagues (2014) also noted that adult female patients with anorexia valued being treated as an individual with unique needs and “not a walking eating disorder.” The findings of the present study add to the existing evidence base, further emphasizing the importance of individualizing therapeutic interventions for patients with anorexia not only because of its complexity but also because patients valued their own personal recovery process.

Employing an interpretative phenomenological (IPA) approach can be useful in understanding which aspects of treatment were personally meaningful in a patient’s individual recovery, informing future quantitative investigations for effectiveness in larger groups. Larkin and Thompson (2011) noted that employing the IPA approach may also be employed to evaluate therapeutic services and interventions for specific groups of people. This study is an example of how IPA can be used in clinical research to support evidence-based practice when developing novel therapeutic interventions.

The majority of research about exposure therapy for anorexia involves a structured protocol, with the clinician guiding patients toward their anxiety-provoking stimulus in a controlled setting. While this type of intervention has been notable, the findings of the current study suggest that having less structure could also be beneficial. Patients with anorexia often fear uncertainty of life outside the structured treatment environment (V. Smith et al., 2014; Sternheim

et al., 2010), and incorporating the unpredictability of a naturalistic environment, such as the exposure outing in the present study, could support the transition process. The present study was the first to study an intervention of this kind for women with anorexia, contributing to a gap in the literature on exposure therapy for women with anorexia performed in a real world setting.

Due to the limited research on body image exposure therapy for women with anorexia, it is important to continue exploring the utility of this type of treatment, both qualitatively and quantitatively, to contribute to the evidence base and support ongoing development of innovative exposure therapies for women with anorexia. Further, qualitative research is lacking on the transition period between hospitalization and outpatient treatment for women recovering from anorexia, as most studies were retrospective in nature. Future studies may wish to focus on how women with anorexia make sense of therapeutic treatments during this critical period of time, when relapse is more likely to occur. The present study is an example of how counseling professionals may employ interpretative phenomenological analysis (IPA) in the treatment setting, as the philosophical underpinnings of this methodology align exceptionally well with mental health counseling. Incorporating IPA research into counseling practice may support evidence-based treatment and foster more meaningful therapeutic interventions for clients with anorexia.

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APPENDIX A

Informed Consent Document

Old Dominion University

PROJECT TITLE: Understanding the Experiences of Women with Anorexia Nervosa who Complete an Exposure Therapy Protocol in a Naturalistic Setting

INTRODUCTION

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. The title of this study is “Understanding the Experiences of Women with Anorexia Nervosa who complete an Exposure Therapy Protocol in a Naturalistic Setting.” The research will be conducted within the state of Virginia.

RESEARCHERS

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DESCRIPTION OF RESEARCH STUDY

Several studies have looked into the topic of people who have eating disorders who participate in exposure therapy as part of their treatment; however, few of them have focused on people who have Anorexia Nervosa, and none of them have explored the perspectives of those who participate in exposure therapy or the personal meaning they attribute to that experience. The following study seeks to understand how women

with Anorexia Nervosa describe the experience of completing an exposure therapy protocol, as well as explore the personal meaning they attribute to that experience as part of their recovery process.

If you decide to participate, then you will join a study involving research about how you thought, felt, and behaved while participating in the exposure therapy. Information will be gathered from you by interviews, a post-interview journal entry, and session notes that were taken by the therapist during the exposure. If you say YES, then your participation will last approximately 60 minutes for the duration of the interview in a private, designated office or conference room at your treatment facility. A second (follow-up) interview may be scheduled to clarify or further discuss topics that came up in the first interview. Your responses will be assigned a special code number to protect your identity, and all identifying information (e.g., specific names and places) will be removed from all data that is collected. Other women diagnosed with Anorexia Nervosa who have completed the exposure therapy will also be asked to participate in this study.

EXCLUSIONARY CRITERIA

You should identify yourself as a females who has been diagnosed with Anorexia Nervosa, who also attends a partial hospitalization program for eating disorders, and has completed the exposure therapy (“shopping trip”) protocol only one time. To the best of your knowledge, you should not be a patient who is currently in the hospital or attending only outpatient therapy, who has not completed the exposure therapy (“shopping trip”) protocol, or has completed the protocol more than once, which would keep you from participating in this study.

RISKS AND BENEFITS

RISKS: If you decide to participate in this study, then you may face a risk of some discomfort in disclosing very personal experiences about your thoughts, feelings, and behaviors associated with food and eating. The researchers strive to reduce this risk by expressing the voluntary nature of participation and the option to withdraw from this study at any time without penalty. Because interviews will be audio-recorded and transcribed, the researchers will take extra care to protect anonymity by destroying audio files once they have been transcribed, removing all identifying information (e.g., names of specific people or locations) and assigning code numbers to data files, which will not be linked with any personally identifying information. The researchers view confidentiality as of the utmost importance. Also, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: Although there are no direct benefits for participating in the study, you may benefit from the reflection of being asked about your experiences, thoughts, and feelings. The researchers hope that the information gathered within this research study will contribute to the overall knowledge and understanding of exposure therapy for disordered eating. If you would like, the researchers will offer you a copy of the results of this study once it is completed.

COSTS AND PAYMENTS

There are no costs to participate. The researchers are unable to give you any payment for participating in this study.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision about participating, then they will give it to you.

CONFIDENTIALITY

All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations, and publications; but the researcher will not identify you. All identifying information, such as specific names and places, will be removed from the data (“de-identified”). Electronic data will be stored in a password-protected electronic file on a

data disk, which will be stored in a locked cabinet in the primary researcher's office; hard copy data will also be stored in a locked file cabinet in the primary researcher's office.

Interview data is NOT a part of your mental health record and will NOT be included in your hospital's files. Interview data will be de-identified and used for the purposes of this research study ONLY. What you talk about with the researcher will not be noted in your patient records. Only members of the research team identified above will have access to the de-identified interview data. Session notes will have all personally identifying information removed by the therapists before given to the primary researcher as data to be analyzed.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time. Participating in this research study will not affect your therapeutic treatment or mental health records in any way.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Dr. Ed Neukrug, the responsible principal investigator, at 757-683-3334 or Dr. Ed Gomez, the current Darden College of Education Human Subjects chair at 757-683-6309, who will be glad to review the matter with you.

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them, or contact Dr. Ed Neukrug, at 757-683-3334.

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should contact Dr. Ed Gomez, the current Darden College of Education Human Subjects chair at 757-683-6309, who will be glad to review the matter with you.

And importantly, by indicating I WILL participate and signing below, you are telling the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

Please check one and sign below:

_____ I **WILL** participate in this study.

_____ I will **NOT** participate in this study.

Participant Printed Name & Signature	Date
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INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Researcher Printed Name & Signature	Date
--	-------------

APPENDIX B**Demographic Questionnaire**

Age:

Race/Ethnicity:

Eating Disorder Diagnosis:

Previous number of hospitalizations for eating disorder:

Are you being treated for another mental health concern as well as an eating disorder (for example, anxiety, depression, obsessive-compulsive disorder, trauma, etc.)? If so, which concern? _____

Are you currently taking medications for a mental health concern? If so, which ones?

APPENDIX C

Interview Questions

1. What did you already know about the shopping trip before you went on it?
2. When you heard that you would be going on the shopping trip that day, how did you react?
 - a. Prompts: What thoughts/feelings came up for you? What behaviors did you notice? What about physical sensations?
3. Tell me about the ride over to the store.
 - a. Prompts: What thoughts/feelings came up for you? What behaviors did you notice? What about physical sensations?
4. Once you arrived at the store, tell me what was going on for you.
 - a. Prompt: While you were picking out pieces of clothing, what was that like?
 - b. Prompts: What thoughts/feelings came up? What behaviors and physical sensations did you notice?
5. How did you feel about having to choose an outfit to try on?
6. What was it like trying on the clothes?
 - a. Prompt: What was it like looking in the mirror?
7. What was the role of the clinician during the shopping trip?
 - a. Prompt: How did you interact with each other?
 - b. Prompt: What were the most helpful things the clinician did? What about the least helpful things?
8. After the shopping trip was over, what were you feeling?

- a. Prompt: What thoughts came to mind, once it was over? What kinds of physical feelings or behaviors did you notice?
9. Overall, how would you describe the shopping trip experience?
 - a. Prompt: Tell me what xxxxx means to you?
 - b. Prompt: What stuck out for you the most throughout the whole experience? (i.e., what was most meaningful to you?)
10. How do you think your recovery might have been different if you had not done the shopping trip, if at all?
11. What have I left out that you would like to share about your experience?

APPENDIX D**Reflexive Journal Entry**

Prompt: After talking about your experiences with the researcher, write about what the experience of the shopping trip means to you, as part of your recovery from Anorexia.

APPENDIX E**Recruitment Flyer****RESEARCH PARTICIPANTS NEEDED!**

- PURPOSE:** To understand how women diagnosed with Anorexia Nervosa describe the experience of participating in exposure therapy (“shopping trip”) as part of their treatment for eating disorders.
- ELIGIBILITY:** Female
18-30 years old
Diagnosis of Anorexia Nervosa
Completed “shopping trip” one time
- COMPENSATION:** This is a voluntary study that does not offer compensation.
- CONTACT:** Gina Polychronopoulos, M.S., M.S.Ed
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VITAE

Gina Marie Bondi Polychronopoulos graduated *cum laude* from James Madison University in 2003, earning a Bachelor of Science degree in Psychology with a minor in Criminal Justice. She proceeded to earn a Master of Science degree in Psychology from Old Dominion University in 2007, while working as a mental health counselor at Virginia Beach Psychiatric Center and providing therapeutic services to children, adolescents, and adults in an acute, inpatient setting. She continued her training at Old Dominion University and earned a Master of Science in Education degree, with a dual concentration in mental health and school counseling, in 2010 and became a Nationally Certified Counselor. Gina began the doctoral program in Counseling at Old Dominion University in 2012, serving as a graduate research and teaching assistant at The Center for Educational Partnerships throughout her studies.

In the past ten years, Gina has gained substantial experience in clinical mental health and educational research settings at Eastern Virginia Medical School, Clinical Research Associates of Tidewater, and Old Dominion University. She has supported federally-funded clinical trials and program evaluation projects for local school districts. Gina has also served in various direct service counseling roles, including outpatient, residential, and inpatient treatment settings. Currently, she is working as a Research Associate for The Center for Educational Partnerships at Old Dominion University. She is also a Resident in Counseling, working toward licensure in the state of Virginia. Gina has served in several leadership roles, including President of Chi Sigma Iota, Omega Delta chapter and Research and Awards Committee chairperson for the Association of Adult Development and Aging. She has published numerous peer-reviewed articles and technical reports, co-authored two book chapters, and presented scholarly research at regional, national, and international conferences across disciplines.