

**THE MEANING OF PET COMPANIONSHIP IN THE NATURAL HEALING OF  
DIAGNOSED EATING DISORDERS, AND SELF-IDENTIFIED DISORDERED  
EATING BEHAVIOURS, ATTITUDES AND EXPERIENCES**

**JULIA M. RANIERI**  
**B.ScH., University of Guelph, 2010**

A Thesis  
Submitted to the School of Graduate Studies  
of the University of Lethbridge  
in Partial Fulfillment of the  
Requirements for the Degree

**MASTER OF EDUCATION**  
**(COUNSELLING PSYCHOLOGY)**

Faculty of Education  
University of Lethbridge  
LETHBRIDGE, ALBERTA, CANADA

© Julia M. Ranieri, 2018

THE MEANING OF PET COMPANIONSHIP IN THE NATURAL HEALING OF  
DIAGNOSED EATING DISORDERS, AND SELF-IDENTIFIED DISORDERED  
EATING BEHAVIOURS, ATTITUDES AND EXPERIENCES

JULIA M. RANIERI

Date of Defense: January 10, 2018

Dr. E. Pijl Thesis Supervisor	Assistant Professor	Ph.D.
Dr. T. Leighton Thesis Examination Committee Member	Assistant Professor	Ph.D.
Dr. P. Kellett Thesis Examination Committee Member	Assistant Professor	Ph.D.
Dr. R. Crowder University of Calgary Calgary, Alberta	Assistant Professor	Ph.D.
Dr. T. Oosterbroek Chair, Thesis Examination Committee	Assistant Professor	Ph.D.

## **Dedication**

This research is dedicated to all who have not sought help because they have believed they are unworthy, and to all who have found help in unexpected ways.

Dedicated to, and in loving memory of:

Andree; I could not have been more blessed to be your little sister,

Marilyn; for the gift of your laughter and for encouraging me to fly,

Heather; for always being my best friend,

Arthur; for encouraging me to chase the extra two percent

## **Abstract**

A narrative inquiry methodology of study was employed to understand the meaning of the relationship between an individual and their personal pet companion, and the impact that that relationship has on healing a diagnosed eating disorder or undiagnosed self-identified disordered eating behaviours, attitudes, and experiences. Participant recruitment was completed with poster advertising and snowball sampling after which seven individuals self-selected to participate in the study. Seven themes emerged which illuminated the chronology of the individual's journey through disordered eating behaviours and experiences with the support of their pet companion. The themes highlight the experience of isolation, connection, vulnerability, shame, mutual trust, love and respect for the interconnectedness of the individual and their pet. The findings of this study appear to indicate that the human-pet relationship is beneficial in aiding individuals to recover from their disordered eating experiences, and further allows for connection to permeate in other aspects of the individual's life.

## Acknowledgements

With deepest gratitude, I thank my committee: Dr. Em Pijl, Dr. Trent Leighton, and Dr. Peter Kellett. Em, thank you for going above and beyond. You have helped to build me up and work with me to achieve my goals. Trent, you have provided me with support, encouragement, and understanding from the first day. It has been a gift to work with you. Peter, thank you for keeping me grounded and for your reminders to enjoy the process. I have appreciated your wisdom, your humour, and your self-reflections.

Dr. Gary Tzu, for teaching me to stand tall.

Dr. Marcia Rich, for your compassion, generosity of spirit, and for helping to shape the idea for my thesis before I even had a committee.

Jason Solowoniuk, for your mentorship, humour, and most of all, friendship. Thank you.

Dr. Hany Bissada, for always believing in me.

Diana Chinnery, for helping me to accept who I have always been.

Jack Weiner at the University of Guelph, you have been a wonderful friend and mentor to me, even long after I graduated.

My sisters at Delta Eta Iota and my friends, for laughter, kindness, compassion, love, and memories. You are beautiful humans that I am honoured to share existence with. Thank you for sharing in beingness.

Mom, there are no words to express the gratitude and love that I have for you. Thank you for walking beside me on my journey. I cherish, honour, and love you.

Patrick, my best friend, my soulmate, my co-pilot, my adventurer. It is a blessing to share my life with you. Thank you, from the bottom of my heart.

And Charlotte, my little weirdo. I love you, I love you, I love you.

## Table of Contents

Dedication .....	iii
Abstract .....	iv
Acknowledgements .....	v
Table of Contents .....	vi
List of Tables .....	xii
List of Abbreviations .....	xiii
Chapter 1: Introduction .....	1
Purpose .....	1
Research Question .....	1
Significance and Overview .....	2
The Implicated Researcher .....	4
Chapter 2: Literature Review .....	6
Introduction .....	6
Defining Eating Disorders and Disordered Eating Behaviours .....	6
Eating disorders. ....	6
Disordered eating behaviours.....	9
Current Treatment Options .....	11
Treatment for eating disorders. ....	11
Treatment options for anorexia nervosa and bulimia nervosa. ....	12

Treatment options for binge-eating disorder.....	14
Treatment for disordered eating behaviours. ....	15
Treatment for social anxiety disorder. ....	17
Treatment for depression and suicidal ideation. ....	19
Treatment for borderline personality disorder. ....	20
Summary. ....	21
Animal Therapies.....	21
Animal assisted therapy .....	21
Equine assisted psychotherapy.....	23
Animal assisted activities.....	24
Pet companionship. ....	25
Healing through an Eco-Psychological Theoretical Approach.....	26
Shame in eating disorders and disordered eating behaviours. ....	26
False core drivers. ....	29
Ecopsychology.....	29
Ecotherapy. ....	30
Summary.....	32
Chapter 3: Methodology .....	34
Introduction.....	34
Narrative Inquiry: Living, Telling, Retelling, and Reliving .....	36

Research Procedure.....	37
Recruitment of research participants. ....	37
Screening process.....	39
Interview procedure. ....	39
Individual interviews. ....	40
Data Collection .....	42
Ethical considerations. ....	42
Data Analysis .....	44
Familiarization with the data set. ....	44
Initial coding. ....	44
Searching for themes.....	45
Reviewing the themes. ....	45
Defining and naming the themes .....	46
Producing the report.....	47
Rigour .....	47
Credibility. ....	47
Transferability.....	48
Dependability.....	48
Confirmability.....	49
Summary .....	49



Chapter 4: Thematic Results .....	51
Introduction.....	51
Participant Profiles.....	52
Nicole.....	52
Becky.....	53
Kate.....	55
Harriet.....	57
Luna.....	60
Jennifer.....	62
Maria.....	63
Thematic Analysis .....	66
The impetus: When disordered eating experiences first began.....	67
The catalyst: isolation intensifies disordered eating symptoms.....	70
Experiencing shame: Embracing vulnerability and connection with a pet companion.....	72
In the midst of self-destruction: Mutual connection occurs.....	75
Mirroring and acceptance of neediness, vulnerability, and imperfections. .....	77
Pet companionship promotes mindfulness: Interrupting the trance.....	79
Interconnected Salvation: Saved by the Rescued.....	81

Summary .....	83
Chapter Five: Discussion .....	85
Introduction.....	85
Answering the Research Question .....	85
Exploring theme one. ....	86
Exploring theme two. ....	87
Exploring theme three.....	89
Exploring theme four. ....	90
Exploring theme five.....	91
Exploring theme six. ....	92
Exploring theme seven.....	93
Implication of Themes in Healing .....	95
The first implication for healing. ....	96
The second implication for healing.....	98
The third implication for healing. ....	99
Discussion of Theoretical Lens.....	100
Limitations of the Research .....	101
Recommendations for Future Research .....	103
Conclusion .....	105
References.....	107

Appendices.....	122
Appendix A: Recruitment of Research Participants .....	122
Appendix B: Screening Process .....	123
Appendix C: Individual Interviews.....	124
Appendix D: Poster.....	126
Appendix E: Referral Phone Numbers.....	127
Appendix F: Consent Form.....	128

## List of Tables

Table 1: Participants' Demographic Profiles .....	51
---	----

## List of Abbreviations

AAA	Animal Assisted Activities
AAT	Animal Assisted Therapy
AN	Anorexia Nervosa
BAI	Beck Anxiety Inventory
BDI-II	Beck Depression Inventory-II
BED	Binge-Eating Disorder
BPD	Borderline Personality Disorder
BN	Bulimia Nervosa
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behavioural Therapy
DSED	Diagnostic Survey for Eating Disorders
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders (fourth edition)
DSM-5	Diagnostic and Statistical Manual of Mental Disorders (fifth edition)
EAP	Equine Assisted Psychotherapy
EAT	Eating Attitudes Test
EAT-26	Eating Attitudes Test-26
EDE-Q	Eating Disorder Examination-Questionnaire
EDI	Eating Disorder Inventory
EDI-2	Eating Disorder Inventory-2
EDNOS	Eating Disorder Not Otherwise Specified
HAQ-II	Helping Alliance Questionnaire
MFT	Multiple Family Therapy
OCD	Obsessive-compulsive Disorder
OQ-45	Outcome Questionnaire 45
OSFED	Other Specified Feeding and Eating Disorders

SAD	Social Anxiety Disorder
SSRIs	Selective Serotonin Reuptake Inhibitors
UFED	Unspecified Feeding and Eating Disorders

## **Chapter 1: Introduction**

### **Purpose**

The purpose of this study was to explore the meaning, through stories (Clandinin, 2013), of adult individuals of all genders who have experienced the healing of a diagnosed eating disorder, or self-identified disordered eating behaviours, attitudes, and experiences, through the assistance of informal pet companionship. In examining the stories of the lived experiences of these individuals, meaning and themes surfaced to elucidate the role that pet companionship may have for individuals who have healed, or who are currently healing, from these disordered eating behaviours or from diagnosed eating disorders. Utilizing a narrative inquiry theoretical perspective (Clandinin, 2013), the researcher sought to understand the individuals' stories of natural healing from self-identified disordered eating behaviours, attitudes, and experiences, and eating disorders through the companionship of a pet.

### **Research Question**

One primary research question was utilized in this study: How do the stories of pet companionship among individuals with a diagnosed eating disorder, or self-identified disordered eating behaviours, attitudes, or experiences, articulate the role and meaning of pet companionship in the management and recovery of their disorder? This question was utilized to gain an understanding into the role a pet may have in the recovery and management of an individual who feels that their eating disorder symptoms or disordered eating behaviours, experiences, or attitudes have, or have had, a negative impact on the social, biological, spiritual, and psychological aspects of being.

## Significance and Overview

Disordered eating behaviours, experiences, and attitudes are separate from having a diagnosis of an eating disorder; while disordered eating behaviours may be symptoms of eating disorders, individuals who experience these symptoms are not limited to having a diagnosis (Williamson et al., 2002). Examples of disordered eating behaviours, attitudes, or experiences, include, but are not limited to, purposeful restrictive eating patterns, a pursuit of thinness, purging through compensatory measures, fear of fatness, and preoccupation with food or body shape and weight (Williamson et al., 2002). Jones, Bennet, Olmsted, Lawson and Rodin (2001) evaluated 1739 adolescent females and found that 23 per cent of participants were engaging in dieting to lose weight. Furthermore, the study found that both binge eating and purging increased significantly with the age of the participants; 18.8 per cent of females under 15 years old engaged in binge eating and purging while 26.3 per cent of the participants over 15 years old engaged in the same behaviours (Jones et al., 2001). Strikingly, only 1.6 per cent of the participant population had received an assessment for an eating disorder (Jones et al., 2001). Body dysmorphic disorder, characterized by a distressing preoccupation with the physical body and accompanied by compulsive and repetitive attempts to address these concerns, is deemed an obsessive-compulsive disorder in the Diagnostic and Statistical Manual (fifth edition), and does not address specific eating disorder-related behaviours (Hollander & Kong, 2016).

For the purpose of this study, disordered eating behaviours, attitudes, and experiences is defined as purposeful restrictive eating patterns with the intent of changing body shape and/or weight, a pursuit of thinness, purging through the compensatory



measures of laxatives, exercise, restriction, diet pills, diuretics, and vomiting, fear of becoming fat regardless of current weight or size, and a preoccupation with food or body weight and shape, and will be assessed based on the narrative of the individual.

While a treatment modality for disordered eating behaviours outside of a mental health diagnosis—including eating disorders—has yet to be established, research has shown that disordered eating behaviours and attitudes can be present in multiple mental health diagnoses including obsessive-compulsive disorder, personality disorders, anxiety disorders including social anxiety disorder, and substance abuse disorder (Aderka et al., 2014; Dakanalis et al., 2014; Goodrick, Carlos Poston, Kimball, Reeves, & Foreyt, 1998; Striegel-Moore, Garvin, Dohm, & Rosenheck, 1999). As such, treatment for disordered eating behaviours, attitudes, and experiences, outside of a diagnosed eating disorder are often overlooked as these main diagnoses are the target for treatments. Furthermore, pharmacotherapy, psychological therapy, animal assisted therapy, and animal assisted activities have all been utilized in the treatment for both physical and mental diagnoses (Baumgartner & Cho, 2014; Brausch & Decker, 2014; Chakraborty & Basu, 2010; Connor & Miller, 2000; Crow, 2014). Natural healing—healing apart from formal medical or psychological interventions—can occur in the form of eco-psychological work (Greffrath, Meyer, Strydom, & Ellis, 2012), healing from false core drivers (Wolinsky, 1999), or potentially through the bond and relationship formed with a personal pet companion.

The significance in conducting this research is that understanding these narratives could illuminate the impact of a readily available therapeutic intervention for individuals. Understanding the narratives for individuals who have experienced recovery and healing

from an eating disorder, or self-identified disordered eating behaviours, attitudes, and experiences, with the help of pet companionship could elucidate a resource that may not otherwise be used in the treatment for the individual. Understanding these personal narratives may further help researchers to develop a greater understanding of the bond between an individual and a pet, which may help to increase an individual's resiliency as well as their capacity to self-soothe as an adjunct to other supports. These potential outcomes may result in a decreased need to rely on medical treatments. Furthermore, understanding this bond may enhance the efficacy of other therapeutic models and could potentially become a treatment modality itself in the future.

To understand the meaning of the individual-to-pet relationship in the recovery and management of an eating disorder or of self-identified disordered eating behaviours, attitudes, or experiences, the qualitative approach of narrative inquiry (Clandinin, 2013) was utilized. During the interview process, the researcher asked one primary question to the participant, followed by select follow-up questions for clarification only.

### **The Implicated Researcher**

How this thesis arose surprised me as I had said time and time again that I did not want to study eating disorders or disordered eating behaviours. The extent to which my own transformational journey occurred implicates me in this research. I believe I first began exhibiting signs of disordered eating behaviours when I was about eight years old and began hiding food in my bedroom and in my desk at school. By ten years old I was telling my classmates on the playground that I was fat and needed to lose weight. By 14, I had memorized the nutritional labels of every food possible and had become a vault of information related to exercise and food. And then at 22 years of age two very

remarkable things happened. First, I was gifted with a beautiful Yorkshire Terrier X Maltese whom my mother affectionately named Charlotte. Second, I was diagnosed with an eating disorder, although I remained in denial about this diagnosis for quite some time. My own journey takes me through two eating disorder support groups at my alma mater, visits to dietitians, university social workers, counsellors, physicians, and three intensive eating disorder treatment admissions. And at the start of every day was Charlotte, and at the end of every day was Charlotte. My constant companion, my best friend, and the one who loved me unconditionally even when I could not love anyone else—most of all myself.

My hope of conducting this research was to gain an understanding of recovery with the connection made with a pet companion. I once noted that it appeared my own experience of recovering with Charlotte was unique in comparison to my co-clients in treatment who did not have the experience of unconditional positive regard (Rogers, 1957) and love from an animal companion. I was left to wonder if there was a difference in how we recover or why we recover. In my own experiences and conversations with others who had disordered eating behaviours or diagnosed eating disorders, I noticed that they often did not seek treatment because they did not think they were worthy or sick enough to warrant treatment. I, too, felt the same way for many years. I began to wonder what it was about feeling unworthy to seek help yet paradoxically feeling worthy due to the unconditional nature of love and acceptance from a pet companion. I began to wonder what role a pet may or may not play in healing from an eating disorder, or from self-identified disordered eating behaviours, attitudes, and experiences, and what the meaning of that role may be.

## Chapter 2: Literature Review

### Introduction

In this chapter, I outline the following: 1) the differentiation between eating disorders and disordered eating behaviours, attitudes, and experiences; 2) the current treatment modalities for addressing eating disorders and disordered eating behaviours, attitudes, and experiences; 3) the benefits of animals in the healing of mental disorders; and, 4) healing through an eco-psychological theoretical approach.

### Defining Eating Disorders and Disordered Eating Behaviours

**Eating disorders.** Eating disorders have among the highest mortality rates of all psychiatric illnesses (Arcelus, Mitchell, Wales, & Nielsen, 2011). Crow et al. (2009) found that, in a sample size of 1,885 individuals, individuals with a diagnosis of anorexia nervosa had a mortality rate of 4.0%, individuals with bulimia nervosa had a mortality rate of 3.9%, and individuals with a diagnosis of eating disorder not otherwise specified had a mortality rate of 5.2%. It is important to understand the changes in diagnostic criteria for eating disorders that have been implemented in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The fourth edition of the DSM (DSM-IV-TR) contained three main eating disorder diagnoses; anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS); a diagnosis for individuals who did not meet the diagnostic criteria of AN or BN (American Psychiatric Association, 2000). However, the Diagnostic and Statistical Manual of Mental Disorders (fifth edition) (DSM-5) removed EDNOS from the manual and added binge-eating disorder, unspecified feeding or eating disorder (UFED) as well as other specified feeding or eating disorder (OSFED) of which there are five subtypes

(American Psychiatric Association, 2013). While the EDNOS category was removed, further changes also occurred to the diagnostic criteria; for example, amenorrhea was previously required in the DSM-IV-TR in postmenarcheal females (American Psychiatric Association, 2000) and is no longer a criterion for the diagnosis of AN (American Psychiatric Association, 2013). Furthermore, the weight criterion for AN has been elevated and the frequency of compensatory behaviours associated with BN has also been decreased (Mancuso et al., 2015).

Multiple other eating disorders exist in the DSM-5 under the Feeding and Eating Disorders category, not limited to anorexia nervosa, bulimia nervosa, binge-eating disorder, and the OSFED diagnoses. These other diagnoses include pica, rumination disorder, and avoidant/restrictive food intake disorder (American Psychiatric Association, 2013). The OSFED category is further broken down into atypical anorexia nervosa, bulimia nervosa (of low frequency and/or limited duration), binge-eating disorder (of low and/or limited duration), purging disorder, and night eating syndrome (American Psychiatric Association, 2013). Lastly, it is noted that obesity is not considered to be a mental disorder, as obesity can arise from several factors including genetic, physiological, behavioural, and environmental factors during which time energy expenditure is less than energy intake (American Psychiatric Association, 2013).

Several studies have demonstrated the changes in prevalence of eating disorders when taking into consideration the changes in diagnostic criteria of the DSM-IV-TR and DSM-5. While anorexia nervosa was previously found to have the highest mortality rate of the eating disorder diagnoses (Arcelus, Mitchell, Wales, & Nielsen, 2011), there is evidence to suggest that the prevalence of anorexia has increased since the adjustments

made for the DSM-5 (Mancuso et al., 2015). Mancuso et al. (2015) sought to re-examine the prevalence rates in comparing the DSM-IV and DSM-5 eating disorder diagnoses utilizing the Eating Disorder Examination-Questionnaire (EDE-Q). In utilizing the EDE-Q, Mancuso et al. (2015) gathered data from 156 individuals in outpatient settings over a fourteen-month period. Thirty-nine individuals were excluded from the analysis of the study due to missing data, therefore 117 individuals were included in the results (Mancuso et al., 2015). The study found that the prevalence of AN increased from 35.0 per cent to 47.0 per cent, the prevalence of BN remained the same at 18.8 per cent, and there was a reduction in the UFED and OSFED diagnoses, which had been combined and was previously EDNOS, from 46 per cent to 29 per cent (Mancuso et al., 2015). It was concluded from the study that further research is required into the UFED and OSFED categories to develop a greater understanding of these diagnoses (Mancuso et al., 2015).

Further research has examined the differences in diagnoses when comparing the DSM-IV and DSM-5 criteria including Fairburn and Cooper (2011) who noted that in their study of 167 adult patients the diagnosis of EDNOS decreased from 52.7 per cent to 25.1 per cent. Additionally, the percentage of individuals with AN increased from 8.4 per cent to 28.7 per cent and the percentage of individuals with BN remained the same at 38.9 per cent (Fairburn & Cooper, 2011). These studies suggest that anorexia nervosa, which has previously been deemed the diagnosis with the highest mortality rate, is increasing in prevalence with the changes made to the DSM-5. Many of those who previously would have been diagnosed with EDNOS may now be diagnosed with anorexia nervosa, leading to the question of the severity of the EDNOS—now OSFED and UFED—category.

Lastly, the literature on both information and forms of treatment for eating disorders in genders other than female is lacking. The prevalence of eating disorders in men is lower than the prevalence of eating disorders in women, where the lifetime prevalence of AN is 0.9 per cent in women and 0.3 per cent in men, the lifetime prevalence of BN is 1.5 per cent in women and 0.5 per cent in men, and the lifetime prevalence of BED is 3.5 per cent in women and 2.0 per cent in men (Hudson, Hiripi, Pope, & Kessler, 2007).

Striegel-Moore et al. (1999) found that in a sample of 466,590 male veterans, multiple co-morbidities were apparent. A high rate of comorbid substance abuse and mood disorder was found for men with anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified, according to the DSM-IV at that time (Striegel-Moore et al., 1999). Although this is but a small snapshot for men with eating disorders, further research into the presentation and treatment of eating disorders or disordered eating behaviours in non-female identifying individuals remains to be needed.

**Disordered eating behaviours.** Disordered eating behaviours are not limited to individuals who have a diagnosis of an eating disorder (Williamson, 2002). Some examples of disordered eating behaviours may include restricting food intake, difficulties with body image, purging through compensatory measures, and preoccupation with food or body shape (Williamson, 2002). Dakanalis et al. (2014) utilized a cross-sectional design of 408 female undergraduate students from four Italian universities, and found that only 11 participants disclosed to having previously been diagnosed or treated for an eating disorder. The findings demonstrated that, even in the absence of a diagnosis of an eating disorder, the internalization of media ideals affect body surveillance, body shame,

social anxiety, and disordered eating behaviours (Dakanalis et al., 2014). Various forms of disordered eating behaviours were included in the study such as believing the value one has is based on an individual's shape or size, body surveillance, as well as the items found in the Italian version of the Eating Disorder Inventory-2 (EDI-2) (Dakanalis et al., 2014). The variables measured in the EDI-2 are: drive for thinness; recurrences of binge eating and purging; body dissatisfaction; ineffectiveness of self; perfectionism; interpersonal distrust; interoceptive awareness to determine whether an individual can differentiate between hunger and satiety; and, maturity fears (Garner, 1991).

Fisher, Schneider, Pegler, and Napolitano (1991) sought to determine whether eating attitudes may also have an association with mental disorders including anxiety and lowered self-esteem. In a study of 268 adolescent females (mean age, 16.2 years), participants completed the Eating Attitudes Test (EAT) as well as questionnaires which gathered information on weight attitudes, self-esteem, anxiety, and health-risk behaviours (Fisher et al., 1991). The results of the study demonstrated that approximately two-thirds of participants self-described as overweight, while approximately three-quarters of the participants felt that they were above a healthy weight for their age and height (Fisher et al., 1991). Statistical analysis showed individuals who felt great dissatisfaction with their weight also scored lower for self-esteem and higher for anxiety (Fisher et al., 1991).

A Canadian study completed by Jones, Bennet, Olmsted, Lawson and Rodin (2001) evaluated disordered eating behaviours and attitudes in a female population of 1739 individuals between the ages of 12 and 18 years old. Questionnaires were completed by each of the participants including the Eating Disorder Inventory of which the subscales Drive for Thinness, Body Dissatisfaction, and Bulimia were utilized, the



Eating Attitudes Test-26 (EAT-26) and the Diagnostic Survey for Eating Disorders (DSED) (Jones et al., 2001). Disordered eating behaviours and attitudes were defined as dieting for weight loss, binge eating with an association of loss of control, self-induced vomiting, and use of diet pills, laxatives, and diuretics (Jones et al., 2001). The results of the study demonstrated that 23 per cent of participants were currently engaging in dieting to lose weight, while 8.2 per cent of the participants were using diet pills (Jones et al., 2001). Furthermore, the study results demonstrated that both binge eating and purging increased significantly with the age of the participants where these symptoms were reported by 18.8 per cent of females under the age of 15 years old and by 26.3 per cent of the participants over the age of 15 years old (Jones et al., 2001). Lastly, only 1.6 per cent, 4 per cent, and 6 per cent of the participants disclosed as having received an assessment or treatment, or a combination of both, for disordered eating behaviours or attitudes, for binge eating, and for purging behaviours, respectively (Jones et al., 2001).

### **Current Treatment Options**

The current treatment options for disordered eating behaviours and eating disorders is complex and often numerous in nature. The following section elucidates the current treatment options for both disordered eating behaviours as well as diagnosed eating disorders and will outline alternate methods of recovery. It is important to understand current treatment approaches to contrast alternative approaches discussed later.

**Treatment for eating disorders.** A literature search yielded multiple results pertaining to treatment options for diagnosed eating disorders both in terms of the DSM-IV-TR and the DSM-5 diagnostic criteria. Several searches were conducted using Google

Scholar, University of Lethbridge library, Academic Search Complete, and PsycINFO. Initially, a primary search of scholarly work was focused between the years of 2010-2016, however as this literature review expanded, all years—including 2017—were used in the literature search. Search terms included “treatment for anorexia nervosa”, “treatment for bulimia nervosa”, “treatment for other specific feeding and eating disorders”, “treatment for eating disorder not otherwise specified”, “treatment for binge eating disorder”, “medical treatments for eating disorders”, “psychological interventions for use in eating disorders”, “family therapy in eating disorders”, “pharmacological interventions for eating disorders”, “partial hospitalization treatment programs for eating disorders”, “nursing practice for eating disorders”, “pharmacological interventions for binge eating disorder”, “psychotherapeutic practices in the treatment of eating disorders” and multiple others were used within the search. The literature in this area is innumerable.

**Treatment options for anorexia nervosa and bulimia nervosa.** Presently, the exact etiology of AN remains unknown; however, there is evidence to suggest that the role of the family of origin can contribute to the development of the disorder (Skarderud, 2007; Buhl, 2002). Furthermore, the symptoms of AN are then maintained by external pressures, a critical inner voice, and through the re-experiencing of the dysfunctional family dynamics (Skarderud, 2007; Buhl, 2002). Some studies have additionally suggested that family therapy and family interventions in the context of the counselling field have greater effectiveness than individual counselling for individuals with AN (Campbell & Patterson, 1995).

Two forms of family therapies which have been used in the treatment of AN are conjoint family therapy and separated family therapy. In a study conducted by Eisler, Simic, Russell, and Dare (2007), female adolescent individuals with AN participated in conjoint family therapy during which an entire family was involved in outpatient counselling at the same time. At the three-month study, the average weight for participants had significantly increased from 87 per cent to 94.3 per cent (Eisler et al., 2007). Furthermore, 72 per cent of the individuals regained their menses at the five-year follow up (Eisler et al., 2007). In the same study, some of the participants engaged in separated family therapy in which the family seeks outpatient therapy from the same therapist as the individual with AN, however the treatment of the family is separate from the treatment for the individual (Eisler et al., 2007). In separated family therapy, it was found that 90 per cent of participants regained their menses at the five-year follow-up; moreover, it was found that only two of the 40 total participants combined had worsened symptoms of binge eating and purging and greater weight reduction after a five-year follow-up (Eisler et al., 2007).

Pharmacological interventions have also been utilized in the treatment of eating disorders. Naltrexone, an opiate antagonist, was utilized in a randomized control trial involving six participants with a diagnosis of either AN or BN (Marrazzi, Bacon, Kinzie, & Luby, 1995). The results of the study showed that the frequency of binge eating and purging was decreased for study participants; however, negative effects of naltrexone include the risk of harm to the liver as the dose utilized was four times the recommended dose (Marrazzi et al., 1995). In a second study on naltrexone as a treatment option for AN and BN, the authors found it to be a superior treatment for BN by reducing the symptoms

of binge eating and purging when compared to a placebo; however, the authors found that the reduction of binge eating and purging behaviours in AN were not significant on their own. They were, however, ameliorated with the incorporation of alternative therapies such as cognitive behavioural therapy (CBT), nutritional rehabilitation, and counselling therapies (Chakraborty & Basu, 2010).

Multiple family therapy (MFT) has been used in the treatment of AN and BN. Gelin, Fuso, Hendrick, Cook-Darzens, and Simon (2015) followed 82 adolescent individuals with a DSM-IV diagnosis of either AN and BN over a 12-month period during which participants received 21 days of therapy. The study results showed that 52.4 per cent of participants had achieved 85 per cent of their expected body weight, while 24.4 per cent of participants had achieved 95 per cent of their expected body weight (Gelin et al., 2015). Furthermore, participants with a diagnosis of AN reported decreased drive for thinness, decreased body dissatisfaction, and decreased perfectionism, whereas individuals with a diagnosis of BN showed no statistically significant reduction in any of these symptoms utilizing the EDI-2 as well as an Outcome Questionnaire 45 (OQ-45) (Gelin et al., 2015).

**Treatment options for binge-eating disorder.** As binge-eating disorder (BED) is a relatively recent diagnosis, being present for the first time in the DSM-5 (American Psychiatric Association, 2013), little is presently known about optimal treatment options. However, some treatments have been formulated to aid in the treatment and recovery of this disorder. Diet and lifestyle support has shown little success in the treatment of the disorder, with just 5-10 per cent of weight loss commonly observed (Crow, 2014). Psychotherapy involving CBT, interpersonal therapy, and dialectical behavioural therapy

(DBT) have shown to be effective on episodes of binge eating as well as binge eating cognitions. Research has shown that a combination of psychotherapy and pharmacotherapy would have the greatest benefit in treating this disorder (Crow, 2014). Lisdexamfetamine dimesylate has shown promising results in a study conducted by McElroy et al. (2015). In a study consisting of 202 participants at the end of the study, where 155 participants were randomized into the treatment group and 47 were randomized into the placebo group, it was found that binge eating behaviours were significantly decreased or ceased (McElroy et al., 2015). Although the results of the study showed benefits in the drug, the researchers concluded that further research continues to be necessary (McElroy et al., 2015).

**Treatment for disordered eating behaviours.** Literature on the treatment for disordered eating behaviours was scant. A current search of the literature does not yield results specific to the treatment of disordered eating behaviours, attitudes, or experiences, outside of a diagnosed eating disorder. A literature search did not yield a differentiation between disordered eating behaviours and eating disorders in terms of treatment, therefore determining what is presently being used in the treatment for disordered eating behaviours, experiences, and attitudes outside of a primary mental health diagnosis is lacking. Several searches were conducted with Google Scholar, the University of Lethbridge library, Academic Search Complete, and PsycINFO. Initially, a primary search of scholarly work was focused between the years of 2006 and 2016. However, upon investigation and determining that there was a lack of written work focusing on the treatment of disordered eating behaviours outside of diagnosed eating disorders specifically, the search of articles was opened to include all years of research. Search

terms including “disordered eating behaviours and treatment”, “disordered eating attitudes and recovery”, “treatment for restrictive eating”, “treatment for dieting”, “treatment of excessive exercise”, “diet pills and therapy”, “eating attitudes and treatment”, “eating attitudes and depression”, “depression and loss of appetite”, “counselling and purging behaviours”, “counselling and restrictive eating”, “counselling and over eating”, “body image treatment”, “counselling body image”, and “treatment for binge eating” were utilized within the search and yielded only one article which emphasized disordered eating behaviours, attitudes, and experiences as external to a diagnosis of an eating disorder. While the literature search did yield many results related to recovery and treatment, these articles were often accompanied by primary diagnoses which could explain disordered eating symptoms separate from the purposeful attitudes, behaviours, and experiences as defined by the research goal of this study.

Goodrick et al. (1998) described a study during which women, described as being overweight, engaged in binge-eating. However, due to the year during which the article was published, and based on the present diagnosis of binge-eating disorder in the DSM-5 (American Psychiatric Association, 2013), the individuals in this study would likely no longer have disordered eating behaviours, but rather would have a diagnosis of binge-eating disorder. The authors also discussed that the individuals experiencing episodes of binge eating and obesity also displayed symptoms of weight concerns, preoccupation with thinness, increased cognitive distortions, as well as mental diagnoses including depression, personality disorders, and anxiety (Goodrick et al., 1998). Therefore, to increase the depth of the literature review, the treatment for disordered eating behaviours has been expanded to include the treatment of other mental disorders with which

disordered eating behaviours has been associated, including depression, personality disorders, and anxiety.

**Treatment for social anxiety disorder.** Social anxiety disorder has been found to potentially have a high association with obsessive-compulsive and related disorders (Aderka et al., 2014). In a study of 68 individuals of male and female gender with a diagnosis of panic disorder, social anxiety disorder (SAD), or obsessive-compulsive disorder (OCD), questionnaires were completed to determine body image disturbance, attitude toward one's appearance, and anxiety (Aderka et al., 2014). It was determined that the symptoms SAD had an association with body image disturbance but the symptoms of OCD did not demonstrate a statistically significant association with body image disturbances (Aderka et al., 2014). However, the symptoms of OCD had an association with one's appearance, although this was found to be a non-pathological experience of appearance (Aderka et al., 2014). Lastly, it was determined that the symptoms of SAD had an association with the cognitive aspects of negative body image, including the negative perception of self (Aderka et al., 2014).

In a study of 1000 university students, 87 participants were found to have SAD (Kartal Yağız, Kuğu, Semiz, & Kavakçı, 2016). These participants were then administered the EAT, the Multidimensional Body-Self Relations Questionnaire, and the State Trait Anger Scale (Kartal Yağız et al., 2016). The results of the study demonstrated that repressed anger could negatively affect body image and eating behaviours in individuals who have SAD (Kartal Yağız et al., 2016). It was determined that treatments toward appropriate anger expression and positive body image and self-perception would be useful in the treatment of SAD (Kartal Yağız et al., 2016).

Presently, there are multiple forms of treatment for SAD including exposure therapy, applied relaxation, social skills training and cognitive restructuring (Rodebaugh, Holaway, & Heimberg, 2004). These therapies are forms of cognitive therapies (Rodebaugh et al., 2004). These cognitive therapies, when applied in a group of individuals with SAD have shown moderate to large effects in comparison with groups who have served as a control during follow-up assessments of 2-6 months post treatment (Rodebaugh et al., 2004). Pharmacological interventions are another form of treatment for SAD. Selective serotonin reuptake inhibitors (SSRIs) have been utilized for the treatment of SAD, with venlafaxine and sertraline being utilized with increasing frequency (Rodebaugh et al., 2004). These SSRIs have been found to be safer than other medications utilized historically in the treatment of SAD such as monoamine-oxidase inhibitors due to decreased side effects in SSRIs, as well as being a better tolerated class of medications (Rodebaugh et al., 2004). However, while SSRIs have demonstrated to have decreased side effects when compared to other medications, there have also been reports of serious adverse effects within the SSRI family of medication as well (Liebert & Gavey, 2009). Examples of the serious adverse effects from SSRIs can include increased aggression, increased suicidality, and akathisia, in which some individuals experience feelings of restlessness and agitation (Liebert & Gavey, 2009). Furthermore, the exact mechanism of SSRIs is yet to be determined (Liebert & Gavey, 2009). While SSRIs have been demonstrated to be effective for the treatment of some psychological disorders, such as SAD, further research into the mechanism is required, and therefore the use of alternative therapies and treatments such as pet therapy, may be beneficial for individuals who are unable to safely take SSRI medications.



While medication and psychoactive substances have been shown to be somewhat effective in treating some mental disorders, it should be noted that SSRIs are specifically a biological intervention (Rodebaugh et al., 2004). As there is no known etiology of eating disorders, utilizing solely a biological intervention would not be effective if there are underlying psychological issues; even as such, Flores (2007) would argue that psychoactive substances are often used when attempting to manage psychological issues:

For better or worse, an increasing number of individuals within our present-day society have become reliant on psychoactive substances to help them manage the fears and difficulties stirred up with interpersonal relationships. (Flores, 2007, p. 43).

**Treatment for depression and suicidal ideation.** Possessing negative body image and negative self-perception of the body has been shown to be predictive in suicidal ideation and depression in both male and female adolescents (Brausch & Decker, 2014). In the study of 392 male and female adolescents it was further found that the relationship between disordered eating, where disordered eating was defined through the completion of the EAT-26, and suicidal ideation was mediated by peer relations (Brausch & Decker, 2014). Furthermore, depression and suicidal ideation were largely impacted through parental support and self-esteem (Brausch & Decker, 2014). Furthermore, deliberate self-harm has been associated with lower self-esteem, adolescent suicide, body dissatisfaction in males and females, and disordered eating (Greydanus & Apple, 2011). The treatment options for deliberate self-harm with respect to body image, negative self-perception, suicidal ideation, and depression have traditionally been psychotherapy, group therapy, psychopharmacological interventions, psychiatric hospitalizations, and art therapies (Greydanus & Apples, 2011).

Both cognitive behavioural therapy and pharmacotherapy have been utilized in the treatment of depression and anxiety (Roshanaei-Moghaddam et al., 2011). However, the differences between CBT and pharmacotherapy when treating depression or anxiety is inconclusive; both treatment modalities seem to be beneficial for both diagnoses (Roshanaei-Moghaddam et al., 2011). In a study examining 267 females with a diagnosis of major depression, participants were assigned to interventions consisting of antidepressant medication, CBT, or provided with a referral to community mental health services (Miranda et al., 2003). The results of the study demonstrated significant findings for both pharmacological interventions as well as psychotherapeutic interventions; the results showed that six months post intervention the participants demonstrated higher social functioning (Miranda et al., 2003).

**Treatment for borderline personality disorder.** Lastly, borderline personality disorder has also shown to have an association with disordered eating behaviours; particularly body image (Sansone, Chu, & Wiederman, 2010). In a study of 126 surveyed female inpatient participants in a psychiatric unit, the authors found that individuals with borderline personality disorder (BPD) experienced less comfort and trust within their own bodies than the participants who were not found to have BPD (Sansone et al., 2010). Furthermore, individuals with BPD were more self-conscious and evaluated self-experience more negatively than individuals without a diagnosis of BPD (Sansone et al., 2010).

As with depression and anxiety, both pharmacotherapy and psychotherapy have been utilized as treatment modalities for BPD. Olanzapine, an atypical antipsychotic has been utilized in the treatment of BPD, and was found to be effective in reducing the

symptoms of the disorder when compared to the placebo in a study of 40 men and women (Bogenschutz & Nurnberg, 2004). Dialectical behavioural therapy (DBT), and general psychiatric management, has also been shown to be an effective form of psychotherapy for individuals with BPD. In a single-blind trial including 180 participants, all of whom were diagnosed with BPD per the DSM-IV, each received either one year of DBT or general psychiatric management (McMain et al., 2009). General psychiatric management consisted of individual counselling with emphasis on emotional dysregulation and disrupted attachments in early life (McMain et al., 2009). It was determined that both groups of interventions showed improvements after a one-year follow-up including a reduction in self-harming behaviours, visits to emergency services, improved depression and levels of anger, as well as improved interpersonal functioning (McMain et al., 2009). The researchers concluded that both DBT and general psychiatric management were effective treatment options for individuals with BPD.

**Summary.** To summarize the current treatment options for disordered eating behaviours: while there is a plethora of literature relating disordered eating behaviours in relation to other psychiatric disorders, there remains a gap in the literature regarding the treatment of disordered eating behaviours and attitudes as separate from a DSM-5 diagnosis. Further investigation into non-diagnosed disordered eating behaviours, attitudes, and experiences, remains to be needed.

### **Animal Therapies**

**Animal assisted therapy.** Animal assisted therapy (AAT) is a form of intervention in which an animal plays an integral role in the therapeutic treatment of the individual or group (Velde, Cipriani, & Fisher, 2005) and has grown considerably since

the 1970s and 1980s (Frewin & Gardiner, 2005). AAT is often colloquially used interchangeably with the terms pet therapy, pet-facilitated therapy, pet-assisted therapy, animal-facilitated therapy and animal visitation (Connor & Miller, 2000). The animals utilized in AAT can include many types including dogs, cats, rabbits, birds, and horses to name a few, and must undergo training programs to ensure predictable behaviour as well as calm temperaments (Connor & Miller, 2000). AAT is utilized to help with an individual's cognitions and physical functioning and has been shown to have multiple benefits including: decreased loneliness, detection of seizures, increased ability to communicate effectively, fostering trust for the individual, decreased stress and anxiety, as well as increased motivation and amelioration of physical vital signs (Connor & Miller, 2000). AAT has also been found to help individuals improve body image in critical and acute care settings (Connor & Miller, 2000). Furthermore, other benefits have found that AAT helps elderly individuals in rehabilitation centres to increase the capacity to walk longer distances when walking with a dog in comparison to walking alone (Velde et al., 2005).

AAT has been shown to reduce fear and anxiety in individuals with mental disorders and can enhance a sense of safety, comfort, self-esteem, and relationships (Velde et al., 2005). Furthermore, AAT has also been shown to provide benefits in the counselling field. Wesley, Minatrea, and Watson (2009) conducted a study in which AAT was used as a part of the therapeutic alliance with 231 individuals in an adult residential substance abuse group therapy population. The participants attended a group therapy in which 96 individuals were part of the control group and 135 individuals were part of the experimental group, which had the addition of a therapy dog (Wesley et al., 2009). The

results of the study found that, using the Helping Alliance Questionnaire (HAQ-II), individuals who were court-ordered, seeking treatment for illicit drugs or multiple substances, had a more positive experience in the experimental group in comparison with the control group. Furthermore, individuals who were seeking treatment for multiple diagnoses, maintained an alcohol addiction, or were involved in social services, found no differences in either the control or experimental groups (Wesley et al., 2009).

**Equine assisted psychotherapy.** In equine assisted psychotherapy (EAP), the horse and the human create a therapeutic relationship through mutual trust and respect (Frewin & Gardiner, 2005). The stubbornness of a horse can be attributed to a lack of engagement of a person; horses are deemed to be non-judgmental and therefore respond to the intent of the individual and the individual's behaviour (Frewin & Gardiner, 2005). McCormick and McCormick (1997) found that individual adolescent gang youth working with horses would attempt to control and overthrow them before gaining an understanding that becoming in touch with vulnerability would elicit a more positive response and relationship with the horse. Furthermore, confidence and self-esteem could be built through handling the horse, as the individual becomes more attuned to the horses' non-verbal communication (McCormick and McCormick, 1997). Lastly, EAP has benefits in substance abuse, eating disorders, depression, anxiety, physical disabilities, increased creative thinking and problem solving, as well as life skills including team work, relationship building, confidence, and attitude (Frewin & Gardiner, 2005).

Equine therapy has shown some promise in the treatment of female-identifying individuals with a diagnosis of an eating disorder (Cumella, Boyd Lutter, Smith Osborne, & Kally, 2012). In a study, which examined 72 females with a diagnosis of anorexia

nervosa, bulimia nervosa, or eating disorder not otherwise specified, equine therapy was explored to determine the efficacy of the treatment on six eating disorder symptoms: drive for thinness, interpersonal distrust, impulse regulation, depression, anxiety, and impaired self-efficacy (Cumella et al., 2012). To measure these six symptoms, three instruments were utilized include the Eating Disorder Inventory-2, Beck Depression Inventory-II (BDI-II), and the Beck Anxiety Inventory (BAI) (Cumella et al., 2012). The study participants participated in multiple activities including grooming, harness driving, and trail rides (Cumella et al., 2012). For the six eating disorder symptoms, there were statistically significant findings on the reduction of all symptoms, suggesting that equine therapy may help individuals with eating disorders to achieve recovery (Cumella et al., 2012).

**Animal assisted activities.** Animal assisted activities (AAA) differs from AAT in that the therapy delivered through AAT is through a professional helper and is designed to improve the functioning of the client or patient (Souter & Miller, 2007). AAA is delivered through volunteers, and involves less of a specific task or intervention; focusing the activity more on the animal visiting an individual, rather being used for a specific therapeutic process (Souter & Miller, 2007). Often, visitation is a form of AAA, which is utilized where a handler or owner of a pet may visit with a group of clients in a recreational manner with the intent to improve the overall well-being of the individual (Lutwack-Bloom, Wijewickrama, & Smith, 2005). AAA was utilized in a study to determine the effects of pets on a geriatric population in a long-term care facility over a six-month period; results from this study indicated that participants experienced a statistically significant positive mood change with visits from a volunteer with a canine

pet (Lutwack-Bloom et al., 2005). Changes in mood were determined using the Geriatric Depression Scale as well as the Profile of Mood Disorders; although there was a trend in which depression symptoms were decreased, the results were not statistically significant (Lutwack-Bloom et al., 2005).

AAA has been shown to benefit children with disabilities, particularly emotional and behavioural disorders, autism, and learning disabilities (Baumgartner & Cho, 2014). Children with these disabilities, and who also demonstrated low self-esteem, expressed an increased willingness to interact with animals during AAA rather than with their human peers (Baumgartner & Cho, 2014). This willingness has been attributed to the non-judgmental and non-threatening presentation and demeanor of the animals that are present (Baumgartner & Cho, 2014).

A study of eight elderly women was conducted over a two-year period in which the participants attended AAA sessions two times per month (Kawamura, M. Niiyama, & H. Niiyama, 2009). Semi-structured interviews were conducted with a phenomenological approach and the researchers found that through the relationships built with the animals during the AAA, the study participants developed greater interest in themselves, other residents within the institution, and their environment (Kawamura et al., 2009). Furthermore, the participants described a feeling of ease in the development of the relationship with the animals (Kawamura et al., 2009).

**Pet companionship.** Pets have demonstrated security and connectivity in various mental health conditions beyond use in formal animal assisted therapy or animal assisted activities (Brooks, Rushton, Walker, Lovell, & Rogers, 2016). In a qualitative study of 54 participants, semi-structured interviews were obtained to determine the importance

participants placed on their pet being within their network of mental health management (Brooks et al., 2016). It was identified that 60% of research participants found that their pet was central in the management of mental health in everyday life, while 32% found that their pet was important, although perhaps not central, to their mental health management, and 8% of participants found that their pet was not a component of their mental health management (Brooke et al., 2016). The factors which were found to aid the participants the most were physical proximity to their pet, relational presence, and how the individual feels that their pet understands them in ways that they found individuals could not (Brooks et al., 2016). The implications of the study suggested that pets should be considered a main source of support for individuals in the management of long-term mental health problems (Brooks et al., 2016).

### **Healing through an Eco-Psychological Theoretical Approach**

**Shame in eating disorders and disordered eating behaviours.** Both shame and guilt have been studied extensively as integral characteristics in certain psychiatric disorders and maladaptive coping strategies including addiction, self-harm and eating disorders (Skarderud, 2007). Shame has been studied in eating disorders—particularly in anorexia nervosa—and has been found to arise from feeling a loss of control, particularly regarding binge eating behaviours (Itulua-Abumere, 2013). Furthermore, shame in eating disorders can be a result of perceived pride or vanity (Skarderud, 2007), or in the context of body dysmorphia due to the relationships and perceived judgments of others in the rapidly growing online community of pro-anorexia users (Knapton, 2013). Furthermore, it has been found that individuals who associate with the pro-anorexia online community perpetuate these feelings of shame by normalizing these experiences among the



community members (Knapton, 2013). While most of the literature regarding shame in eating disorders centres around specific eating disorders, this section will tease out the particular symptoms of these disorders—particularly the pursuit of thinness, feeling a loss of control, self-esteem, and others—which can also be symptoms of disordered eating behaviours and attitudes separate from a DSM-5 diagnosis of an eating disorder.

In a study conducted by Skarderud (2007), shame and pride in individuals with a diagnosis of anorexia nervosa were investigated. Thirteen individuals with AN participated in a qualitative research study which explored their experiences of past and present shame (Skarderud, 2007). It was found that shame resulted from experiences within the family of origin during early attachment (Skarderud, 2007). Shame that has been derived within the family of origin during early development can later be perpetuated with an inner critical voice, external pressures, and through reliving the trauma experienced previously within the family of origin (Skarderud, 2007; Buhl, 2002). Therefore, per Skarderud (2007), this shame can result in a shame-shame cycle during which the initial shame is perpetuated through future shame, resulting in greater shame about past experiences.

Shame has also been investigated as a potential protective factor by helping individuals to cope through experiences of withdrawal and isolation (Skarderud, 2007; Gilbert, 1998). The experience of this withdrawal and isolation is that of protecting oneself from potential hurt, emotional connection, and furthermore, the preservation of the identity of self (Skarderud, 2007). In the online pro-anorexia community, eating disorders and disordered eating behaviours and attitudes are hidden through pseudonyms, anonymity, and secrecy and are encouraged; however, this anonymity furthers an

individual's experience of shame as they then behave inauthentically of their true experience outside of the virtual world (Knapton 2013; Skarderud, 2007).

Gilbert (1998) makes a distinction between positive and negative shame in which positive shame is protective, in essence protecting and respecting both others and the self. Conversely, negative shame can be described as harmful, preventing respect to other and to the self (Gilbert, 1998). This negative shame can create a negative self-perception including: self-disgust, feelings of unworthiness, inadequacy, imperfection, unlovability, and worthlessness (Gilbert, 1998; Skarderud, 2007). Lastly, a distinction between internal and external shame is made. Gilbert (1998) described external experiences of shame as the perceived shame from others, including: perceived judgments based on physical appearance; likeability; social status; and other external characteristics. Moreover, internal shame is linked to the negative shame of negative self-perception as above, and seeing the self as innately bad, flawed, unattractive, and unworthy (Gilbert, 1998). Lastly, internal shame is deemed as the truth to the individual (Gilbert, 1998).

The experience of men and women with respect to shame in eating disorders or disordered eating may differ. In a study of 188 adult participants of a diagnosis of binge-eating disorder, it was found that shame was significantly associated with the attitudinal features of the disorder, including the frequency of binge eating with a perception of a loss of control, concern regarding shape and size, and body dissatisfaction (Jambekar, Masheb, & Grilo, 2003). The results of the study demonstrated that shame was associated with body dissatisfaction in men, while shame was associated with weight concern in women, after controlling for depression and self-esteem (Jambekar et al., 2003). The experience of shame in men and women may potentially differ in other diagnoses, or in

individuals who have not received a diagnosis but who feel that these behaviours, attitudes, or experiences are negatively affecting their lives. As such, further research into all populations is important in gaining a continued understanding of how the experience and meaning of shame differs for individuals in this population. Furthermore, how the experience and meaning of shame differs in relationship with a pet companion may impact individuals regardless of gender or diagnosis.

**False core drivers.** False core drivers speak to the core belief(s) which individuals have lived by, which has been kept out of the awareness and consciousness of the individual (Wolinsky, 1999). False core drivers are often self-derogatory statements such as, “I’m not good enough”, or “I am bad”, or “I am out of control”, which often speaks to the level of reduced self-esteem (Wolinsky, 1999). These core beliefs are often accompanied by the opposite beliefs, known as false core compensators (Wolinsky, 1999). False core compensators are often used unconsciously to resolve and heal the false core beliefs (Wolinsky, 1999). However, rather than healing or transforming the false core drivers, the false core compensators actually reinforce the false core drivers, which ultimately results in the individual believing that the false core driver is truth (Wolinsky, 1999). Individuals with disordered eating behaviours may experience these false core drivers, particularly that of “I’m not good enough” and perhaps seek to compensate for that belief by striving for thinness or towards an ideologic perfectionism, which in turn may result in feeling greater, more intense feelings of “I’m not good enough”.

**Ecopsychology.** Ecopsychology intersects ecological and psychological principles to highlight the connection between humans and nature within the greater earth (Roszak, 1992). The intersection of the ecological sense of nature explores the natural

world and the earth, whereas the psychological sense of nature explores human nature (Fisher, 1996). Ecopsychology seeks to explore the relationship of humans to the natural world in which the earth is not solely for the use of humans, but rather that humans and the natural world are to exist in peaceful symbiosis, in which greater self-understanding and wellness is fostered (Fisher, 1996; Aparicio Parry, 2016). Ecopsychology argues that consciousness is not a product of the human brain, but rather, consciousness is a result of nature as a whole (Aparicio Parry, 2016). Furthermore, ecopsychology centres on the awareness that lacking the experience of the nonduality of humans and nature can lead to suffering for both humans, and nature (Davis, 2011).

Research locations have expanded to include interaction with nature including wilderness trips, city parks, gardens, working with images of nature, hikes, and more (Davis, 2011; Greffrath, Meyer, Strydom, & Ellis, 2012). Experiences in these research settings have demonstrated benefits for mental health including relaxation, greater social capacity, greater capacity for joy, and cognitive benefits (Davis, 2011; Weinstein, Przybylski, & Ryan, 2009).

**Ecotherapy.** Ecotherapy takes into consideration the aspect of various helping professions in developing the individual who relies on the wellness of the world as a whole (Clinebell, 2013). As such, ecotherapy is considered a holistic approach in which values, behaviours, and attitudes, are ecologically-and therapeutically-centred (Clinebell, 2013). Counsellors who operate from an ecotherapeutic lens can facilitate a client to view heartache, pain, hurt, trauma, and other shadow emotions as a natural ebb and flow of life; one that mirrors the death and rebirth found in nature (Clinebell, 2013). Ecotherapy centres on mutual healing between the human mind and the natural world, and involves

horticultural therapy, wilderness excursion work, and animal-assisted therapy (Chalquist, 2009). Furthermore, ecotherapy has been recommended as an adjunctive treatment to multiple mental health disorders and has been shown to decrease symptoms of depression, anxiety, and aggression, while improving self-esteem, positive affect, interpersonal skills, and overall general health (Wilson et al., 2010).

According to the American Disabilities Act (ADA), an animal must be specifically task trained to be able to work as a service animal, and it is this task training which differentiates a service animal from a personal pet companion (Froling, 2009). Task training for service animals can include a wide variety of tasks depending on the disability for the individual, and can range between emotional and physical supports such as bringing a beverage so a person can take medication or providing space for an individual experiencing emotional overload (Froling, 2009). Service animals can be trained to mitigate the symptoms experienced by individuals with post-traumatic stress disorder, panic disorder, and depression (Froling, 2009). A further differentiation between a service animal and a personal pet companion, is that service animals work in conjunction with an individual in a specific partnership which helps the individual to understand their own symptoms, and helps to work toward treatment goals (Froling, 2009). Froling (2009) further argues that basic obedience training and housebreaking are essential to both pet companions and service animals; however, although pet companions may offer the emotional support, comfort, and sense of security that trained service animals provide as an adjunct to conventional therapies, this does not qualify an animal as a legal service animal if task training has not occurred.

An aim of the present study is to understand the meaning of the natural therapeutic relationship between an individual and their pet in the recovery from an eating disorder or from self-identified disordered eating behaviours, experiences, and attitudes. Furthermore, the aim of this study is to further understand how personal pet companions can offer emotional support, comfort, and security and the impact that that has on an individual in their recovery from disordered eating experiences in the absence of more formal animal therapy. Therefore, ecopsychology and ecotherapy provide the theoretical frameworks to explore how the health and well-being of an individual with a diagnosis of an eating disorder or self-identified disordered eating behaviours, experiences, and attitudes, could be ameliorated through the experience of a human-pet relationship.

### **Summary**

This literature review outlined the current knowledge of disordered eating separate from eating disorders, and summarizes the present treatment models. Furthermore, this review established the current gaps in knowledge related to the role of pet companionship in the management of eating disorders and disordered eating symptoms, and contextualizes the articulated purpose and research question. Utilizing the theoretical frameworks of ecopsychology helped to guide this thesis in examining the natural relationship of an individual and pet, noting that it is reflective of a relationship found in nature, and will help to support the narratives of the experiences of the research participants.

Understanding the narratives of individuals who have experienced recovery and healing of an eating disorder or disordered eating behaviours, attitudes, and experiences,

with the assistance of a pet could illuminate the impact of a readily available resource for individuals. Understanding the meaning of a person-pet relationship in recovery may further help researchers to develop a greater understanding of a bond which may help to increase an individual's resiliency and capacity to self-soothe in the absence of other supports, such as formal medical or psychological treatment. The absence of these supports can be during the day-to-day living of the individual, or after the individual's treatment experience has been terminated. These potential outcomes may result in a decreased need to rely on medical treatments, and could potentially become a treatment modality itself.

## Chapter 3: Methodology

### Introduction

I used a qualitative approach for this research to gain a personalized understanding of the meaning of the natural human-pet relationship, and the experience of the healing properties which may arise from that relationship. Qualitative research can facilitate the description of events or experiences that occur in its natural setting, and therefore, often centres around the subjective experience (Abusabha & Woelfel, 2003). While quantitative research has been shown to have importance when testing hypotheses, seeking statistically significant results, and measuring variables (Abusabha & Woelfel, 2003), gaining an understanding of the meaning of a human-pet relationship in terms of recovery from an eating disorder or from self-identified disordered eating behaviours, attitudes, and experiences, is best suited to a qualitative design.

In this section I describe the methodology used to explore the following research question: How do the stories of pet companionship among individuals with a diagnosed eating disorder, or self-identified disordered eating behaviours, attitudes, or experiences, articulate the role and meaning of pet companionship in the management and recovery of their disorder? I decided to use narrative inquiry (Clandinin, 2013) to examine the meaning of the narrative of individuals who have experienced the effects of pet companionship in the natural healing of self-identified disordered eating.

Narrative inquiry operates on the premise that individuals understand and give meaning to one's life and experiences through stories (Andrews, Squire, & Tamboukou, 2008). Polkinghorne (1995) explains that it is often retrospectively, when one reflects upon a historical experience, that an individual comes to understand and give meaning to



the events one has experienced. Narrative inquiry delves into the meaning of an individual's experience as expressed through a story of personal experience, through which themes and categories of information can emerge (Creswell, 2011). I chose narrative inquiry above other methodologies because of its connection with meaning-making. When reflecting upon an individual's personal narrative, it is a product of the understanding of their experience that creates meaning for the individual—not necessarily the specific facts of the story (Wertz, Charmaz, & McMullen, 2011).

Multiple other qualitative methodologies could have been employed in for this research including grounded theory, phenomenology, ethnography or general qualitative methodologies. While these qualitative methods are equally valuable, it is important to consider what one is hoping to achieve through the study. Of these qualitative approaches, phenomenology may have been the next most-likely chosen methodology for this research. Phenomenology uses words and language to explore the lived experience of individuals, and places emphasis in the interpretive power of the narratives (Wertz et al., 2011). Furthermore, phenomenology focuses on the essential structure of the experience and utilizes hermeneutic analysis (Thorne, 2000). Unlike phenomenology, however, narrative inquiry has greater freedom with its philosophical stance and theoretical traditions (Wertz et al., 2011), and uses the individual's account of the experience to determine meaning of that experience (Thorne, 2000). In narrative inquiry, the participants narrate their own experiences, which allows for thick descriptions to emerge and builds rapport between the participants and the researcher (Clandinin, 2013). Clandinin (2013) would argue that in narrative inquiry the researcher is not separate from the participant, and that the researcher must examine their own experiences prior to

engaging in a narrative inquiry process. It is with this openness that the thick descriptions arose from the participants as they describe their personal truth of their experiences, and the meaning making that they derive from those experiences themselves (Wertz et al., 2011).

### **Narrative Inquiry: Living, Telling, Retelling, and Reliving**

Narrative inquiry enables an in-depth exploration of the experience and meaning of the stories of individuals (Clandinin, 2013). Clandinin (2013) describes narrative inquiry as a methodology from which transactional and relational ontology is integral. Transactional and relational ontology depicts the information as not only reality for the individual, but places emphasis on the relation between the individual and the individual's environment, taking into consideration the individual's inner life, social influences, and their personal history (Clandinin, 2013). Lyons (2010) views narrative inquiry three-fold: as a story, as a way of knowing, and as a method of investigation. Lyons (2010) further describes the process of conducting narrative inquiry research in terms of exploration, rather than developing a research hypothesis.

In narrative inquiry four main terms are explored to understand the experience and phenomenon of the individual (Clandinin, 2013; Cresswell, 2011). I utilized these four terms laid out by Clandinin (2013). The first of these terms is *living*; the individual lives out the experience in the moment (Clandinin, 2013). The second of these terms is *telling*, during which time the individual tells the story of the experience (Clandinin, 2013). The narrative inquiry research process facilitates the last two terms: retelling and reliving. During *retelling*, the researcher and the participant inquire into the experience and retell the narrative (Clandinin, 2013). Retelling can aid a researcher in understanding

the chronology of events that the individual has experienced (Cresswell, 2011). This retelling can be beneficial to understanding any links that the storyteller, or participant, may draw meaning from, relative to their experiences (Cresswell, 2011). Lastly, *reliving* is the fourth key term during which time the participants gain awareness and insight into how they have changed through the retelling of the story, and how the personal landscape of the experience is now changed with the landscape of the present moment (Clandinin, 2013).

### **Research Procedure**

**Recruitment of research participants.** Research participants were recruited by placing posters within public locations in the Lethbridge community including: coffee shops, postal offices, churches, grocery store bulletins, animal daycare locations, veterinary clinics, counselling agencies, physician offices, and at the local university and college. The posters included my university e-mail contact information, as well as my cell phone number for ease of access. Lastly, as eating disorders are often under-diagnosed and under-treated, particularly in males, (Strother, Lemberg, Standford, & Turbeville, 2012), snowball sampling (Browne, 2005) was utilized to augment the number of individuals who came forward and inquired into this study. Snowball sampling is often used for populations of participants in which recruitment may be difficult due to potential low numbers because of a sensitive topic (Browne, 2005), such as under-reporting or under-diagnosing, as in the case of eating disorders. Snowball sampling was carried out by asking current participants within the study to recommend others who may also have experiences similar, or related to, the study (Kuper, Lingard, & Levinson, 2008). Because of snowball sampling, the participants in the study were not limited to Lethbridge, but

also included individuals from Ontario, Manitoba, other areas of Alberta, and Yukon Territory.

The following inclusion criteria was utilized in the initial screening for participants (Appendix A):

- Individuals over 18 years of age
- Individuals who self-identify as having had and/or used disordered eating behaviours, attitudes, or experiences as a means of coping, self-regulating, or self-soothing – OR – individuals who have a diagnosis of an eating disorder
- Individuals who identify that their pet played an important role in the natural healing or recovery process from disordered eating behaviours, attitudes, and experiences, or from an eating disorder

Length of time of recovery in natural recovery was not a criterion for this study, as length of time in recovery is a subjective experience for an individual and will vary from one individual to the next (Fisher, 2003). To remain congruent with a narrative inquiry approach, the participants in this study were selected with the previously listed criteria to illuminate the natural healing and recovery process of individuals who have a diagnosis of an eating disorder or who self-identify as having disordered eating behaviours with the assistance of a personal pet companion. Although all the participants in this study were female, gender was not a limiting factor for inclusion criteria. There were a total of seven participants. In narrative inquiry, attaining a sample size of six participants has been demonstrated to adequately communicate the essence and meaning of an experience (Morse, 1994).

**Screening process.** The initial screening process (Appendix B) was conducted over the phone, during which time I introduced myself to the individual, and explained the details of the study. I described the inclusion criteria of the study to the individual and determined if the individual met all criteria. Then, I explained the interview process to the individual to inform them that an audio recording will be conducted. The primary questions that I asked the individual during the initial screening process were:

- Have you ever been diagnosed with an eating disorder?
  - If yes, the primary researcher will ask the individual to provide the diagnosis
- Do you feel that you experience disordered eating behaviours?
  - If yes, the primary researcher will ask the individual to provide examples
- Do these behaviours negatively impact your life?
- Have you found that your pet companion has played a role in your recovery?

Other questions which may have arisen during the initial screening were contained to general information questions to determine whether the individual was a suitable candidate for the study. Once this initial screening process had taken place, I asked the individual if they would like to participate in the study, and if so, I then scheduled a date and time to meet in person, or via Skype if they were living outside of Lethbridge, to complete the interview process.

**Interview procedure.** Once an individual had been found to meet all the inclusion criteria, an interview date was established. At the interview, I outlined the role of the researcher and participant to the individual. My role as the researcher was to help the individual to describe their experience and be aware of any preconceived ideas,

themes, or notions related to the topic. An additional role as the researcher was to maintain ethical boundaries with the participants, from obtaining informed consent from the individual, which was explained in detail, to keeping the information of the individual confidential. The role of the participant was to authentically communicate their experience of natural healing with their pet companion from disordered eating behaviours, or from an eating disorder, which had been identified by the individual. Lastly, it is important to note that the research methodology of narrative inquiry is a collaboration of both researcher and research participant (Clandinin, 2013); therefore, as narrative inquirers we become a part of our participants' lives and experiences, and they become a part of ours (Clandinin, 2013).

**Individual interviews.** Semi-structured interviews (Appendix C) were conducted for 60 to 120 minutes during which time the research participants elucidated the experience of pet companionship and the natural healing from a diagnosed eating disorder or from self-identified disordered eating behaviours, attitudes, or experiences. The interviews took place either in person in an office on the University of Lethbridge campus, or via Skype for individuals not residing in Lethbridge. Prior to the commencement of the interview itself, a short list of demographic questions was asked of the participant. These questions consisted of the following:

- What is your current age?
- From what age was the onset of your eating disorder-related experiences?
- What is your highest level of education that you have completed, if any?
- What is your religious affiliation, if any?
- What is your ethnicity?

- What is your marital status?

The demographic questions helped the researcher to define the participant population. The primary interview question was, “Can you please tell me all about your experience with your pet and your journey through your eating disorder or self-identified disordered eating behaviours?” Pet companionship was defined as any creature that has facilitated the natural recovery process from disordered eating symptoms for the individual. The pet may or may not have belonged to the individual. Lastly, the natural healing or recovery process was defined as relief from a diagnosed eating disorder or self-identified disordered eating behaviours, attitudes, or experiences. After asking the initial question, the primary researcher gave the research participant time to completely answer the question without interruption. Once the individual had concluded telling their story, based on personal experience, the primary researcher then went back and asked for more information or clarification about specific parts of their story. Some clarification questions included the following, to understand the participant’s personal story of their experience:

- How would you describe your disordered eating behaviours?
- How did you become aware that these behaviours were impacting your life?
- How did these behaviours impact your life?
- What feelings were elucidated from that experience?
- How did you notice your pet companion was helpful?
- What changes did you observe in yourself?
- What role did your pet play for you?
- What role did you play for your pet?

- At what point, did you realize something was changing for you?
  - How, if at all, was this attributable to your pet?
  - What is the best part of your natural healing with the help of your pet?

During the interview, I ensured no interruption for the participant during the telling of the story; I demonstrated empathic listening (Corey, 2013), and I sought to maintain a semi-structured approach to provide the space for the participant to narrate their own experience in their own way. Any follow-up questions asked of the participant were for clarification and understanding of the participant's narrative.

### **Data Collection**

Data was collected utilizing a digital recorder, which was kept on my person or in a locked cabinet except for when it was being utilized in an interview setting or during a transcribing session. Further notes were made with paper and a pen during the interview process. These notes were utilized to probe a participant during the interview, and were kept in a locked cabinet until the end of the transcription. All locked cabinets were in locked offices. Furthermore, all recordings were encrypted with a password, placed on a password protected laptop which were also kept in a locked room.

**Ethical considerations.** The primary ethical considerations were confidentiality, anonymity, and nonmaleficence. To maintain the anonymity of the participants, the participants were asked to self-select a pseudonym and had the contact information of my research supervisor, my own contact information, and the contact information for the University of Lethbridge Research Ethics Committee. The participant's identities were also kept confidential from any other members of the research team including the supervisory committee. Furthermore, all confidentiality was maintained for the research



participants, although it was explained that confidentiality could be broken under the circumstances of a disclosure of abuse of a child, or of an elder or dependent, as well as the threat to harm themselves or others. Lastly, doing no harm to the participant was of utmost importance, as the participant population may have had pre-existing triggers which could have created emotional turmoil for them. All participants were provided with a referral list of potential mental health specialists, organization, and therapeutic practices within the city of Lethbridge, along with a copy of the consent form (Appendix E). To prevent any stress regarding being seen in an interviewing location, the location of all interviews was held in an office at the University of Lethbridge, or via Skype for individuals not residing within Lethbridge. The participants residing outside of Lethbridge recruited by snowball sampling from individuals who were residing within Lethbridge, which allowed for an increase in sample size.

The participants had full knowledge of informed consent, and were offered a copy of their consent form (Appendix F). The consent form included the title of the proposed research, the purpose of the intended research, as well as the criteria of experiencing natural healing from self-identified disordered eating behaviours or a diagnosed eating disorder with the assistance and relationship of a personal pet companion. Moreover, the consent form included the process of voluntary participation, the length of the interview process, and the opportunity to withdraw from the study at any time without consequence. The consent form also included information about where the results of the study could be disseminated, including within this written thesis, at professional conferences, at educational community events, and within publications for academic

journals and research. Consent forms and interview transcriptions will be kept for five years, after which time they will be destroyed.

### **Data Analysis**

Interviews were transcribed and uploaded to NVivo software for analysis. The data were analyzed utilizing thematic analysis (Creswell, 2011), which is an appropriate method of analysis for narrative inquiry (Clandinin, 2013). The aim of thematic analysis in narrative inquiry is to analyze narratives taken from life stories (Vaismoradi et al., 2013). Braun and Clarke (2006) describe thematic analysis in terms of six phases. These phases include becoming familiar with the data, transcribing the data, generating initial codes, searching for themes, reviewing themes, defining and naming the themes, and lastly, writing the report (Braun & Clarke, 2006). I utilized the methods outlined by Hunter (2010) and Braun and Clarke (2006), with some components of the qualitative analysis described by Creswell (2014) for the coding and thematic identification in this study.

**Familiarization with the data set.** Immediately following each interview, I listened to the recording and began transcribing. Often, I would listen to the interview repeatedly to understand the intonation and inflection of the participant's voice during the interview. As this occurred, I familiarized myself with both the depth and the breadth of the content, and began to understand the meaning of the narrative as I sought to make sense of that preliminary data (Braun and Clarke, 2006; Creswell, 2014).

**Initial coding.** Themes and codes can be identified at any part of the analysis (Ryan & Bernard, 2000), therefore as I began to review the data, I often went back and forth between field notes and the transcribed interviews. Moving fluidly with the data

was supported through Braun and Clarke (2006) who described that data analysis requires fully engaging with the data itself. Hunter (2010) described coding the data into themes and sub-themes by using the language of the participants, and then highlighting quotes that would be important to include in the written portion of the analysis. Additionally, Hunter (2010) suggested continuously interrogating the data and understanding that analysis and writing are interconnected processes. When analyzing the data from the participant interviews in this study, I coded the data into themes and subthemes by using the language of the participants. Some of the language that the participants revealed were “shame”, “safety”, “companionship”, “vulnerability”, “isolation”, “self-loathing”, and “connection”. Out of these terms, the quotes used in this thesis were identified and the themes themselves began to emerge. I additionally followed Braun and Clark’s (2006) suggestion to code for as many potential themes and patterns as possible.

**Searching for themes.** When I began looking for initial codes, I started to look at what my data was authentically showing. The process of creating codes began by subjectively determining what the significant sentences might be. At times, this entailed looking for patterns that related to themes or narratives that spoke of repeating situations across participant interviews. In conjunction with initial coding, themes started to emerge. I sorted the codes into potential themes and grouped themes with subthemes (Braun and Clarke, 2006). Through each interrogation of the data, and by continuously reviewing field notes, transcriptions, through member checking and through discussion with the thesis committee, the seven themes of this study started to emerge.

**Reviewing the themes.** After developing the preliminary set of themes, I checked all the themes again with the transcribed interviews to ensure that they matched what was

described by the participants, and to ensure that each theme was separate on its own and did not need to be collapsed into one central theme. The validity of the themes was checked with the members of the thesis committee as well as with the participants, which will be described in the rigour section below.

Data saturation (Fusch & Ness, 2015), usually associated with other qualitative methodologies such as grounded theory and ethnography (Creswell, 2011) occurred when sufficient evidence had been gathered to replicate the study, and when further coding was no longer feasible as no new themes emerged. Data saturation is a subjective determination of the researcher that new data will not contribute to developing any new categories or codes (Creswell, 2011). After the fifth interview, I suspected that no new themes would emerge with further interviews; however, as I am a novice researcher, I consulted with my thesis committee and was advised to continue with interviews for a few additional participants. Knowing that six participants can communicate the meaning of an experience in narrative inquiry (Morse, 1994) I continued recruiting until seven individuals were in the study. After seven participant interviews, I was certain that I had achieved data saturation as no new themes emerged from coding.

**Defining and naming the themes.** Once the themes were developed, defined, and refined, I presented a written analysis to the members of my committee in conjunction with some aspects of the narratives from the interviews. I provided a detailed analysis regarding how these themes contribute to the research question and the meaning the participants provided based on their experiences. After clearly delineating the themes, and meeting with an external source, the themes were given concise and representative names (Braun & Clarke, 2006).

**Producing the report.** After the themes were developed and appropriately named, I produced a report of the analysis which represented the complex narratives and meanings that had been derived from the participant interviews. Feedback was provided to me by thesis committee members and the study participants when provided with a copy of the thematic report in accordance with a rigorous qualitative data analysis (Baillie, 2015; Braun & Clark, 2006; Lincoln & Guba, 1985)

### **Rigour**

There has been much debate about the place of rigour in qualitative research, where some argue that rigour implies rigidity and inflexibility (Thomas & Magilvy, 2011), whereas others argue that rigour in a qualitative setting denotes integrity and competence (Tobin & Begley, 2004). According to Baillie (2015), there are multiple ways to ensure that a qualitative study has been conducted with rigour. Techniques which promote rigour in qualitative studies include reflexivity, peer debriefing, prolonged engagement in a research setting, triangulation, member checking, examining negative or exceptional cases, rich descriptions, and having an audit trail. In the following section I will explain how rigour was achieved in this study, and what methods I employed in attaining integrity and competency in qualitative research.

This study ensured rigour, accuracy and trustworthiness of its findings by using the four criteria of Lincoln and Guba (1985). These four criteria are: credibility, transferability, dependability, and confirmability.

**Credibility.** The first of these criteria, credibility, speaks to internal validity and believability from the perspective of the participants. According to Lincoln and Guba (1985), there are five ways of producing credible data: member checking, triangulation,

peer debriefing, persistent observation, and prolonged period of engagement. In this study, I used member checking for both the participant profiles and developing themes. First, each proposed participant profile was sent to the participant for verification of accuracy. Second, the themes were sent to each participant with request for validation and accuracy. The results of member checking were documented as part of the audit trail. The research achieved triangulation of data by using the notes taken during interviews, the reflective responses of the participants when were sent their personal profiles and the emerging themes, and the interview transcripts themselves. I also debriefed with my peers and my thesis committee as I tried to make sense of the findings and the emerging themes. These meetings were documented as part of the audit trail. Prolonged periods of engagement typically refer to spending extended periods of time with the participants checking for information and building trust (Lincoln & Guba, 1985), and although prolonged periods of engagement did not occur for this study, accuracy of information was checked with the participants through member checking. Similarly, persistent observation is utilized to ensure depth of experience through prolonged engagement (Lincoln & Guba, 1985).

**Transferability.** In qualitative research, transferability is achieved by collecting a vast array of information from the data collection to make the data transferable (Lincoln & Guba, 1985). In this study, seven profiles and narratives helped to achieve the thick descriptions, to assist readers in determining whether the findings are transferable to other contexts (Lincoln & Guba, 1985).

**Dependability.** In qualitative research, dependability refers to evidence that the study has been conducted in a dependable way that can be audited and that produces

findings that are consistent and potentially repeatable (Lincoln & Guba, 1985).

Throughout the study, I maintained an audit trail of documented decision-making. This audit trail, demonstrated through field notes and an external audit, contributed to the study's repeatability (Lincoln & Guba, 1985).

**Confirmability.** Confirmability refers to whether the findings of the study were subjected to researcher bias (Lincoln & Guba, 1985). To avoid researcher bias, throughout the course of this research I engaged in the practice of reflexivity, the “continuous process of self-reflection” to generate awareness about my actions on the research process (Darawsheh, 2014, p.561). I engaged regularly in keeping a reflexive journal and stayed in frequent communication with my thesis committee and supervisor to ensure that what was becoming apparent through the narratives and themes were attributable to the participant experience. I bracketed my own personal biases to prevent preconceptions from influencing the data collection and analysis processes (Gill, 2014).

### **Summary**

While qualitative research can be considered as interpretive, it is important that the researcher remain self-reflective in determining the role that the researcher plays in the collection, analysis, and dissemination of information (Creswell, 2011). Therefore, throughout the data analysis portion of this research, the primary researcher completed personal journaling to maintain awareness and bracketing (Gill, 2014) of personal biases or personal preconceived notions regarding the research. To ensure methodological rigour, and to increase trustworthiness and credibility of the qualitative design (Graneheim & Lundaman, 2004), I was in regular consultation with the thesis committee members to continue gaining knowledge and experience throughout the data analysis

process. Through ongoing dialogue with the thesis committee members, I worked towards a consensus on themes, increasing the trustworthiness and credibility of the findings (Graneheim & Lundaman, 2004). Lastly, communication with the thesis committee was integral in remaining as impartial as possible, given the subjective nature of a qualitative study.



## Chapter 4: Thematic Results

### Introduction

This chapter presents the results of the thematic analysis of the participant's narratives including a chronological account of the individual's diagnosed eating disorder or disordered eating behaviours, attitudes, and experiences. The participants of this study included seven females from cities in four Canadian provinces and one Canadian territory. The age range of the participants was from 24 to 41 years of age. See Table 1 for a summary of participant demographics. The interviews were transcribed by the primary researcher which facilitated coming to know and understand these data (Braun & Clarke, 2006). Each participant self-selected a pseudonym. The pseudonyms the participants chose were Nicole, Becky, Kate, Harriet, Luna, Jennifer, and Maria (see Table 1).

**Table 1**

*Participants' Demographic Profiles*

<u>Name</u>	<u>Current Age</u>	<u>Age of Onset</u>	<u>Highest level of Education</u>	<u>Religious Affiliation</u>	<u>Ethnicity</u>	<u>Marital Status</u>	<u>Gender</u>
Nicole	30	12	Undergraduate	None	Caucasian	Single	Female
Becky	24	14	College	Jehovah's Witness	Caucasian	Married	Female
Kate	25	9	Graduate	None	Caucasian	Single	Female
Harriet	24	21	Graduate	None	Caucasian	Single	Female
Luna	41	10-11	Graduate	None	Caucasian	Divorced	Female
Jennifer	26	8	Graduate	None	Caucasian	Single	Female
Maria	23	22	Undergraduate	None	Métis	Single	Female

Table 1

## Participant Profiles

**Nicole.** Nicole is a 30-year-old single female who first began experiencing symptoms of disordered eating at age 12. Nicole described not being conscious of what her behaviours were, or what they meant, at that time. Nicole described her behaviour as ‘shame-driven’, indicating that she would save money and buy food in secret, making sure that she would consume it without people knowing. Nicole stated that as a young adult in university, this behaviour shifted into overeating and eating feelings. To overcome overeating, Nicole stated that she developed a “healthier lifestyle”—which became highly addictive, and ultimately transformed into anorexia nervosa, which she would formally be diagnosed with at age 25. Nicole stated that when it became full-blown anorexia is when she ended up having enough symptoms that negatively impacted her life, and she then sought out intensive eating disorder day treatment.

Nicole noted that leading up to her formal diagnosis, and even after she began seeking treatment, her disordered eating behaviours intensified in waves. She described the difficulties with her daily functioning in the height of her anorexia—feeling weak, tired, irritable, and experiencing suffering within her relationships with her family and friends. Nicole described an inability to perform cognitively, particularly at her place of employment, and ultimately needed to take a leave of absence from her job to seek more intensive treatment—all because of not eating even enough to sustain day-to-day living. Treatment, Nicole described, required her to look at more intense issues including her relationship with her mother. Nicole relayed that she began to mirror the relationship her own mother had with food and body image, introjecting and internalizing those same feelings and thoughts as her mother. Nicole confronted those issues on a deeper level

through intensive treatment—although her experience through an eating disorder did not end with intensive recovery. Instead, after a period of recovery, anorexia nervosa morphed into bulimia nervosa—and that is when Nicole first met Nova.

Nova is Nicole's three-year-old cat, who Nicole adopted two years ago after Nova had been living on the streets. Nicole was previously living independently, and had moved into a new apartment when she felt that having a companion would be helpful to her life, her recovery, and to help fight feelings of isolation. Nicole noticed that Nova helped with many facets of Nicole's life, including a profound reduction in symptoms of bulimia nervosa. Nicole described moments of feeling guilty for being symptomatic around Nova—feeling guilty, repulsive, and low—and apologizing to Nova for subjecting her to the heinous nature of the disorder. Nova would often follow Nicole to the bathroom if Nicole was going to engage in purging behaviours, and consequently propelled Nicole towards further recovery.

Nicole described her living space prior to Nova as being 'unsafe'—and felt that her home was the most unsafe, and emotionally darkest, space in her life at that time. Nicole recognizes that her relationship with Nova—the companionship, accountability, validation, and mutual joy, trust, and love they have for each other—played a major role in her recovery. Seemingly, the same could be said for Nova as well, who also came to trust Nicole, and seemed to have developed her own sense of safety and comfort in her mutual relationship with Nicole.

**Becky.** Becky is a 24-year old married female who first began experiencing symptoms of disordered eating at the age of 14. Becky described growing up in a volatile home while struggling with borderline personality disorder. Becky indicated that her

mother also had undiagnosed borderline personality disorder, and had difficulties with her own body weight—something that Becky would introject from a young age. As a young adolescent and teenager, Becky found solace from the volatile environment by connecting with the family golden retriever. Becky recounted that the death of the family pet propelled her eating disorder in significant ways. Becky noticed that she began dieting excessively, and found external validation for her weight loss efforts. Becky became a vegetarian, but found herself creating rules around many things—including diet and exercise.

When Becky moved out of her family home and started living alone, she found rock bottom with her eating disorder and depression. Becky exercised and pushed herself physically to the point of vomiting and, at times, fainting. Becky used salt water flushes for months at a time, and severely restricted her food intake. At one point in the height of her anorexia nervosa symptoms, Becky found herself consuming just two types of food for weeks at a time. Additionally, Becky began abusing laxatives, meticulously counted calories, and obsessively weighed and measured her food. Furthermore, Becky became aware that the issues she thought she had left in her nuclear family home had followed her into her new home—and she knew that she had to deal with these underlying issues to achieve recovery. Becky, who has long felt connected to animals, contacted the local rabbit rescue, and began to rescue rabbits.

Becky described her relationship with the rabbits as fun—noting that the rabbits brought tremendous amounts of joy into her life. Becky noted that she previously did not enjoy being overly emotional, but noted that the rabbits brought out a different side of her, particularly as she began to provide them with the best possible life that they could

have. When Becky first met some of the rabbits, she noticed that some were sick, some needed medication, and some “just needed love.” Becky described one rabbit, who came to Becky emaciated and matted. Becky characterized this rabbit as one who needed a buddy, and who followed Becky everywhere—even into the washroom. Becky expressed wanting to be there for this rabbit too, wanting to give her the best chance that she could.

Becky illuminated some of the differences she noticed in her own attitudes and the attitudes of the rabbits she loved to care for. Becky referred to how her rabbits would not overthink things as humans sometimes do—noting that they are just happy and grateful for the little things in life—something that Becky noticed she had forgotten to do along her journey. Becky was reminded that her struggles with depression and her eating disorder did not define her, and her rabbits provided that message for her for many years; a daily reminder of joy and perspective.

**Kate.** Kate is a 25-year-old single female who first began experiencing symptoms of disordered eating at nine years of age. Kate’s journey with an eating disorder began at a young age, and the symptoms were heavily influenced by her mother. Kate recalled keeping journals of weight and exercise routines, and planned ‘sugar-free weeks’ and exercise plans with her mother. Kate described her disordered eating experiences morphing into struggles with body image by the 11<sup>th</sup> grade, at which time she began severely restricting her food intake, and noted that her participation in figure skating also played a role in the development of her struggles with body image. Throwing out her lunches after getting to school became a common routine, combined with calorie counting, and eating low calorie packets when feeling hungry.

Kate described being diagnosed with depression, at which time her disordered eating symptoms began to include episodes of binge eating as well, particularly toward the end of her undergraduate degree. Toward the end of Kate's undergraduate degree, she experienced worsened binge eating, but also had emetophobia, which led Kate to use severe food restriction as a compensatory measure. Emetophobia is the specific fear of vomiting, and can result in individuals avoiding people or food which may be associated with an increased risk of nausea or vomiting (Boschen, Veale, Ellison, & Reddell, 2013). Kate recalled times during which she would binge eat at night, and then would restrict the next day for the entirety of the day, at times resulting in dizziness, light-headedness and fainting. Once Kate began her master's degree, she developed full-blown bulimia nervosa.

In 2015, Kate began to see a psychologist who formally diagnosed her with bulimia nervosa. Since working with a psychologist, Kate noticed a reduction in her symptoms of binge eating and purging through restriction. At the beginning of Kate's master's degree, she moved out on her own and met Ava, a cat that she would adopt. Having studied psychology in university, Kate disclosed that she was aware of pet therapy and how it could be useful in mental health recovery. Kate described always being aware of her symptoms of depression and the impact those symptoms had on her life, but was in denial about having an eating disorder for quite some time. Her awareness of her eating disorder and its impacts heightened as she experienced losing her intimate relationship with her partner at that time.

Throughout the interview, Kate described the balance in her mutual relationship with Ava. Kate illuminated feeling that Ava, in some ways, saved Kate from the

devastation of her eating disorder and mental health struggles, while Kate saved Ava by adopting her and bringing her into a warm, loving home. Ava has helped Kate become more mindful in her eating habits by Ava's own sense of intuitive eating. This mirroring helped Kate become more intuitive into her own hunger and nutritional needs as well. Furthermore, Ava brought Kate into present moment awareness during periods of binge eating. Kate identified pizza as a binge food and described times during which Ava would sit on the pizza box, ultimately stopped Kate from continuing to binge eat. Kate described this to be a form of emotional support in her recovery, by providing Kate with love, affection, and attention.

Kate expressed how Ava's company resulted in experiencing decreased feelings of loneliness and isolation, and that coming home to her has made her feel like she has someone important in her life. Kate identified having something else to care for, thus making her take more care of herself. When Kate cries, Ava comforts her on days of restriction when Kate has no energy to leave the house. At those times, Ava keeps her company. Kate described still struggling from time to time and has had re-occurrences in her eating disorder, but stated how the frequency of these symptoms continues to diminish.

**Harriet.** Harriet is a 24-year-old single female who first began experiencing symptoms of disordered eating at 21 years of age. Harriet was diagnosed with anorexia nervosa in 2015 after several changes occurred in her life, including moving to a new province, moving away from her family, and starting a master's degree. Harriet began to work at a job that she did not like, and which ultimately began to affect her mental health. Harriet recalled feeling the symptoms of depression sink in after experiencing bullying in

the workplace by a co-worker who would comment on Harriet's food and body, and who started a competition on weight, exercise, and dietary intake. Harriet had become involved in the local running club and initially began to train for half-marathons, only to develop an obsessive relationship with exercise, running, and using this as a means of purging.

Harriet noticed that obsessions were overtaking her life—obsessions about running, meal planning, what exercise she was going to do every day, and baking. Harriet described baking hundreds of cookies at time for her roommate, but never eating any for herself. At the same time, Harriet's depression worsened. With the help of her roommate, Harriet noticed that her behaviours were not healthy. She stopped talking to friends, she lost closeness with people that she cared about, and she had to take time off school and work as well. Finally, Harriet went to the hospital for help with symptoms of depression. There, she was formally diagnosed with anorexia nervosa.

After gaining support for depression in the hospital, Harriet received referrals to an eating disorder treatment program. However, during the wait to be admitted, Harriet's eating disorder morphed into bulimia nervosa when Harriet's compensatory measures changed from compulsive running to vomiting, which was further accompanied by binge eating behaviours. Through the course of treatment, Harriet learned that her eating disorder pattern is one of restriction over periods of months or years, which then changed to binge eating and purging through vomiting or exercise.

One week after Harriet completed the eating disorder treatment program she met Bruce, a cat she would come to adopt. Bruce allowed Harriet to pet his belly and began purring at her from the moment that they met. Harriet described Bruce's initial health



problems to include being medically obese and requiring a prescription diet. Harriet described the irony, given that at that stage in her recovery, diets for herself were non-negotiable.

Bruce provides support and healing to Harriet in a multitude of ways. Specifically, Harriet felt Bruce helped hold her accountable in her eating disorder recovery. Harriet noted that during the height of her disordered eating behaviours, her roommate and Harriet had to part ways as her symptoms had begun to detrimentally affect their relationship. Now that Harriet lives alone, there is no one there to hold her accountable, except Bruce. During an episode of binge eating, Harriet noticed that after setting out all her food on the table, Bruce would paw at the food—which would be enough to break Harriet out of her ritualistic patterns, and bring her back to the present moment, and away from her binge. During a purge, Bruce had been known to meow at Harriet at the bathroom door, reminding Harriet that he is there for her. This helped Harriet to remember the loneliness of an eating disorder, and reminded her that engaging in these disordered eating experiences was not worth what she would otherwise be sacrificing.

Harriet completed an eating disorders treatment program less than six months prior to the study, and has been learning to live a new normal without an eating disorder, and with the help of her pet companion. She learned she can have a fresh start every day, and she has been able to learn a new routine that involves caring for her companion. Spaces in Harriet's apartment can still remind her of symptoms from time to time, but Harriet now feels that there is safety in her own space because of Bruce's presence.

**Luna.** Luna is 41-year-old divorced female who first began experiencing symptoms of disordered eating at approximately 10 or 11 years of age. Luna indicated the she had never been formally diagnosed with an eating disorder, but identified early patterns of disordered eating dating back to childhood. Luna expressed learning from her mother that emotions were “scary” and that people could self-soothe from their emotions by using food. When Luna was in her twenties, she stopped comfort eating and began to binge eat and purge through the compensatory measure of vomiting. Luna described a period of secrecy, during which she completely hid her behaviours from others, and how she developed cyclical behaviours. Luna described her experiences as a combination of self-reward and self-soothe—from experiencing something stressful or emotional, or working hard to deserve a reward, and then binge eating and vomiting. Often, she would vomit at the side of the road so that nobody would become aware of her experiences.

When Luna got married these behaviours continued, unbeknownst to her husband. At that time, Luna’s husband had pets but she did not feel that they were truly hers and did not feel a connection with them. Then, Luna adopted her dog Chicklet. As time went on, Luna described that it had become increasingly difficult to continue the roadside purging behaviours due to work schedules, and continuing to try and hide these behaviours from her husband. Chicklet would often accompany Luna into the bathroom during a purging experience, watching what Luna was doing. Luna described this as being both comforting and shame-inducing; something that Luna had not experienced previously.

In addition to binge eating and purging behaviours, Luna became aware of the other ways in which her disordered eating symptoms began to negatively affect her life,

including in financial ways. Not only did binge eating cost extra money, but Luna found herself sneaking money out of the joint bank account that she shared with her husband to hide her behaviours. Luna described this experience as creating a more dishonest side of herself which led to feeling that she was leading a subversive alternate life other than the one that she was showing on the outside.

Luna's connection with Chicklet made it difficult for her to continue purging. Luna viewed the experience as a shift, noticing that it became increasingly difficult to engage in this behaviour in front of a being that Luna loved—at times, Luna would close the bathroom door so Chicklet could not enter, but when the door was re-opened Chicklet reflected Luna's own shame back to her—something that Luna did not have to previously face. Luna stated that instead of vomiting, she then began crying instead, turning to Chicklet for comfort, and Chicklet reciprocated by staying extra close to her, or would snuggle her when sensing that Luna was upset about something.

Luna described having a difficult childhood and felt that she needed to protect herself from people to keep herself safe. Luna resorted to these self-defeating behaviours therefore, and although still engages in eating as a means to self-soothe, had significantly reduced her purging behaviours, now occurring only a few times every six months to a year. Luna credits Chicklet with the changes in her disordered eating experiences and stated that Chicklet was the first being that she “let into her heart” after her childhood. Luna disclosed that she allowed Chicklet to see her own inner ‘brokenness’, which ultimately helped Luna in being more vulnerable with people. It was with Chicklet that Luna learned to “take down the walls that [I] had built” around herself to keep her safe—

and that without Chicklet, Luna is not sure if she would have ever been able to learn how to let others into her life so deeply.

**Jennifer.** Jennifer is a 26-year-old single female who first began experiencing symptoms of disordered eating at eight years of age. Jennifer recalls growing up in a home where the family diet largely involved processed food, and where Jennifer always wanted to have the biggest piece of cake, or the largest amount of food. Jennifer grew up in the shadow of an older sister who involved herself in fitness competitions at the age of 16, and who was very critical of her own body shape, and subsequently was very critical of Jennifer's body weight and eating habits.

When Jennifer was approximately 13 years old, her older sister was preparing to be married. It was this experience during which Jennifer actively attempted to lose weight for the first time. Jennifer recalled losing a significant amount of weight in a very short period of time. Although she was never diagnosed with an eating disorder, she experienced amenorrhea and her hair started to fall out because of severe dietary restriction and subsequent weight loss.

When Jennifer was in high school her family and parents drew attention to her weight loss, and two major factors propelled her into starting to gain weight. First, her parents discouraged further weight loss with the threat of her grades potentially dropping. Second, Jennifer was supposed to have a surgery—however, the surgeon refused to perform the procedure unless Jennifer agreed to put on weight. Jennifer did gain weight, and has consistently maintained the same weight since then, but is aware that within the last year or so these disordered eating experiences have returned. Jennifer developed an even greater awareness into the negative impact that her disordered eating behaviours had

caused, including detrimental digestive issues from purging behaviours, decreased energy levels, and difficulty forming relationships and connecting with others.

When asked about being formally diagnosed, Jennifer described purposefully avoiding physicians to prevent being labelled with a diagnosis. Jennifer described being “strategic” about visits to doctors—specifically never visiting the same doctor more than once, or for the same reasons. Moreover, Jennifer was clear that for her, a diagnosis would not help her change her patterns of behaviour. Additionally, Jennifer found that diagnosis or not, her cat Gracie made a lasting impact in her personal recovery through her disordered eating behaviours and experiences.

Jennifer described experiencing a series of deaths in a short amount of time during her undergraduate degree, including the death of her 19-year-old cat. Jennifer described this experience as the first time she “ever felt true heartbreak”. Shortly thereafter, in 2012, a friend’s mother had some workers at her house who came across a stray cat who had recently given birth to kittens. The stray cat was bleeding heavily in a shed, and Jennifer decided to take her home, describing this cat, who she named Gracie, as the “best thing to ever happen” to her. When describing some of her favourite things about Gracie, Jennifer stated that Gracie was there for her in some of her most vulnerable moments, and never carried the weight of judgment. Gracie reminded Jennifer that it was okay to pause for reflection, to have joy, and to live and do better, every day.

**Maria.** Maria is a 23-year-old single female who first began experiencing symptoms of disordered eating at 22 years old. For one year, Maria was working with a personal trainer to focus on health and found herself becoming very strict with her dietary intake. Maria noticed that the restrictions and rules around her nutrition began to

negatively impact her life when she felt like she could no longer leave her house—due to the consequences of her disordered eating behaviours.

Maria described going to the gym for four hours every day during five days of the week after joining a specific workout program at her gym. Maria noted that she would weigh out all her food with a portable scale that she carried with her at all times—and that if the food weighed even 0.2 grams more than it was “supposed to”, she would “break down crying on the floor in shambles”. Maria described reaching a point during which time she intuitively knew how much a food item would weigh even without using her scale, simply because she had weighed her food for so long. Maria found herself drinking between five and six litres of water per day, would weigh herself more than 50 times per day, and would body check to the same extent as well. Furthermore, Maria described feeling as though she would have a breakdown if she were to consume anything outside of her five planned meals per day, finding herself crying on the floor.

Maria noted that her disordered eating symptoms became increasingly severe when the friends she had attended university with graduated and moved back to their hometowns, leaving her feeling isolated and alone in a city that she previously had felt so connected to. Maria noted that without any connection through friendship, she felt completely isolated and struggled emotionally and physically. She decided to go see a counsellor for support and started to work on the disordered eating symptoms which had started to affect multiple facets of her life.

Although receiving counselling, Maria’s disordered eating experiences continued to escalate. She found herself isolating even further, choosing to work from home so that she would not be required to be in the office. Maria also stopped picking up shifts from

work, feeling that there was too much pressure in the workplace to consume snacks that were often shared between co-workers. Maria described actively avoiding the pursuit of any intimate relationships as she felt that she was too fat to be worthy of such a connection. Maria then found herself turning to Tucker, her dog, for support. Maria first met Tucker three years prior to developing disordered eating behaviours, but noticed that in the height of her symptoms, Tucker was the only being to whom she allowed herself to connect.

Maria's counsellor referred her to a medical doctor who then diagnosed her with binge-eating disorder. As Maria began to heal and overcome her disorder, she leaned on Tucker for every day support, and found that Tucker began to give her a new outlook on the meaning of her life. Maria began to spend less time at the gym, and more time connecting with Tucker, and described how her compulsive need to exercise or binge turned into a kinder relationship with herself, by walking with Tucker as exercise instead of isolating herself in a gym for several hours per day.

Maria noticed that spending at least one hour per day with Tucker allowed for their bond to grow—and noted that Tucker had become her best friend. Maria felt that Tucker mirrored unconditional love to her, and non-judgment during the height of her disordered eating symptoms. She credited Tucker with helping her to reach out to other people and develop more social connections as well. Furthermore, Maria's relationship with Tucker enabled her to feel safe enough to reach out for more human supports and taught her how to emotionally regulate in uncomfortable situations.

While Maria felt that she was still on the road to her personal recovery, she illuminated that working with her best friend helped her in significant ways. Tucker

helped her develop the confidence to assertively walk away from people who make her feel uncomfortable, and instead of isolating and crying alone Maria reported feeling that she can now cry into Tucker who stays by her side. Maria experienced reciprocity in her relationship with Tucker as well; Tucker did not trust men easily and Maria described initially trying to change that about Tucker. Now, she accepts Tucker the way he is and experienced mirroring from Tucker as well; he accepts and loves Maria unconditionally in return.

All seven participants experienced disordered eating symptoms, with only two participants never having received a formal diagnosis. All the participants, except for Maria, either adopted or rescued their pets that helped them through their recovery process. Furthermore, although all seven participants received some form of formal psychological treatment to aid them in their recovery journey, every participant found that it was the connection to their pet who helped them to heal in the absence of more formal supports, as their pet companion provided them with comfort, relationship, and connection every day.

### **Thematic Analysis**

The following themes were developed chronologically to demonstrate the natural progression of disordered eating symptomology and subsequent recovery which was apparent in each descriptive narrative from the participant. Each theme was checked with the participants to understand the landscape of their experience, and the meaning that had been derived in their healing alongside their pet companions. The themes are as follows:

- 1) The Impetus: When Disordered Eating Experiences First Began,
- 2) The Catalyst: Isolation Intensifies Disordered Eating Symptoms,
- 3) Experiencing Shame: Embracing



Vulnerability and Connection with a Pet Companion, 4) In the Midst of Self-Destruction: Mutual Connection Occurs, 5) Mirroring and Acceptance of Neediness, Vulnerability, and Imperfections, 6) Pet Companionship Promotes Mindfulness: Interrupting the Trance, 7) Interconnected Salvation: Saved by the Rescued.

**The impetus: When disordered eating experiences first began.** The first stage in the journey for the participant was the backdrop to how the journey first began. The participants did not identify the same cause for their disordered eating behaviours and experiences, however, what was clear is that each participant did identify that there was a major contributing factor; for some, it was interpersonal familial relationships. For others, it was losing closeness with their support systems, or losing the security of familiarity.

Five participants outlined that it was their familial upbringing which initially led them to have a difficult relationship with body image or food. For instance, Nicole disclosed that it was the relationship with her mother which she needed to work on to continue her recovery. She explained:

Treatment helped me recognize what a lot of my eating disorder was stemming from, like a lot of root causes. My relationship with my Mom...I'd say primarily my relationship with my Mom and the relationship my Mom has had with food and her body image...and how that sort of was absorbed by me growing up. [I] internalized a lot of that.

It was this experience of being aware of her own mother and her mother's relationship with body image and food which led Nicole down her own journey through an eating disorder. Nicole explained how this early relationship with her mother also expanded into her relationships with others:

[I] tried for so many years as I was growing up to change who my Mom was, or wished that she was somebody who would show me affection and love me because she was very, very cold growing up. As a result, my pattern in relationships with people who have...not always treated me very well... and

people who have been really distant but only reaching out to me when they need something. So, I felt very used in relationships but I've tried to change those people so that they could be affectionate and show me love...and it just doesn't work that way. You can't always change people.

Nicole identified the root causes of her disorder, and identified that in the absence of working on these root issues, her eating disorder recovery would be stalled. The impetus for the development of her own eating disorder may have originated in childhood with the cold relationship with her mother. Nicole reflected upon these experiences and how they related externally to her connections with others—noticing a pattern that developed unconsciously as she was growing up, and how she had to change this pattern to continue working toward her recovery.

Kate illuminated her own childhood experience during which time her mother would organize a weight loss journal and exercise regime for her, although she was only approximately 9 years old at the time. She explained:

I guess the start of my eating disorder...I was nine. So, it was about...it was more like disordered eating back then. I had a journal of my weight loss and exercise routine. I would do sugar-free weeks, and I think at that point it was very much ruled by my Mom. She would sit down with me and plan those sugar-free weeks and those exercises, so I guess that's when the disordered eating behaviours started.

Kate identified that it was those early days with her mother which initially led her to have a disordered relationship with food and body image. As Kate got older, her disordered eating experiences intensified, noting that:

In high school is when I developed more of the body image side so, just very conscious about the way I looked. I was a figure skater too, so that definitely played into it. I would say at around grade 11 is when I started really restricting...counting my calories in the morning, and when I was hungry I would like having those low-calorie packets, and throw out my lunches when I got to school.

Kate's narrative clearly distinguishes that although the initial impetus may have been working with her mother to develop sugar-free weeks and specific exercise regimes, her view of her sense of self continued to develop throughout high school, and particularly with being an athlete as well.

Similarly, while Harriet did not identify any impetus in her childhood, it was an intense experience of workplace bullying as a young adult which acted as the stimulant for the development of her eating disorder. Harriet recalled that:

I had started working at a job that I really, really, didn't like. I was...stuck in a contract and wasn't able to get out of it. I got really...depressed in the job, and...things kind of spiralled. By the fall, I was able to get a new job, and at that job there was a co-worker. She commented a lot on my weight and what I was eating, what I was wearing, what my hair looked like...everything. But a lot of comments on my food, and it almost started a competition between her and [I]. It was never verbalized, but I was like...I [wanted] to prove to her that I can eat the healthiest and run the most and lose weight. I just felt like...that the only thing I could really focus on well, the only thing I did focus my energy on, was running, my diet, and losing weight.

Harriet identified that it was the combination of her depression and her experience of workplace bullying that acted as the stimulant for the development of her disorder, which only began as a young adult in her twenties.

It is evident that the impetus for each of the participants differs, in that some identified familial upbringing or family dysfunction as an impetus, for others it was an intense experience of workplace bullying, and for one participant it was living away from home, attending university, and becoming isolated when her friends graduated and moved away from her—resulting in isolation and loneliness. Each participant had a unique experience which led to the development of their disordered eating experiences. Each participant had a unique impetus which led them on a journey which would affect their

mental health, relationships, sense of self, for vulnerability and connection, and desire to make change in their own lives.

**The catalyst: isolation intensifies disordered eating symptoms.** Drawing on the experience of The Impetus, The Catalyst is the component of the disordered eating journey during which time the initial disordered eating experience has intensified. For each participant, there was a catalyst which lead to the intensification of symptoms: for six of the seven participants, this is the time during which their periods of severe food restriction became binge eating and purging through various compensatory measures. For every participant, isolation became a key component in worsening their disordered eating experiences.

In the narratives for the participants, it is evident that periods of isolation led to the aggravation of disordered eating experiences, including binge eating. Moreover, for six of the participants, their experiences of intense restrictive eating patterns furthered the change into symptoms of binge eating and purging through various compensatory measures. Nicole explained her own experiences of isolation:

I lived alone through most of my diagnosed eating disorder. I had a lot of symptoms growing up that, looking back, have been disordered, but having been diagnosed and having a more severe eating disorder, I find having been completely alone without any sort of accountability...like things were completely out of control. I didn't care. I felt completely alone. I felt if I was destined to be sick and unwell then there was no point in trying. I didn't like myself...especially because when I'm alone, I'm alone with my disordered thinking, and I'm alone with depression and anxiety...alone with symptoms. I can just do whatever I want, and the self-hatred is so much louder when I'm just sitting here by myself.

Nicole described that her eating disorder changed over time, in conjunction with isolation, from anorexia nervosa to bulimia nervosa:

I...went back to over eating and it turned into full bulimia which was...a totally difference experience than anorexia. But it kind of naturally progressed into that because I had restricted so much that I had allowed myself to eat everything.

Like Nicole, Harriet also found that isolation lead to an increase in symptoms and disordered eating experiences, noting that her experience of anorexia nervosa also subsequently morphed into symptoms of binge eating and purging, leading to a new diagnosis of bulimia nervosa.

Initially when I was diagnosed, I was diagnosed with anorexia. Then...I was brought into the hospital for depression and simultaneously was diagnosed there. Initially it started out as compensatory exercising, specifically, running. Initially, it started as training for half marathons and I thought it was kind of...a positive thing. I had moved to Ottawa, it was something I really got into. I got into the running community then it became an obsession. And then that kind of morphed into actual purging by vomiting. And then it went to more bingeing and purging.

Harriet had recently moved provinces, away from her family and friends, and to a new city where she did not know anybody. Harriet felt isolated, and although she had found a roommate and was leaning on her roommate for support, she eventually found that her relationships around her became strained as her symptoms worsened. Harriet illuminated her experience:

When [the symptoms] became my life and exercise became everything to me...I stopped talking to my friends. Stopped doing things. My roommate at the time also started call me out on things I was doing. I became obsessed with baking and I couldn't stop. I would make cookies obsessively, and I wanted to give them to people, but I couldn't eat them myself. I wouldn't eat them myself. My roommate eventually just...it was too much for her. We had to part ways and I had to move out because I was drawing on her a lot for support because my family... was not [living in the same city as I was]. I lost a lot of friends [and] the closeness with my family members.

Harriet's disclosure illuminates how her experience of moving away from home and moving between provinces, resulting in isolation, intensified her symptoms. Symptoms of obsessively baking cookies became representative of how her experiences

began to spiral out of control—resulting in further loss of connection and relationship with her roommate. The worsening of her symptoms resulted in Harriet taking seven months off from work and school as further consequences to her disordered eating experiences. We can see that in these experiences, Harriet felt the devastating impacts that isolation had on her socio-emotional functioning.

The participants, in their own ways, were experiencing pain which they experienced as a part of who they were, and turned to symptoms of disordered eating to self-soothe. It was these symptoms which began to negatively affect the lives of the participants, as they reached for something outside of themselves for relief.

**Experiencing shame: Embracing vulnerability and connection with a pet companion.** The participants described feeling shame in connection to their disordered eating behaviours and experiences. The participants who engaged in purging behaviours, specifically, noted shame as the emotion that they felt during those times. The participants described their pet following them during the purging episodes, and frequently described an overwhelming sadness that would occur when facing their pet after purging. The participants also described a sense of sorrow when apologizing to their pet, with whom they had their greatest connection. Therefore, these experiences served as a major catalyst in the reduction of purging symptoms.

Luna described her own experience of shame and vulnerability in her experience with Chicklet:

I would try to coordinate my behaviours for when my husband wasn't home so that he wouldn't hear me throwing up. And Chicklet would always have to be in the bathroom with me, and just sitting beside me, but watching me. It was comforting, but it also created shame that I didn't have before that. Like she saw what I was doing and understood what I was doing. I don't know if she did, but

that was the sense. Like I was being watched by someone who loved me, and didn't like what I was doing. So, it actually started getting harder for me to do it.

Luna's experience of shame in the presence of her relationship with Chicklet allowed her the freedom to decrease the symptoms because she allowed herself to be vulnerable with her pet. She could connect with Chicklet on a deeper level and to allow Chicklet to see Luna for who she really was. Luna further illuminated her connection with Chicklet:

I've had very strong walls around myself since I was a child; I had a rough childhood. I protected myself from other people a lot and I didn't really let people in. But there was something about the way that Chicklet interacted with me in those moments that did teach me to let my walls down for her. I think she was probably the first...being...that I really let into my heart after my childhood. I think because I let her see my brokenness, it also helped me to be more vulnerable with people. Yeah, [took] those walls down a little bit because it was safe to do it with her so I think that's where I started to learn how to do that. If I had not been doing those things around her, I don't know that I would have had those experiences. And it's an understatement, but...from then to now I've changed drastically in terms of those walls coming down. I'm able to connect with people so...she may have saved me in that regard.

Luna's experience with shame and vulnerability with disordered eating experiences and her connection with Chicklet opened her to be able to connect with others, as Chicklet provided nurturing and elements of healing to her, and by helping Luna become aware of her disordered eating behaviours.

When Luna connected with Chicklet on a deep level, rather than on a surface level, true connection and growth began. Luna began to begin to heal and break down some of the walls that she had built up around herself, and only then was she able to grow.

Jennifer had a similar experience of feeling shame in her purging behaviours and the way it impacted her when faced with her pet companion. Jennifer explained:

I know Gracie isn't picking up on my purging behaviours. That's not something that she's going to do. But it's humiliating...you don't want to see...I don't want to see something that I love do something that's so shameful. And even though I don't think animals have the same capacity, I think they still understand when people are in distress. I don't feel judgment eating in front of her. She's seen me in my most vulnerable moments...including purging. And yeah, she's been there for those moments as well.

For Jennifer, her purging behaviour itself left her feeling vulnerable. Jennifer would feel shame purging in front of Gracie, the companion with whom she felt the greatest connection in her life, and it helped Jennifer to see that she would not want someone that she loved to engage in similar self-destructive behaviours.

Becky felt that her connection with her rabbits and the impact of her rabbits in her recovery also helped to open her up to vulnerability, particularly after a period of isolation. Becky explained:

I was living alone, and I was realizing that I was having to deal with some trauma. The eating disorder got really bad; I was hyper-exercising, I wasn't eating, I was using laxatives all the time...it was awful. And my depression was really bad at that time...at the end of the day when you feel like crap and you don't really care about yourself and you could just walk away from everything and you say, 'I just need this to be over now...I can't handle this anymore'—...there's something kind of great about having an animal that loves you and relies on you. I became a lot more patient and loving with people. I also got to be more honest and very vulnerable with other people. I think in order to fully recovery properly, you need to be open-hearted and somewhat vulnerable. And you have to be willing to look at that...the ugly, crappy side of yourself and not freak out. And being able to do that helps you to be more honest in every aspect of your life, including your relationships with other people. So, I think it made me more patient and more forgiving and it helped me realize how I want to treat other people.

Becky identified that her connection with her rabbits helped her to embrace her relationship with herself, which allowed her to flourish in her relationships with others. The vulnerability that she felt in the presence of her rabbits connected her with her own vulnerability and the sides of herself that she disliked. Furthermore, in connecting with



the sides of herself that she did not like, she was able to experience a fullness in the honesty that she brought into her connections with others.

**In the midst of self-destruction: Mutual connection occurs.** The participants in the study described a sense that their disordered eating behaviours, attitudes, and experiences became—at some point—all consuming. The participants identified how lonely and isolating their experiences became when they were experiencing the intensity of the disordered experience, and felt a level of self-destruction with these behaviours.

Becky highlighted her own experience with self-destruction and selfishness, and how opening to the relationship between herself and her rabbits made her selfless, and enveloped her in compassion. At the height of her disordered eating behaviours, Becky felt that her disordered eating behaviours and experiences were all-consuming. She noticed that she was meticulous in counting, measuring, and weighing food in the hopes of burning off anything extra. Although she attempted purging through vomiting as a compensatory measure, she found that she was unable to activate her gag reflex. As such, she would exercise to extremes instead, which ultimately affected other areas of her life as well, including her relationships. Becky explained:

In the worse of it, it was a lot of exercising and punishing yourself and counting all the food and making sure your food is safe. All you can think about is food. You're obsessed. You can't leave the house without thinking about it. I would try and do stuff and my husband...I like being active, but it got to the point where I was so dizzy all the time. You can't just exist like a normal person. You can't feel joy...it's emotionally exhausting. So, when you have fluffy little things that love you and just need you and you know that no one else can take care of them...it means that you're going to make it through the next day. There's something nice about the caregiver routine that comes with taking care of something else, of taking care of something other than yourself. [The rabbits] have personalities, and there's something really good about being in touch with your feelings and knowing what it's like to have empathy for a little critter that's been badly treated. And knowing you are worth something—maybe not to other people, maybe not to

yourself—but to that fluffy little thing, it loves you. And it doesn't care about anything else.

Becky outlined an experience that demonstrates something different from selfishness. Becky described an experience of self-loathing and self-destruction which she turned into love for creatures with whom she felt a deep connection. She accepted the love that the rabbits provided her, which allowed her to have great empathy in return. Similarly, Nicole developed a selflessness with Nova; however, in Nicole's experience, she explained how Nova did not come to her as a trusting cat, and trust itself had to be established in their relationship from both Nova and Nicole, prior to developing a heartfelt connection. Nicole reflected to a time when the consequences of severe food restriction permeated into other areas of her life. Nicole stated that she felt physically weak, tired, and irritable. She explained that she started to develop awareness that her relationships with her family and friends began to suffer, and that she felt her ability to perform cognitively decreased. This decrease in cognitive performance then began to affect her ability to function in her employment. Nicole explained feeling completely alone:

That feeling of being completely by yourself... [and] having no purpose. When you have such low self-esteem [and] don't think highly of yourself...there's very little drive to do well in all areas of my life. I just [didn't] care about work or relationships or anything. It's pretty dire. So...having something that is around that you're just not alone...she's a thing that needs you, and gives you a sense of purpose. A real sense of purpose. She's dependent on me and I need to be there for her. Physically, because I need to provide her with food and water. And, emotionally, like she needs the affection from me and I need the affection from her. I kind of chose her as...she was this...not like the perfect cat. She didn't have a perfect demeanor, she was isolated in her own room because she wouldn't get along with other cats, and I was warned that she would bite me if I petted her like back. I can pick her up now! She doesn't really like being held, but she...she trusts me. [She] knows who I am. When you build a relationship with your animal it just becomes such an every day part...it was a necessary part of my day just to

make sure that I was interacting with her. As much as I was dependent on her relationship and her affection, she was dependent on me too.

Nicole felt the impact of her disordered eating experiences in her relationships and at her job. When Nicole made the decision to adopt a cat, she chose Nova: a cat whose story Nicole did not know, and a cat who was not trusting. Nicole found that she also struggled to trust, and they worked on that mutual relationship together. Nicole abandoned her behaviours which kept her isolated and to herself, and worked on spending time with Nova, an aspect which is now an every day part of their relationship together.

**Mirroring and acceptance of neediness, vulnerability, and imperfections.**

Often, the participants of this study described mirroring in their relationships with their pets. The participants elucidated a phenomenon where qualities that they disliked within themselves were mirrored back to them in their pets. The participants became aware that they learned to love these qualities within their pet companions, which subsequently slowed the participants down in their judgements and allowed them to love those same qualities within themselves.

Nicole noticed that this was her experience in terms of her relationship with Nova. Nicole recounted that some of the qualities that she noticed and hated in herself, Nova mirrored back to her—providing Nicole with space for acceptance and love for herself in return. She disclosed:

I find we have a very similar personality and I'm able to appreciate some of the things that I hate about myself, in her. Like she's very...she's very independent, likes doing her own thing, but needs affection—which I do too. And I like being alone...well, I think I like being alone...and I think I like to isolate myself. But I really do crave affection from people and she does too. And so, I've become...less judgmental of myself, I suppose, in appreciating some of the things with her.

Because Nicole noticed that Nova had similar qualities to herself, she shifted from a place of self-hate to one of self-acceptance. This was further made possible because of the connection and relationship that they share in building mutual affection, respect, and trust. Similarly, Maria noticed that in the beginning of her relationship with Tucker, she would try to change things about him that she did not like—much like she was trying to change aspects of herself that she also did not like.

I am [Tucker's] advocate. He doesn't like other dogs or men. So, I have gotten better at knowing when somebody is coming toward me with their dog. I don't yell, but I'm very assertive about making space between them and us. For a long time, I tried to change him, but now I just take care of him. I align with what he's comfortable with! Initially I tried to change him, and then I realized I can't change who he is...and ultimately, we both just accepted each other as we are.

Over time, Maria began to simply love and advocate for Tucker instead, and began to understand that while Tucker was already mirroring back to Maria love and unconditional acceptance, she slowly began to mirror these same qualities back to Tucker—further deepening their relationship and connection.

Likewise, Jennifer noted a similar experience with Gracie which made room in her own experience to accept some of her own qualities as well. Jennifer described how independent Gracie was and, in some ways, self-confident—not worrying about external judgements in the same ways that people often do. Jennifer explained the mirroring and reciprocity within her relationship with Gracie, including some of the lessons that Gracie had taught her in terms of engaging in her own level of self-care:

[Gracie is] just doing her own thing. And seeing how something is so confident doing her own thing...it's pretty amazing. So, she brings me so much joy, and I guess a desire to keep on living and do better every single day. I want the best for my cat so...that includes giving her food and water and provide her with love and all of the things that... why wouldn't I also apply the same level of care to

myself? It's pause for a lot of self-reflection. Just in terms of how you help another living organism to thrive so, why I can't do this for myself as well?

Not unlike Nicole and Jennifer, Becky also valued the mirroring that her pet companionship brought into her life, describing how the rabbits helped her to put into perspective of how she viewed her own self-described 'neediness'.

I've always had a hard time with feeling needy or like I was asking too much of others or I was too draining, and yet I was so happy to provide care for my rabbits and I never resented them for needing me. I think caring for a pet really does allow you to re-analyze or re-define how you view caretaking and support...when you have a healthy relationship with someone, those things are a privilege, not a burden.

In illuminating the deep relationship that an individual can have with their pet, each participant described feeling completely connected, without condition, to their pet, and learning about some of the qualities of independence, neediness, and vulnerability in those connections helped the participants to learn to love those same qualities within themselves, even during disordered eating experiences.

The participants in this study were, and in some ways still are, on the journey to discovering that they are already enough, even with their imperfections, their vulnerabilities, and their neediness. These qualities that they may not have loved, or even liked, within themselves were mirrored back to them as a gift from their pet companion, and the participants felt that sense of safety to allow that gift to sink in—providing just enough space to allow for healing and acceptance that the individual is already enough as they are.

**Pet companionship promotes mindfulness: Interrupting the trance.** The participants of this study experienced a form of numbness, dissociation, or tunnel vision when engaging in disordered eating symptoms. Specifically, episodes of binge eating

occurred concurrently with these trance-like states. The behaviours of their pet companions would often help the participants to break out of the experience of numbness, dissociation, or tunnel vision and return to the present moment.

Kate elucidated her disordered eating behaviours, specifically binge eating, as times when she would feel as though in a trance-like state. She noted how Ava helped to pull her out of these experiences and, ultimately, help decrease those symptoms altogether.

I got a cat so I wouldn't be alone, so I would still have support.... She's been very helpful in that...I guess she has taught me to be more mindful in the way that I'm eating. Whenever I feed her in the morning she goes back and forth between her bowl and so at the end of the day it makes me more mindful of my eating because I have a hard time eating intuitively. I shovel my food, so I see her doing that and it makes me more mindful of it. I found that she really helped me as well with the bulimic symptoms because when I would get into that binge phase or whatever, I find you get a lot of tunnel vision. Like you're so caught up in what's going on and everything around you doesn't exist and it's just you and the food. My typical binge food would be pizza, so I would always get pizza and being a cat, she loves being in boxes, so I'd be in the middle of my binge and she would come and sit in the pizza box and that would kind of stop me and help me focus on the environment. It would pull me out of the bingeing craze; she would knock me out of it, in a way.

Kate noticed that she would experience self-described 'tunnel vision' during episodic binge eating but that Ava, who gravitated toward a box, would be able to bring Kate's awareness back to the present moment with this small gesture. Kate's awareness of her relationship with her cat, and allowing her cat to be present with her during her symptoms of bulimia nervosa, helped to decrease Kate's experiences of binge eating.

In the same regard, Harriet noticed that Bruce also helped her to decrease her symptoms of binge eating and purging, noting that he would help to ground her in the present moment, when she would otherwise be caught up in the experience. Having

Bruce during episodes of binge eating and purging has also helped to connect with Harriet on an emotional level, and remind her of the devastation of the symptoms:

[Bruce] is a very relaxed cat. He's just like...sitting there with me when I eat my meals at my dining room table. It's a clear table, like a glass table, and he'll come and sit in a chair beside me...and he can see through the glass. One thing I really struggle with is eating alone, and there's no accountability in my apartment because I'm by myself, so if I want to skip a meal or something...he'll be there. He'll sit with me while I'm eating and also if I am...having a binge, I'll usually put all of my food on the table and he'll try and paw at it. I'm like, 'oh my god, stop touching it'. And sometimes that'll give me a second to think, like 'what am I doing right now?' because sometimes it's almost like autopilot. I'm in zombie-mode.

Similarly, Harriet noticed that her cat helped to remind her that she did not have to be alone, even when engaging in disordered eating symptoms. Harriet recalled when Bruce would engage in normal cat behaviour, and scratch at the door when she would be in the washroom purging:

Another thing is he doesn't like when doors are closed, he liked to be able to see what's going on. So, when I purge I don't like him to be in the bathroom...I know he doesn't really know what's going on, but I don't want him to see me like that. But he'll meow at the door and so I think it's kind of like somebody remind me that...'I just want to be with you'. So, it kind of reminds me of the loneliness of it. I don't even want my cat to be around me when I'm having symptoms. He reminds me that it's not really worth it. It just gives me a second to think: he's meowing or he's pawing at the door and like, what am I actually doing? Because I find it's like autopilot. Binge. Purge. Let's go. So he gives me space to think.

Ultimately, each participant had been able to connect with their pet companion in a way that was meaningful for them in their recovery, including facilitating the cessation of symptoms which otherwise would have continued in a dissociative or trance-like state. Allowing the pet companion to introduce symptom interruption was a tool that lends itself to further vulnerability, connection, and acceptance of oneself.

**Interconnected Salvation: Saved by the Rescued.** All the participants felt that they would be able to provide a good life for their pets, and although some of the

participants had hoped that their pet companion would be able to help them in a reciprocal relationship, none of the participants had expected that their pet companion would impact their lives in the way that they did: through mutual salvation.

Six out of seven of the participants met their pet companions through an adoption or rescue agency. Maria, the seventh participant, met her pet companion through someone who had been selling puppies out of a farm. Maria adopted Tucker as an 8-week old puppy from what was supposed to have been a reputable breeder. Maria soon discovered that Tucker was not from a reputable breeder, still had not received his first vaccinations, and his pedigree was unknown. Maria consciously chose to keep Tucker in her life despite their rough beginnings with each other. While Maria did not formally adopt or rescue Tucker, she ‘saved’ him in many ways, as his early beginnings did not set him up for a life of happiness and success. Similarly, Tucker ‘saved’ Maria by providing support, connection, and compassion which enabled her to continue her recovery journey.

Luna characterized her relationship with Chicklet as one of salvation. Chicklet became a part of Luna’s life when Luna adopted her, and found that this reciprocity also played a role into their connection and relationship. Without being adopted, it is possible that Chicklet would not have lived. Through Luna adopting Chicklet, she—in some ways— ‘saved’ Chicklet. Similarly, Chicklet ‘saved’ Luna as well. Luna described:

My pets all came from rescue organizations. And even though Chicklet didn’t make it there, that’s where she was headed. But I feel like it...it helped it to be more reciprocal...I may have saved them from something but, but they saved me in return. The best thing is that my animals can be there for me as much as I can be there for them. They may have been on death’s door when I rescued them, I don’t know. But there’s a very good chance that if they didn’t help me through this process, I would probably have died from the behaviours...definitely, my animals saved my life.



In the same way, Jennifer noted that if she had not rescued Gracie, it was likely that Gracie would also have died. Jennifer described the experience of meeting Gracie and integrating her into her home, and into her life:

[A friend] was renovating and there was this stray cat that had just given birth to a litter of kittens and one of the construction workers had found her just bleeding out in the shed. And she was like, ‘just come over and see the cat’. All of the kittens had homes and Gracie...was going to get put down. So, she’s 2, and she’s perfectly healthy so I took her in and it was like...she’s the best thing that’s ever happened to me. Honestly, I just look at her sometimes and think, ‘I love you so much’. Honestly, taking naps with cats is pretty great. Pet therapy is such a simple thing, but it’s had such a profound impact on [me]. The change is still ongoing; it’s still a daily struggle. But I would say that there is increased awareness and wanting more recovery, and hope for recovery.

Jennifer chose to take Gracie in after finding her bleeding out in a shed alone, and the reciprocity in their relationship has provided Jennifer with the space to want further recovery, and to hope that recovery is possible. Neither Luna, nor Jennifer, set out consciously to adopt a pet companion who would have such a profound impact on their lives. They both chose to perform an act of kindness, and to adopt or rescue their animals, and found that they were saved by their animals instead.

### **Summary**

The narratives of the seven participants brings a close to chapter four. The seven themes that arose from the narratives became representative, in some ways, of chapters in the life stories of the participants. The chronology, or story, of the disordered eating experiences began with an impetus, a shared experience of the participants which ultimately led to the development of disordered eating symptoms. These symptoms eventually negatively impacted their lives. In all participants, isolation served as a catalyst to intensify the symptoms of their disordered eating behaviours. Experiencing intense shame in front of a pet companion allowed the participants to embrace

vulnerability and connection. Mutual connection with the pet companion occurred although the participants engaged in self-destructive behaviours. The disordered eating symptoms often resulted in loss of relationships, difficulties at work or school, and further isolation, however mutual connection with the pet would often become the gateway into re-connection and recovery. Next, while the participants would often attempt to shun aspects of themselves that they did not like or accept, their pet companion would mirror back the same qualities in themselves. Often, this mirroring would result in the participants appreciating those qualities in their pet, and allowing that softness and kindness to emanate back toward themselves. Additionally, disordered eating symptoms was often experienced as trance-like or dissociative states, but those experiences coupled with the relationship and connection with the pet frequently resulted in breaking otherwise automatic behaviours. And lastly, six of the participants chose to adopt or rescue their pets, with the seventh participant choosing to keep their pet after a difficult beginning, and found that although they had saved their pet companions in some ways, it was the mutual love, reciprocity and interconnectedness from the pet companion that truly saved the participants.

## **Chapter Five: Discussion**

### **Introduction**

In this section, two pivotal areas will be discussed. First, I will discuss what the results of this study may demonstrate for individuals who have experienced eating disorders, or disordered eating behaviours and attitudes. Second, I will discuss how a relationship or connection with a pet companion may be beneficial to the recovery process. Furthermore, in this section I will examine the themes that pertain to the research question: How do the stories of pet companionship among individuals with a diagnosed eating disorder, or self-identified disordered eating behaviours, attitudes, or experiences, articulate the role and meaning of pet companionship in the management and recovery of their disorder? Using these themes, I will discuss how the implications of the themes relate to healing from disordered eating-related experiences. Additionally, I will then discuss the implications of healing with the help of a pet companion. Lastly, the strengths and limitations of the current study will be explored, including areas for future research.

### **Answering the Research Question**

Analysis of the participants stories revealed seven themes, which represented common phases in the narratives of those who found the meaning of pet ownership to be integral to their recovery from either a diagnosed eating disorder, or from self-identified disordered eating behaviours, attitudes, and experiences. These seven themes were outlined in chronological representation which paralleled the experience of the journey the participants undertook with their individual disordered eating experience and connection to their pet companion. What is evident from the themes that emerged from the narratives of the individual, is that connection to the pet companion was integral to

recovery. After experiencing isolation, shame, decreased self-esteem, and withdrawal, the participants of this study emerged from their disordered eating experiences because of the relationship with their pet companion. Therefore, this thesis would not have even been possible without the pets with whom the participants were so connected, as it was only through the human-pet relationship that the participants are able to embrace vulnerability in present day experiences.

**Exploring theme one.** The first theme was representative of the genesis of the individual's disordered eating experience. For some participants, it was the early relationship and attachment to the primary caregiver, specifically the mother, which was the impetus to the experience. For others, it was moving away from home and away from all that had been familiar when their disordered eating experiences first began. For Nicole, Kate, Becky, Jennifer, and Luna, the experiences first began within the childhood home. For Harriet and Maria, the experiences began in their early 20s after suddenly losing their connections with family and friends, from moving to a new province, or from having friends graduate and move away.

Although there is no currently known cause for the development of an eating disorder, there are factors which are known to potentially contribute to their development (Polivy & Herman, 2002). Some of these contributing factors include sociocultural factors, familial factors, cognitive factors, and biological aspects (Polivy & Herman, 2002). It has been hypothesized that eating disorders may be a way for an individual to cope with problems of identity and personal control (Polivy & Herman, 2002); however, the stories of the participants demonstrate the impetus for their own experience in their eating disorder journey in a different light. There is evidence that suggests that the role of

the nuclear family can play into the development of an eating disorder (Skarderud, 2007; Buhl, 2002). Furthermore, it is suggested that the early interactions with or primary caregivers or families are what teaches individuals the capacity to engage in self-care:

As we grow up, we gradually learn to take care of ourselves, both physically and emotionally, but we get our first lessons in self-care from the way that we were cared for. Mastering the skills of self-regulation depends to a large degree on how harmonious our early interactions with our caregivers are. (van der Kolk, 2014, p. 112).

These experiences with primary care figures may help to illuminate some contributing factors to the development of disordered eating experiences, as these upbringings impact our ability to self-regulate later in life. While many stereotypes exist for individuals with eating disorders, including a stereotype of vanity (Bishop, 2001; Skarderud, 2007), it is important to emphasize the unique etiology of the participant's experience, to minimize potentially damaging reductionism for the individual based on a stereotype.

**Exploring theme two.** The participant's disordered eating intensified in the second stage in response to a situation that catalyzed their disordered eating behaviours. During this time, there was a catalyst which occurred that provided a marked difference in their behaviours—something occurred which morphed their behaviours into something more unmanageable, and largely detrimental. As a result, their experiences began to culminate in loss of relationship with others, difficulties with functioning, not being able to go to work or school, or developing sneaky or manipulative behaviours from the people that they cared for. This experience then worsened feelings of shame, increased self-hatred, and increased disconnection with the self and others.

While multiple factors have been identified in the worsening of an individual's disordered eating behaviours, it has been found that social-emotional isolation positively relates to body dissatisfaction and binge eating (Zaitsoff, Fehon, & Grilo, 2009). For some of the participants, social-emotional isolation played an integral role in the worsening of their disordered eating experiences. For example, symptoms often escalated when the participants moved into homes of their own and away from previous social support networks. One participant, Becky, explained how she had felt that her experiences would improve once she was no longer living with her family of origin. Instead, she became aware that her struggles followed her to her new home—and worsened.

Mate (2009) notes that the Hungry Ghost Realm is one of constant yearning, constantly seeking something outside of oneself to ease the pain that an individual is experiencing on the inside:

The inhabitants of the Hungry Ghost Realm are depicted as creatures with scrawny necks, small mouths, emaciated limbs and large, bloated, empty bellies. This is the domain of addiction, where we constantly seek something outside ourselves to curb an insatiable yearning for relief or fulfillment. The aching emptiness is perpetual because the substances, objects or pursuits we hope will soothe it are not what we really need. We don't know what we need, and so long as we stay in the hungry ghost mode, we'll never know. We haunt our lives without being fully present (Mate, 2009, p. 1).

Individuals who experience the devastating consequences of disordered eating symptoms may not know the exact etiology of their own experiences, and they may also not know what they need to heal or recover. What the participants became aware of at the height of their disorders, was a constant yearning or searching for something else, which often resulted in the intensification of disordered eating symptoms. The participants in this study found that their pet was integral to their own healing—and that the connection

with their pet pulled them out of the constant searching and yearning of the Hungry Ghost Realm (Mate, 2009).

**Exploring theme three.** In the third stage, the participants' deepening experience of shame was mirrored to them in their pet companions, often through purging behaviours, which allowed for vulnerability and connection to permeate into other aspects of their lives. Being in vulnerability in each moment with nothing to hide can provide an individual with a sense of freedom (Almaas, 1996). The presence of the pet during moments of intense shame increased shame to an extent—but simultaneously allowed the participant to develop a new perspective of their symptoms, and the impact that these symptoms were having not only on themselves, but also on the beings connected to the participant—particularly the pet. Brown (2010) invites individuals to have the courage to be imperfect, by first experiencing compassion for the self. Brown (2010) would argue that connection arises out of our risks to be authentic, as numbing vulnerability also numbs our ability to experience joy and delight. Once we embrace our own vulnerabilities, we allow ourselves to be seen by others (Brown, 2010).

Shame has been studied as an intrinsic characteristic of eating disorders, among other psychiatric illnesses (Skarderud, 2007). Feeling a loss of control, particularly regarding the symptoms of binge eating behaviours, has related to an increased feeling of shame, particularly within anorexia nervosa (Itulua-Abumere, 2013). Furthermore, shame can be experienced as layers of disconnection from the self and from others (Dayal, Weaver, & Domene, 2015). Brown (2012) argues that individuals cannot feel an openness to vulnerability when a person is completely guarded. For Luna, she described

experiences of growing up with “walls” built up around her. These walls did not serve to keep her open, but rather were built to protect. It can be illuminated in this way:

So, how do we create a safe space for vulnerability and growth when we’re not feeling open? Armoured feedback doesn’t facilitate lasting meaning change—I don’t know a single person who can be open to accepting feedback or owning responsibility for something when they’re being hammered (Brown, 2012, p. 205).

Luna described purging in the washroom. As their connection grew, Luna would allow Chicklet to be present during the purging experience. It was at these times that Luna would feel more vulnerable. Therefore, in letting down the “walls” that Luna felt she had built, Chicklet and Luna’s relationship continued to deepen. This shared experience added depth of connection to their relationship and allowed for authenticity and growth.

**Exploring theme four.** In the fourth stage, the participants began to see that their disordered eating behaviours and experiences were all-consuming. They began to identify that having an eating disorder, or experiencing disordered eating symptoms, is all about them: from calorie counting, body checking, planning exercise or sugar-free weeks, to planning a binge eating and purging session for when a spouse would be absent, the disordered experience became all about the individual. Within the context of social media, eating disorders are often portrayed to be issues of vanity, with which the sufferer is viewed as selfish (Bishop, 2001). Individuals with eating disorders are easily viewed as driven solely by the need for perfection, and by selfishness—as though trying to absorb all the attention from family and friends (Bishop, 2001). It is not uncommon for individuals with eating disorders to feel selfish, and often blame themselves for problems—even if the problem is not related to them—particularly if there are relational



issues within the family. However, by forming a relationship or deepening the connection with the pet, the disordered eating symptoms began to transform from being somewhat self-centred in nature, to a more selfless attitude.

The participants turned their focus from their compulsive disordered eating behaviours, their narcissistic preoccupation (Almaas, 1996), to becoming attuned to the pet companion; recognizing the pet's need for food, water, affection, trust, and advocacy, to name a few. Understanding the bond between the individual and the pet companion caused a shift to occur: from focusing solely on the self, to focusing on something—or someone—other than the self. The natural and organic bond is capable of interrupting the destructive loop of distortion at the heart of the eating disorder cycle, demonstrated by a marked shift in attitude, mutual connection and paradoxical dependence and independence.

**Exploring theme five.** In the fifth stage, the participants became more open to the pet companionship, and could understand some of the gifts that they possessed innately, by recognizing those gifts within their pet companion. This finding was confirmed by Gilbert and Orlans (2011) who found that experiencing mirroring from others can facilitate healing and wellness in the development of healthy relationships and attachments. Some of these characteristics or qualities that the participants viewed negatively were: being dependent on others or relying on others, being paradoxically independent and dependent, being vulnerable, being needy, and desiring affection from others. The mirror mechanism describes how observing, or knowing, an action in another can automatically activate the same representation in ourselves, when we perform that same action in the absence of other people (Kuhbandner, Pekrun, & Maier, 2010).

Furthermore, mirroring of individuals from infancy can facilitate experiences of attachment, affect development, and emotion regulation (Gilbert & Orlans, 2011). The process of mirroring from others can be healing and crucial to our healthy development of relationship, attachment, and affect development (Gilbert & Orlans, 2011).

Hornbacher (1998), who experienced eating disorders herself, described a time in her own journey when she realized that despite all the imperfections, that she was already enough:

There is never a sudden revelation, a complete and tidy explanation for why it happened, or why it ends, or why or who you are. You want one and I want one, but there isn't one. It comes in bits and pieces, and you stitch them together wherever they fit, and when you are done you hold yourself up, and still there are holes and you are a rag doll, invented, imperfect. And yet you are all that you have, so you must be enough. There is no other way. (Hornbacher, 1998, p. 280).

The coinciding pet companion provided space for the participants to recognize the participant's own self-hatred of these qualities, yet simultaneously promoted acceptance of these qualities in another. In turn, the participants could experience self-acceptance and self-appreciation, rather than self-hatred for possessing these qualities. This is supported by work done within formal animal assisted therapy. Animal assisted therapy itself has been shown to reduce fear and anxiety in individuals who otherwise might suffer from mental disorders (Velde et al., 2005). Working with animals, therefore, has demonstrated an improvement in an individual's sense of safety, comfort, and self-esteem which then permeates into social relationships (Velde et al., 2005).

**Exploring theme six.** In the sixth stage, the participants developed greater awareness in the here-and-now (Kabat-Zinn, 1994) when the companionship of the pet aided in symptom interruption. Particularly during the disordered eating symptom of binge eating, participants became aware of an experience of feeling as though they were

on autopilot, or experiencing a trance-like state. The presence of the pet companion and innate behaviours of the pet companion, such as a cat sitting in a box, or the presence of a dog or rabbit in the bathroom, provided a safe symptom interruption for the participant.

A binge can be described as:

The inside of a binge is deep and dark; it is a descent into a world in which every restriction you have placed on yourself is cut loose. The forbidden is obtainable. Nothing matters—not friends, not family, not lovers. Nothing matters but food. Lifting, chewing, swallowing—mechanical frenzied acts, one following the other until a physical limit, usually nausea, is reached. Then comes the sought-after numbness, the daze, the indifference to emotional pain (Roth, 2002 p. 13).

This symptom interruption by the help of the pet companion returned the participant to the present moment and provided them with the space to reflect on their behaviours and enable them to stop, or decrease, those symptoms. The literature also supports the experience of the participants in terms of experiencing tunnel vision or numbness during disordered eating experiences. Compulsive eating, or eating during binges, can take on a form of dissociation or can be experienced in a trance-like state (Lightstone, 2004). Lightstone (2004) differentiates between dissociation in terms of a specific mechanism of previous traumas being projected onto the individual and their disordered eating symptoms, and dissociative or trance-like episodes of binge eating during which time an individual is engaging in binge eating and is aware of binge eating, but feels that they are in a trance-like state. Lightstone (2004) further argues that purging behaviours can follow similar trance-like state experiences.

**Exploring theme seven.** In the last stage, the participants developed an awareness of the gravity of their experiences and the possibility of impending death, either physically, emotionally, or socially, that may have occurred if they had continued engaging in their severe disordered eating experiences. The original concepts of salvation

and deliverance originated within Judaic traditions (Dobkin de Rios, Grob, & Baker, 2002). It has further been described that, moving away from Judaic traditions, redemption has been linked with salvation—and that in its personal aspects, salvation represents integrating faith within itself and within an external community (Dobkin de Rios et al., 2002). Additionally, salvation would mean deliverance from internal and external evils, which prevented an individual from achieving one's maximum capabilities (Dobkin de Rios et al., 2002).

The existential philosopher Soren Kierkegaard noted that the human condition is in an eternal state of shifting through the possibilities and limitations that the spirit can offer to an individual (Mautner, 2000). Consequently, Kierkegaard believed that individuals have the ability and connection with their own will to choose from other extremes (Mautner, 2000). For individuals with disordered eating symptoms, individuals often attempt to end their despair by seeking out their disordered eating behaviours. These behaviours then intensify and control their lives. Their eating disorders offer momentary solitude and are used as a defense mechanism against the catalyst and impetus that was first experienced in the first and second stages of their process. In those first two stages, individuals are can experience a fear of death and terror that they will fall into nothingness and become nothing themselves. Ultimately, individuals with eating disorders are both grasping at death through the severity of their symptoms, and grasping at life, by allowing connection with a pet companion.

Six of the seven participants adopted or rescued their pet companion. Maria, the seventh participant, did not formally adopt or rescue her dog. Maria consciously chose, however, to keep Tucker despite Tucker's difficult beginnings. In doing so, each

participant saved their animals from an uncertain future. While the participants set out to create a better life for their pets, it was their pets, in turn, who helped to create a better life for each of the participants.

The question first posed within this thesis was, ‘How do the stories of pet companionship among individuals with a diagnosed eating disorder, or self-identified disordered eating behaviours, attitudes, or experiences, articulate the role and meaning of pet companionship in the management and recovery of their disorder?’ Viewing the themes through a narrative inquiry lens, I suggest that the stories of pet companionship for individuals experiencing disordered eating symptoms and diagnosed eating disorders elucidate the deepened meaning behind pet companionship: increased vulnerability, increased connectedness, increased sense of safety, increased mindfulness in the moment, decreased sense of aloneness, decreased self-destructive behaviours, and day-to-day acceptance, love, and reciprocity. This finding is supported by extant literature and furthers what is known about the impact of pet companionship on individuals who had disordered eating behaviours, attitudes, and experiences.

### **Implication of Themes in Healing**

The current body of literature suggests that animal assisted therapies and animal assisted interventions can have a meaningful benefit in physical, mental, and emotional aspects of healing; therefore, one can infer that pet companionship, in the absence of specifically-trained animal therapists, may also present benefits in physical, mental, and emotional aspects of healing. The relationship that a pet can have with an individual can provide counsellors with a readily available resource in the healing and recovery journey from a diagnosed eating disorder or from disordered eating behaviours and attitudes. This

author suggests implications which may be important in utilizing this approach as an adjunct therapy to more formal psychological therapies.

**The first implication for healing.** The first of these implications is that one must understand the nature of an eating disorder, whether diagnosed or undiagnosed, prior to working with potential treatment modalities.

Eating disorders, according to the American Psychiatric Association (2013) in the DSM-5, are characterized as: “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” (p. 329). The DSM-5 contains descriptions, and symptoms for diagnosing mental disorders (American Psychiatric Association 2013) but does not address causes of the disorders. While this definition provides a clinical introductory explanation to eating disorders, the experience, as posed by the participants in this thesis, provided a somewhat different definition. While ‘psychosocial functioning’ can potentially encompass some of the loss that the participants in this study experienced, it does not highlight the gravity with which individuals with eating disorders (diagnosed or undiagnosed) may experience. The very nature of the term ‘eating disorder’ implies within itself that it is a disorder of eating—this author would argue that the name of the disorder itself is an unjust term to describe the devastating consequences of behaviours and experiences which, predominately, have very little to do with eating itself.

This hypothesis of the writer is further supported by a study conducted by Tozzi, Sullivan, Fear, McKenzie and Bulik (2003). Tozzi et al., (2003) explored the subjective accounts of the patient experience of 70 female participants diagnosed with anorexia nervosa. While each participant had a DSM-IV diagnosis of anorexia nervosa, the

etiology of their disorder differed significantly (Tozzi et al., 2003). Some of the causes included dysfunctional family dynamics, perceived pressure, stressful life experiences, and weight loss and dieting (Tozzi et al., 2003). When examining the DSM-5 diagnostic criteria, the purpose of the DSM-5 is to identify the symptoms of the disorder, however those underlying causes continue to be subjective to the individual.

Furthermore, in the growing body of literature it is evident that weight restoration and the return of menses is often viewed as 'recovery' (Eisler, 2007; Gelin et al., 2015). Or, opposite to weight restoration, weight loss has been viewed as a pillar of recovery as in the case of binge-eating disorder (Crow, 2014). This can further be problematic to understanding the nature of eating disorders as weight restoration or loss addresses merely the symptom of the disorder, and does not recognize the emotional or psychological implications of the experience.

Redgrave et al. (2015) completed a cohort study over an 8-year period which demonstrated that weight restoration in combination with psycho-therapeutic approaches yielded the greatest outcome for the participants. In a study of 361 adolescent and adult, male and female participants, participated in an integrated inpatient-partial hospital eating disorder program (Redgrave et al., 2015). The outcome measures that were studied were rates of hypophosphatemia, an electrolyte imbalance in which there is an abnormally low level of phosphate in the blood, transfer to medicine wings, rates of death, and rates of weight gain and percent achieving weight restoration (Redgrave et al., 2015). Of the 361 participants, one percent of individuals were transferred to a medical wing and there were no deaths in the study (Redgrave et al., 2015). The mean inpatient weight gain was measured at approximately 1.98kg/week, resulting in 71.8% of adults reaching a body

mass index within a healthy range upon discharge (Redgrave et al., 2015). Furthermore, progress and active medical and behavioural issues were addressed during daily assessment and individualized treatment plans by a multi-disciplinary team (Redgrave et al., 2015). These findings support the need for both weight restoration and psychological work to address both the physical symptoms and the underlying psychological causes.

For counsellors working with individuals who have experienced disordered eating behaviours and their consequences, the counsellors must first understand the some of the limitations of a DSM-5 diagnosis and be able to work with the client in the here-and-now (Kabat-Zinn, 1994), and based on their own personal experience of their disorder. For example, Jennifer purposely ensured that no health care professional was ever able to give her a diagnosis. Jennifer felt that a diagnosis would not change the way she felt about herself, her experiences, the gravity that the symptoms had on her life, and the meaning that she derived from her personal recovery with her pet companion. Receiving a diagnosis would not impact Jennifer directly—Jennifer expressed that possessing a label would not actually change her behaviours or experiences. Similarly, Luna also felt that receiving a diagnostic label would likely have been unhelpful. Luna noted that if she had been given a diagnosis, she would likely have clung to it as a part of her identity. Both participants identified that having a formal diagnosis would not have altered their personal experiences.

**The second implication for healing.** The second implication for healing is relevant to the first: that the current therapeutic models for the treatment of eating disorders are not necessarily the gold standard for all eating disorders at an individual level. Specifically, while some treatment modalities do currently exist for the treatment of



diagnosed eating disorders, this author hypothesizes that an individual can choose the treatment modality that would work best for that individual, based on their own personal experience. All seven of the participants in this study sought some form of counselling or treatment interventions, with five participants seeking out eating disorder-specific support. While the participants identified that the treatment they received provided them with a platform for recovery, the participants also identified that it was the relationship with their personal pet companion which played a greater role in the everyday recovery they experienced, particularly when more formal treatments were not available.

Conversely, it could be argued that, if in the trance of their disordered eating experiences, the individual may not know what treatment modality would be best suited to their own experience. The participants in this study did not know from the beginning of their disordered eating experiences that it would be a human-pet relationship that would continue to solidify their recovery and maintenance process, but something that was born intuitively out of experience and relationship with their pet. Therefore, perhaps it could be hypothesized that it is only through pursuing multiple therapeutic avenues that an individual finds the treatment modality best suited for their own recovery experience.

**The third implication for healing.** An additional implication for healing is the meaning that can be derived from the interaction between humans and animals, and the bond and connection which is created between an individual and their pet when the individual permits their pet to enter their lives in the emotional domain. Within the context of nursing practice, it has been found that human-animal interaction has positive implications in both physical and mental health (Vitztum, 2013). Furthermore, the relationship between animals and humans has been found to have a positive effect in

multiple settings including hospitals, prisons, farming communities, schools, seniors' homes, and within community programs (Walsh, 2009).

These findings support the assertion that meaning can be derived from a relationship between individuals experiencing disordered eating symptoms and a pet companion. From the human-pet relationship, the participants derived emotional, spiritual, and physical changes which then translated into other aspects of their lives. These changes arose not only for their specific disordered eating recovery, but also within their emotional, psychological, and social connections with other people, and their academic and professional obligations as well.

### **Discussion of Theoretical Lens**

The theoretical lens which drove this research was the integration of ecopsychology and ecotherapy. Ecopsychology integrates both ecology and psychology in a reflection of the connection between humans and nature (Roszak, 1992). Ecotherapeutic practices have revealed benefits in mental health including an increased capacity for social interaction, cognitive focus, and relaxation (Davis, 2011; Weinstein, Przybylski, & Ryan, 2009). Ecotherapy can work in conjunction with ecopsychology in that the individual receiving ecotherapy as an intervention relies on the wellness of the world to achieve healing and recovery (Clinebell, 2013). Among the many tenets of ecotherapy, there is a central notion that mutual healing can occur between the human mind and the natural world (Chalquist, 2009). Animal assisted therapy is classified as an example of an ecotherapeutic intervention (Chalquist, 2009).

Although perhaps not consciously, the participants in this study chose ecopsychology and ecotherapy as adjunctive therapies to the counselling and medical

interventions they were already receiving. Developing a relationship with their pet and using that connection as a means of healing, increasing one's capacity to self-soothe, increase cognitive function, and decreasing symptoms of their disordered eating behaviours resulted from a mutual human-animal interaction. The wellness of the participants in their journey of recovery from disordered eating behaviours and attitudes was ameliorated through a connection with the natural world; the relationship with their pet.

### **Limitations of the Research**

Although there are limitations of this research, it is by no means a reflection of the participants in this study, their experiences, or the meaning that they derived from their relationship with their pet companion. The first limitation of this study is its lack of generalizability to a larger population. This study had only seven participants who self-selected into the study, and as such, the meanings the participants derived, and their experiences of their disordered eating odyssey may not be representative of a larger population.

The second limitation to the study is that the information received during the interviews, which were conducted with a narrative inquiry lens, were merely a snapshot of that participant's story at that time. If the interview had been conducted on a different day, or at a different point in the participant's journey, and given the different landscape of the experience at that time, the resulting narrative may have been completely different for that individual. Given that four main terms are utilized in narrative inquiry (living, telling, retelling, and reliving), the snapshot in time for the individual may be different. This is particularly salient in the fourth term of 'reliving' during which time the

participants gained awareness and insight into how they had changed through the retelling of the story, and how the personal landscape of the experience was now changed with the landscape of the present moment (Clandinin, 2013).

A third limitation to the study is that all the participants were women. Although gender was not a specific inclusion or exclusion criteria for the study, that other genders did not make up the participant population is a limitation of the study. Genders other than women are already underreported and underrepresented within eating disorder diagnoses (Strother et al., 2012); therefore, individuals not identifying as women may derive a completely different meaning to their experience of recovery with the help of a pet companion.

A fourth limitation which is evident in this study—and which is tied in with the third limitation—is that snowball sampling was utilized. Snowball sampling can lead to bias within the sample of participants, such as self-selection bias resulting in a non-representative sample, and homophily, as the participants may share similar characteristics outside of the study which may affect the narrative of the individuals (Kowald & Axhausen, 2012).

A fifth limitation to the study is the experience of myself, as a researcher. While I have had the opportunity to work on quantitative studies, this is the first qualitative study of my own undertaking, and would therefore consider myself to be a novice researcher at this time.

An additional limitation of the study is self-selection in terms of participant recruitment. Self-selection inherently involved individuals who found that their pets were helpful to their recovery, as this was an inclusion criterion. Given that there were no

negative experiences of individuals who found their pet companion was unhelpful to their recovery, this would be a limitation to the study.

### **Recommendations for Future Research**

These study findings open several avenues for future research, which may contribute to the strengthening and diversification of scholarship in this area of study. While seven participants is considered an appropriate sample size for a qualitative study in general (Morse, 1994) and narrative inquiry in particular, further investigation into the meaning of the human-animal relationship relative to a disordered eating experience with a larger and more diversified sample, could lead to additional insight into the phenomenon experienced by the participants in this study. Additionally, exploring the phenomenon through different avenues of inquiry—such as phenomenological hermeneutics—may shed new light on the role of pets in recovery from disordered eating experiences. A phenomenological hermeneutic approach may be relevant to this area of research as it could potentially take the meanings derived from this study and deepen them through the exploration of a lived experience phenomenon (Heidegger, 1962).

As the individuals in this study became connected to their pet through adoption or rescuing, it may be beneficial to investigate if that adoption or rescue avenue provides an additional implication in recovery in comparison to an individual who may acquire their pet through a specific breeder, for example. It may help to elucidate if further meaning can be derived from the mutual experience of salvation, or whether it is specifically the companionship itself, regardless of how the pet and human are first introduced, that has implications in recovery.

A consideration for further research in this area would be to include participants who no longer experience symptoms of their eating disorder or disordered eating behaviours or attitudes. Each participant in this study was still experiencing slips or relapses in disordered eating behaviours or attitudes, and therefore in the future it may be beneficial to investigate any similarities or differences for individuals who consider themselves to be completely recovered, in comparison with individuals who feel that they are still in their personal recovery process.

Another area for future research may be to examine meaning-making from neurobiological and attachment theory perspectives. In examining what may be occurring for individuals at a neurobiological level in terms of building neurobiological and neurochemical pathways, it may help researchers further understand the connections being made with the pet companion, and how that translates into connection with the individuals around them. Furthermore, understanding how those connections relate for the individual in terms of attachment theory, connection, and interpersonal growth may be an area for further research as well.

Finally, the role of anthropomorphism in healing in the human-pet relationship is an area for future research. Participants attributed human cognition and emotion to their pets, and while pets certainly have both cognitive and emotive capability (Grandin & Johnson, 2009), it is unlikely they possess these to the degree the participants articulated. Beetz (2017) would argue that there are multiple reasons for why interactions with animals can result in a decrease in stress reactions, depression, anxiety, aggression, and pain while simultaneously increasing trust, motivation, calmness and concentration. Multiple processes are now being investigated into the mechanism by which that human-

animal interaction operates including potential biological, psychological, and social processes (Beetz, 2017). Of these processes, it is possible that anthropomorphism, experiential engagement with an animal, activation of oxytocin, attachment and caregiving, and providing social support during times of stress may contribute to the foundation of the human-animal bonds (Beetz, 2017) and connections that are highlighted in this study.

### **Conclusion**

In conclusion, the journey of the seven participants in this study illuminated the experience of meaning and pet companionship in the natural healing from a diagnosed eating disorder, or from self-identified disordered eating behaviours, attitudes, and experiences. It appears the relationship of the pet companion is not sufficient in and of itself to be utilized in the treatment of an individual who has experienced a diagnosed eating disorder, or who has experienced self-identified disordered eating behaviours and attitudes. Rather, the human-pet relationship can be used as an adjunct with other treatment modalities or as a co-intervention. The relationship between an animal and a person who is experiencing disordered eating behaviours and attitudes may, not be sufficient on its own to help an individual to recover fully; however, the implications of increased vulnerability and connectedness appears to have played a pivotal role in continued recovery and the lessening or cessation of symptoms. Recognizing the role of mutual respect, love, and connectedness could then be translated into other areas of life for the individual, who may otherwise be isolated due to the impacts of shame, fear of vulnerability, or self-hatred.

In this thesis, I have explored the meaning of the relationship between an individual and their pet companion and the impact that that relationship has had on their recovery through their disordered eating related experiences, behaviours, and attitudes. While this study shines a light on the potential for close pet relationships to facilitate recovery from disordered eating symptoms, further investigation into the role and meaning of this relationship is warranted, and may continue to elucidate the strong impact that those vulnerable connections can have on recovery, and every day living.



## References

- Abusabha, R., & Woelfel, M.L. (2003). Qualitative vs quantitative methods: Two opposites that make a perfect match. *Journal of the Academy of Nutrition and Dietetics*, 103(5), 566-569. doi: 10.1053/jada.2003.50129
- Aderka, I.M., Gutner, C.A., Lazarov, A., Hermesh, H., Hofmann, S.G., & Marom, S. (2014). Body image in social anxiety disorder, obsessive-compulsive disorder, and panic disorder. *Body Image*, 11(1), 51-56. doi: 10.1016/j.bodyim.2013.09.002
- Almaas, A.H. (1987). *Diamond heart: The elements of the real in man: Book one*. Berkeley, CA: Diamond Books.
- Almaas, A.H. (1996). *The point of existence: Transformations of narcissism in self-realization*. Berkeley, CA: Diamond Books.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed.). Arlington, VA: American Psychiatric Publishing.
- Andrew, M., Squire, C., & Tamboukou, M. (Eds.) (2008). *Doing narrative research*. London: Sage.
- Aparicio Parry, G. (2016). Ecopsychology: Remembering the true source of our consciousness. *Cosmos and History: The Journal of Natural and Social Philosophy*, 12(2), 226-236.
- Arcelus, J., Mitchell, A.J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: A meta-analysis of 36 studies.

*Archives of General Psychiatry*, 68(7), 724-731.

doi:10.1001/archgenpsychiatry.2011.74

Baumgartner, E., & Cho, J. (2014). Animal-assisted activities for students with disabilities:

Obtaining stakeholders' approval and planning strategies for teachers. *Childhood Education*, 90(4), 281-290. doi:10.1080/00094056.2014.936221

Beetz, A.M. (2017). Theories and possible processes of action in animal assisted

interventions. *Applied Developmental Science*, 21(2), 139-149. doi: 10.1080/10888691.2016.1262263.

Bishop, R. (2001). The pursuit of perfection: A narrative analysis of how women's

magazines cover eating disorders. *The Howard Journal of Communications*, 12, 221-240. doi: 10.1080/106461701753287732

Bogenschutz, M.P., & Nurnberg, H.G. (2004). Olanzapine versus placebo in the

treatment of borderline personality disorder. *Journal of Clinical Psychiatry*, 65(1), 104-109.

Boschen, M.J., Veale, D., Ellison, N., & Reddell, T. (2013). The emetophobia

questionnaire (EmetQ-13): Psychometric validation of a measure of specific phobia of vomiting (emetophobia). *Journal of Anxiety Disorders*, 27(7), 670-677.

doi: 10.1016/j.janxdis.2013.08.004

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and*

*code development*. Thousand Oaks, CA: Sage Publications.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative*

*Research in Psychology*, 3(2), 77-101.

- Brausch, A.M., & Decker, K.M. (2014). Self-esteem and social support as moderators of depression, body image, and disordered eating for suicidal ideation in adolescents. *Journal of Abnormal Child Psychology*, *42*, 779-789. doi: 10.1007/s10802-013-9822-0
- Brooks, H., Rushton, K., Walker, S., Lovell, K., & Rogers, A. (2016). Ontological security and connectivity provided by pets: a study in the self-management of the everyday lives of people diagnosed with a long-term mental health condition. *BMC Psychiatry*, *16*, 409-421. doi: 10.1186/s12888-016-1111-3
- Brown, B. (2010). *The gifts of imperfection: Let go of who you think you're supposed to be and embrace who you are*. Center City, MN: Hazelden.
- Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. New York, NY: Gotham Books.
- Browne, K. (2005). Snowball sampling: Using social networks to research non-heterosexual women. *International Journal of Social Research Methodology*, *8*(1), 47-60. doi: 10.1080/1364557032000081663
- Buhl, C. (2002). Eating disorders as manifestations of developmental disorders: Language and the capacity for abstract thinking in psychotherapy of eating disorders. *European Eating Disorders Review*, *10*, 138-145. doi: 10.1002/erv.440.
- Campbell, T.L., & Patterson, J.M. (1995). The effectiveness of family interventions in the treatment of physical illness. *Journal of Marital and Family Therapy*, *21*(4), 545-583. doi: 10.1111/j.1752-0606.1995.tb00178.x.

- Chakraborty, K., & Basu, D. (2010). Management of anorexia and bulimia nervosa: An evidence-based review. *Indian Journal of Psychiatry, 52*(2), 174-186. doi: 10.4103/0019-5545.64596
- Chalquist, C. (2009). A look at the ecotherapy research evidence. *Ecopsychology, 1*(2), 64-74. doi: 10.1089/eco.2009.0003
- Clandinin, D.J. (2013). *Engaging in narrative inquiry*. Walnut Creek, CA: Left Coast Press.
- Clinebell, H. (2013). *Ecotherapy: Healing ourselves, healing the earth*. New York, NY: Haworth Press.
- Connor, K., & Miller, J. (2000). Animal-assisted therapy: An in-depth look. *Dimensions of Critical Care Nursing, 19*(3), 20-26.
- Connor, K., & Miller, J. (2000). Help from our animal friends. *Nursing Management, 31*, 42-46.
- Corey, G. (2013). *The theory and practice of counselling and psychotherapy*. Pacific Grove, CA: Brooks/Cole.
- Creswell, J.W. (2011). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (4<sup>th</sup> ed.). Boston, MA: Pearson Education.
- Crow, S.J., Peterson, C.B., Swanson, S.A., Raymond, N.C., Specker, S., Eckert, E.D., & Mitchell, J.E. (2009). Increased mortality in bulimia nervosa and other eating disorders. *The American Journal of Psychiatry, 166*(12), 1342-1346. doi: 10.1176/appi.ajp.2009.09020247
- Crow, S. (2014). Treatment of binge eating disorder. *Current Treatment Options in Psychiatry, 1*, 307-314. doi: 10.1007/s40501-014-0023-4

- Cumella, E.D., Boyd Lutter, C., Smith Osborne, A., & Kally, Z. (2012). Equine therapy in the treatment of female eating disorder. *Scientific Online Publishing Transactions on Psychology, 1(1)*, 13-21. doi: 10.15764/STP.2014.01002
- Dakanalis, A., Clerici, M., Caslini, M., Favagrossa, L., Prunas, A., Volpato, C., ... Zanetti, M.A. (2014). Internalization of sociocultural standards of beauty and disordered eating behaviours: The role of body surveillance, shame and social anxiety. *Journal of Psychopathology, 20*, 33-37.
- Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy & Rehabilitation, 21(12)*, 560-568. doi: 10.12968/ijtr.2014.21.12.560
- Davis, J.V. (2011). Ecopsychology, transpersonal psychology, and nonduality. *International Journal of Transpersonal Studies, 30(1-2)*, 137-147. doi: 10.1080/08873267.1998.9976967
- Dayal, H., Weaver, K., & Domene, J.F. (2015). From shame to shame resilience: Narratives of counselor trainees with eating issues. *Qualitative Health Research, 25(2)*, 153-167. doi: 10.1177/1049732314551988
- Dobkin de Rios, M, Grob, C.S., & Baker, J.R. (2002). Hallucinogens and redemption. *Journal of Psychoactive Drugs, 34(3)*, 239-248. doi: 10.1080/02791072.2002.10399960
- Eisler, I., Simic, M., Russell, G.F.M., & Dare, C. (2007). A randomized controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: A five-year follow-up. *Journal of Child Psychology and Psychiatry, 48(6)*, 552-560. doi: 10.1111/j.1469-7610.2007.01726.x

- Fairburn, C.G., & Cooper, Z. (2011). Eating disorders, DSM-5 and clinical reality. *The British Journal of Psychiatry*, 198, 8-10. doi:10.1192/bjp.bp.110.083881
- Fisher, A. (1996). Toward a more radical ecopsychology: Therapy for a dysfunctional society. *Alternatives Journal*, 22(3), 20-27.
- Fisher, M., Schneider, M., Pegler, C., & Napolitano, B. (1991). Eating attitudes, health-risk behaviors, self-esteem, and anxiety among adolescent females in a suburban high school. *Journal of Adolescent Health*, 12(5), 377-384. doi:10.1016/0197-0070(91)90051-M
- Fisher, M. (2003). The course and outcome of eating disorders in adults and in adolescents: A review. *Adolescent Medicine*, 14(1), 149-158.
- Flores, P.J. (2007). *Group psychotherapy with addictions populations: An integrated step of twelve-step and psychodynamic theory* (3rd ed.). New York, NY: Routledge.
- Frewin, K., & Gardiner, B. (2005). New age or old sage? A review of equine assisted psychotherapy. *The Australian Journal of Counselling Psychology*, 6, 13-17.
- Froling, J. (2009). Tasks to mitigate certain disabling illnesses classified as mental impairments under The Americans with Disabilities Act. Service Dog Tasks for Psychiatric Disabilities. Retrieved from [http://www.iaadp.org/psd\\_tasks.html](http://www.iaadp.org/psd_tasks.html)
- Fusch, P.I., & Ness, L.R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, 20(9), 1408-1416.
- Garner, D.M. (1991). *Eating disorder inventory-2 professional manual*. Odessa, FL: Psychological Assessment Resources.

- Gelin, Z., Fusco, S., Hendrick, S., Cook-Darzens, S., & Simon, Y. (2015). The effects of a multiple family therapy on adolescents with eating disorders: An outcome study. *Family Process Journal, 54*(1), 160-172. doi: 10.1111/famp.12103
- Gilbert, P. (1998). *What is shame? Some core issues and controversies*. Oxford: Oxford University Press.
- Gilbert, M., & Orlans, V. (2011). *Integrative therapy: 100 key points and techniques*. New York, NY: Routledge.
- Gill, M.J. (2014). The possibilities of phenomenology for organizational research. *Organizational Research Methods, 17*(2), 118-137. doi: 10.1177/1094428113518348
- Goodrick, G.K., Carlos Poston, W.S.II., Kimball, K.T., Reeves, R.S., & Foreyt, J.P. (1998). Nondieting versus dieting treatment for overweight binge-eating women. *Journal of Consulting and Clinical Psychology, 66*(2), 363-368.
- Grandin, T., & Johnson, C. (2009). *Animals make us human: Creating the best life for animals*. Houghton Mifflin Harcourt.
- Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112. doi: 10.1016/j.nedt.2003.10.001
- Greffrath, G., Meyer, C.D.P., Strydom, H., & Ellis, S. (2012). The symbolic uniqueness of wilderness participation. *African Journal for Physical, Health Education, Recreation and Dance, 18*(1), 20-38.

- Greydanus, D.E., & Apple, R.W. (2011). The relationship between deliberate self-harm behavior, body dissatisfaction, and suicide in adolescents: Current concepts. *Journal of Multidisciplinary Healthcare, 4*, 183-189. doi: 10.2147/JMDH.S11569
- Heidegger, M. (1962). *Being and time*. J. Macquarie & E. Robinson, Trans.). London: SCM Press.
- Hollander, E., & Kong, H. (2016). Relapse prevention and the need for ongoing pharmacological treatment in body dysmorphic disorder. *The American Journal of Psychiatry, 174*(9), 857-859. doi: 10.1176/appi.ajp.2016.16050624
- Hornbacher, M. (1998). *Wasted: A memoir of anorexia and bulimia*. New York, NY: HarperCollins Publishers.
- Hunter, S.V. (2010). Analysing and representing narrative data: The long and winding road. *Embracing Multiple Dimensions, 1*(2), 44-54.
- Hudson, J.I., Hiripi, E., Pope, H.G., & Kessler, R.C. (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry, 61*(3), 348-358. doi: 10.1016/j.biopsych.2006.03.040
- Itulua-Abumere, F. (2013). Anorexia nervosa and bulimia nervosa critical analysis of its treatment: Implications and interventions. *The Open Access Journal of Science and Technology, 1*, (1-5). doi: 10.11131/2013/100007
- Jambekar, S.A., Masheb, R.M., & Grilo, C.M. (2003). Gender differences in shame in patients with binge-eating disorder. *Obesity Research, 11*(4), 571-577. doi: 10.1038/oby.2003.80



- Jones, J.M., Bennett, S., Olmsted, M.P., Lawson, M.L., & Rodin, G. (2001). Disordered eating attitudes and behaviours in teenaged girls: a school-based study. *Canadian Medical Association Journal*, *165*(5), 547-552.
- Kartal Yağız, A., Kuğu, N., Semiz, M., & Kavakçı, Ö. (2016). The relationship between anger expression, body image and eating attitudes in social anxiety disorder. *Türk Psikiyatri Dergisi = Turkish Journal of Psychiatry*, *27*(1), 15.
- Kawamura, N., Niiyama, M., & Niiyama, H. (2009). Animal-assisted activity: Experiences of Institutionalized older adults. *Journal of Psychosocial Nursing & Mental Health Services*, *47*(1), 41-47.
- Knapton, O. (2013). Pro-anorexia: Extensions of ingrained concepts. *Discourse and Society*, *24*(4), 461-477. doi: 10.1177/0957926513482067
- Kuhbandner, C., Pekrun, R., & Maier, M.A. (2010). The role of positive and negative affect in the “mirroring” of other persons’ actions. *Cognition and Emotion*, *24*(7), 1182-1190. doi: 10.1080/02699930903119196
- Kuper, A., Lingard, L., & Levinson, W. (2008). Critically appraising qualitative research. *British Medical Journal*, *337*, 687-692. doi: 10.1136/bmj.a1035
- Liebert, R., & Gavey, N. (2009). “There are always two sides to these things”: Managing the dilemma of serious adverse effects from SSRIs. *Social Science & Medicine*, *68*, 1882-1891. doi: 10.1016/j.socscimed.2009.02.047
- Lightstone, J. (2004). Dissociation and compulsive eating. *Journal of Trauma & Dissociation*, *5*(4), 17-32. doi: 10.1300/J229v05n04\_02
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

- Lutwack-Bloom, P., Wijewickrama, B.A., & Smith, B. (2005). Effects of pets versus people visits with nursing home residents. *Journal of Gerontological Social Work, 44*(3-4), 137-159. doi: 10.1300/J083v44n03\_09
- Lyons, N. (2010). Seeing into suspicion: Weighing the probabilities of contending narratives, developing as a narrative inquirer. *The Journal of Educational Research, 103*, 103-112. doi: 10.1080/00220670903323602
- Mancuso, S.G., Newton, R., Bosanac, P., Rossell, S.L., Nesci, J.B., & Castle, D.J. (2015). Classification of eating disorders: Comparison of relative prevalence rates using DSM-IV and DSM-5 criteria. *The British Journal of Psychiatry, 206*, 519-520. doi:10.1192/bjp.bp.113.143461
- Marrazzi, M.A., Bacon, J.P., Kinzie, J., & Luby, E.D. (1995). Naltrexone use in the treatment of anorexia nervosa and bulimia nervosa. *International Journal of Clinical Psychopharmacology, 10*, 163-172.
- Mate, G. (2009). *In the realm of hungry ghosts: Close encounters with addiction*. Toronto, Canada: Vintage Canada.
- McCormick, A.R., & McCormick, M.D. (1997). *Horse sense and the human heart: What horses can teach us about trust, bonding, creativity, and spirituality*. USA: Health Communications Inc.
- McElroy, S.L., Hudson, J.I., Mitchell, J.E., Wilfley, D., Ferreira-Cornwell, M.C., Gao, J., ... Gasiior, M. (2015). Efficacy and safety of lisdexamfetamine for treatment of adults with moderate to severe binge-eating disorder: A randomized control trial. *Journal of the American Medical Association Psychiatry, 72*(3), 235-246. doi: 10.1001/jamapsychiatry.2014.2162

- McMain, S.F., Links, P.S., Gnam, W.H., Guimond, T., Cardish, R.J., Korman, L., & Streiner, D.L. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry*, *166*, 1365-1374. doi: 10.1176/appi.ajp.2009.09010039
- Miranda, J., Chung, J.Y., Green, B.L., Krupnick, J., Siddique, J., Revicki, D.A., & Belin, T. (2003). Treating depression in predominantly low-income young minority women: A randomized controlled trial. *The Journal of the American Medical Association*, *290*(1), 57-65. doi:10.1001/jama.290.1.57
- Morse, J. (1994). Designing funded qualitative research. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: Sage.
- Polivy, J., & Herman, C.P. (2002). Causes of eating disorders. *Annual Review of Psychology*, *53*, 187-213. doi 10.1146/annurev.psych.53.100901.135103
- Polkinghorne, D.E. (1995). Narrative configuration in qualitative analysis. In J. Amos Hatch & Richard Wisniewski (Eds.), *Life history and narrative* (pp. 5-23). London: Falmer Press.
- Redgrave, G.W., Coughlin, J.W., Schreyer, C.C., Martin, L.M., Leonpacher, A.K., Seide, M., Verdi, A.M., Pletch, A., & Guarda, A.S. (2015). Refeeding and weigh restoration outcomes in anorexia nervosa: Challenging current guidelines. *International Journal of Eating Disorders*, *48*, 866-873. doi: 10.1002/eat.22390
- Rodebaugh, T.L., Holaway, R.M., & Heimberg, R.G. (2004). The treatment of social anxiety disorder. *Clinical Psychology Review*, *24*, 883-908. doi: 10.1016/j.cpr.2004.07.007

- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103. doi:10.1037/h0045357
- Roth, G. (2002). *Feeding the hungry heart: The experience of compulsive eating*. New York, NY: MacMillan Publishing USA.
- Roshanaei-Moghaddam, B., Pauly, M.C., Atkins, D.C., Baldwin, S.A., Stein, M.B., Roy-Byrne, P. (2011). Relative effects of CBT and pharmacotherapy in depression versus anxiety: Is medication somewhat better for depression, and CBT somewhat better for anxiety? *Depression and Anxiety, 28*, 560-567. doi: 10.1002/da.20829
- Roszak, T. (1992). *The voice of the earth: An exploration of ecopsychology*. New York, NY: Touchstone.
- Ryan-Nicholls, K., & Will, C. (2009). Rigour in qualitative research: Mechanisms for control. *Nurse Researcher, 16*(3), 70-85. doi: 10.7748/nr2009.04.16.3.70.c6947
- Sansone, R.A., Chu, J.W., & Wiederman, M.W. (2010). Body image and borderline personality disorder among psychiatric inpatients. *Comprehensive Psychiatry, 51*(6), 579-584. doi: 10.1016/j.comppsy.2010.04.001
- Skarderud, F. (2007). Shame and pride in anorexia nervosa: A qualitative descriptive study. *European Eating Disorders Review, 15*, 81-97. doi: 10.1002/erv.774
- Souter, M.A., & Miller, M.D. (2007). Do animal-assisted activities effectively treat depression? A meta-analysis. *Anthrozoös, 20*(2), 167-180. doi 10.2752/175303707X207954
- Striegel-Moore, R.H., Garvin, V., Dohm, F.A., & Rosenheck, R.A. (1999). Psychiatric comorbidity of eating disorders in men: A national study of hospitalized veterans.

- The International Journal of Eating Disorders*, 25(4), 399-404. doi:  
10.1002/(SICI)1098-108X(199905)25:4<399::AID-EAT4>3.0.CO;2-0
- Strother, E., Lemberg, R., Stanford, S.C., & Turberville, D. (2012). Eating disorders in men: Underdiagnosed, undertreated, and misunderstood. *Eating Disorders*, 20(5), 346-365. doi: 10.1080/10640266.2012.715512
- Thomas, E., & Magilvy, J.K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing*, 16(2), 151-155. doi: 10.1111/j.1744-6155.2011.00283.x
- Thorne, S. (2000). Data analysis in qualitative research. *Evidence-Based Nursing*, 3, 68-70. doi: 10.1136/ebn.3.3.68
- Tobin, G.A., & Begley, C.M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388-396. doi: 10.1111/j.1365-2648.2004.03207.x
- Tozzi, F., Sullivan, P.F., Fear, J.L., McKenzie, J., & Bulik, C.M. (2003). Causes and recovery in anorexia nervosa: The patient's perspective. *International Journal of Eating Disorders*, 33(2), 143 – 154. doi: 10.1002/eat.10120
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, 15, 398-405. doi: 10.1111/nhs.12048
- van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Penguin Books.
- Velde, B.P., Cipriani, J., & Fisher, G. (2005). Resident and therapist views of animal-assisted therapy: Implications for occupational therapy practice. *Australian*

*Occupational Therapy Journal*, 52, 43-50. doi: 10.1111/j.1440-1630.2004.00442.x

Weinstein, N., Przybylski, A.K., & Ryan, R.M. (2009). Can nature make us more caring? Effects of immersion in nature on intrinsic aspirations and generosity. *Personality and Social Psychology Bulletin*, 30(10), 1315-1329. doi: 10.1177/0146167209341649

Wertz, F.J., Charmaz, K., & McMullen, L.M. (2011). *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*. New York, NY: Guildford Press.

Wesley, M.C., Minatrea, N.B., & Watson, J.C. (2009). Animal-assisted therapy in the treatment of substance dependence. *Anthrozoös*, 22(2), 137-148. doi: 10.2752/175303709X434167

Williamson, D.A., Womble, L.G., Smeets, M.A.M., Netemeyer, R.G., Thaw, J.M., Kutlesic, V., & Gleaves, D.H. (2002). Latent structure of eating disorder symptoms: A factor analytic and taxometric investigation. *The American Journal of Psychiatry*, 159, 412-418. doi: 10.1176/appi.ajp.159.3.412

Wilson, N.W., Fleming, S., Jones, R., Lafferty, K., Cathrine, K., Seaman, P., & Knifton, L. (2010). Green shoots of recovery: The impact of a mental health ecotherapy programme. *Mental Health Review Journal*, 15(2), 4-14. doi: 10.5042/mhrj.2010.0366

Wolinsky, S. (1999). *The way of the human: The quantum psychology notebooks volume 1: Developing multidimensional awareness*. Capitola: Quantum.

Zaitsoff, S.L., Fehon, D.C., & Grilo, C.M. (2009). Social competence and socio-emotional isolation and eating disorder psychopathology in female and male adolescent psychiatric inpatients. *International Journal of Clinical and Health Psychology, 9*(2), 219-228.

## Appendices

### Appendix A: Recruitment of Research Participants

Research participants will be recruited by placing posters within public locations in the community including coffee shops, postal offices, churches, grocery store bulletins, animal daycare locations, veterinary clinics, counselling agencies, physician offices, and at the local university and college avenues. The posters will include my university e-mail contact information, as well as my cell phone number for ease of access.

The following inclusion criteria will be utilized in the initial screening for participants:

- Individuals over 18 years of age
- Individuals who self-identify as having had and/or used disordered eating behaviours, attitudes, or experiences as a means of coping, self-regulating, or self-soothing – OR – individuals who have a diagnosis of an eating disorder
- Individuals who identify their pet played a role in their recovery process from disordered eating behaviours, or from an eating disorder



## Appendix B: Screening Process

The initial screening process will be conducted over the phone, during which I will introduce myself to the individual, and explain the details of the study. I will describe the inclusion criteria of the study to the individual and determine if the individual meets all criteria. Then, I will explain the interview process to the individual to inform them that an audio recording will be conducted. The primary questions that I will ask the individual during the initial screening process will be:

- Have you ever been diagnosed with an eating disorder?
  - If yes, the primary researcher will ask the individual to provide the diagnosis
- Do you feel that you experience disordered eating behaviours?
  - If yes, the primary researcher will ask the individual to provide examples
- Do these behaviours negatively impact your life?
- Have you found that your pet companion has played a role in your recovery?

Other questions may arise during the initial screening process; however, the questions will be contained to general information questions to determine whether the individual is a suitable candidate for the study. Once this initial screening process has taken place, I will ask the individual if they would like to participate in the study, and if so I would schedule a date and time to meet in person if they are living within the city of Lethbridge, or over Skype if they are living outside of Lethbridge, to complete the interview process.

## Appendix C: Individual Interviews

Semi-structured interviews will be conducted for 60 to 120 minutes during which time the research participants could elucidate the experience of pet companionship and the natural healing from a diagnosed eating disorder or from self-identified disordered eating behaviours, attitudes, or experiences. The interviews will take place in person in an office on the University of Lethbridge campus if the individual is living in Lethbridge, or the interview will take place via Skype for individuals living outside of Lethbridge. Prior to the commencement of the interview itself, a short list of demographic questions will be asked of the participant. These questions will be the same as the demographic questions asked of the individual during the screening process, and will consist of the following:

- What is your current age?
- From what age was the onset of your eating disorder-related experiences?
- What is your highest level of education that you have completed, if any?
- What is your religious affiliation, if any?
- What is your ethnicity?
- What is your marital status?

The demographic questions will help the researcher to define the participant population. The primary interview question that will ensue is, “Can you please tell me all about your experience with your pet and your journey through your eating disorder or self-identified disordered eating behaviours?” Pet companionship will be defined as any creature that has facilitated the natural recovery process from disordered eating for the individual. The pet could belong to the individual or the pet could not. Lastly, the natural healing or recovery process will be defined as the relief from a diagnosed eating disorder

or self-identified disordered eating behaviours, attitudes, or experiences. After asking the initial question, the primary researcher will give the research participant time to completely answer the question without interruption. Once the individual has concluded telling their story, based on personal experience, the primary researcher will then go back and ask for more information or clarification about specific parts of their story. Some clarification questions could include the following, to understand the participant's personal story of their experience of their experience:

- How would you describe your disordered eating behaviours?
- How did you become aware that these behaviours were impacting your life?
- How did these behaviours impact your life?
- What feelings were elucidated from that experience?
- How did you notice your pet companion was helpful?
- What changes did you observe in yourself?
- What role did your pet play for you?
- What role did you play for your pet?
- At what point, did you realize something was changing for you?
  - How, if at all, was this attributable to your pet?
  - What is the best part of your natural healing with the help of your pet?

Any follow-up questions will only be for clarification and understanding of the participant's narrative.

**Appendix D: Poster**

THE EXPERIENCE OF PET COMPANIONSHIP IN THE NATURAL HEALING OF  
DIAGNOSED EATING DISORDERS, AND SELF-IDENTIFIED DISORDERED  
EATING BEHAVIOURS, ATTITUDES AND EXPERIENCES

SEEKING VOLUNTEER PARTICIPANTS

Principle Researcher: Julia M Ranieri, Master of Education (Counselling Psychology)

Candidate

Research Supervisors: Dr. Trent Leighton and Dr. Em Pijl

This study is a component of a Master's thesis conducted with the University of Lethbridge. The amount of time required will be 1-2 hours through a one-on-one interview. If you have experienced disordered eating behaviours, or if you have received a diagnosis of an eating disorder, and have recovered through the help of a pet and you are interested in volunteering in this study, please contact Julia Ranieri for more details at [Julia.ranieri@uleth.ca](mailto:Julia.ranieri@uleth.ca) or 587-220-3821. Your support in this project would be greatly appreciated.

**Appendix E: Referral Phone Numbers**

- 1) Lethbridge Counselling Services: 403-942-0452
- 2) Associates' Counselling Services Inc: 403-381-6000
- 3) Crossroads Counselling Centre: 403-327-7080
- 4) YWCA Lethbridge & District: 403-329-0088
- 5) Distress Line of South Western Alberta: 403-327-7905 OR 1-888-787-2880
- 6) Lethbridge Family Services: 403-317-4624
- 7) University of Lethbridge Counselling Services: 403-317-2845
- 8) McMan Youth Family and Community Services Association: 403-328-2488

## Appendix F: Consent Form



# Appendix A

## PARTICIPANT (ADULT) CONSENT FORM

---

### **The Experience of Pet Companionship in the Natural Healing of Diagnosed Eating Disorders, and Self-Identified Disordered Eating Behaviours, Attitudes, and Experiences**

You are being invited to participate in a study entitled THE EXPERIENCE OF PET COMPANIONSHIP IN THE NATURAL HEALING OF DIAGNOSED EATING DISORDERS, AND SELF-IDENTIFIED DISORDERED EATING BEHAVIOURS, ATTITUDES AND EXPERIENCES that is being conducted by JULIA M RANIERI. JULIA M RANIERI is a GRADUATE STUDENT in the Faculty of Education at the University of Lethbridge and you may contact her if you have further questions by e-mail at [julia.ranieri@uleth.ca](mailto:julia.ranieri@uleth.ca).

As a graduate student, I am required to conduct research as part of the requirements for a degree in Master of Education Counselling Psychology with a focus on addiction and mental health. It is being conducted under the supervision of Dr. Trent Leighton and Dr. Em Pijl. You may contact Dr. Leighton at 403-332-4536.

The purpose of this research project is to explore the meaning, through stories, of adult individuals of all genders who have experienced the healing of a diagnosed eating disorder, or self-identified disordered eating behaviours, attitudes, and experiences, through the assistance of informal pet companionship. In examining the stories of the lived experiences of these individuals, meaning and themes will surface to elucidate the role that pet companionship may have for individuals who have healed from these disordered eating behaviours or from diagnosed eating disorders. Utilizing a narrative inquiry theoretical perspective, the researcher seeks to understand the individual's story of natural healing from self-identified disordered eating behaviours, attitudes, and experiences, and eating disorders, through the companionship of a pet.

Research of this type is important because disordered eating behaviours, experiences, and attitudes are separate from having a diagnosis of an eating disorder; while disordered eating behaviours may be symptoms of eating disorders, individuals who experience these symptoms are not limited to having a diagnosis. Understanding these personal narratives may further help researchers to develop a greater understanding of the bond between an individual and a pet, which may help to increase an individual's resiliency as well as their capacity to self-soothe in the absence of other supports. These potential outcomes may result in a decreased need to rely on medical treatments. Furthermore,

understanding this bond may decrease the time needed in engaging in therapeutic models and could potentially become a treatment modality itself.

You are being asked to participate in this study because you have either been diagnosed with an eating disorder, or have self-identified that you experience disordered eating behaviours, attitudes, and experiences and feel that these negatively impact your life. You also feel that your pet companion has helped you in your recovery.

If you agree to voluntarily participate in this research, your participation will include a screen process and a semi structured individual interview.

Participation in this study may cause some inconvenience to you, including emotional discomfort or distress. There are some potential risks to you by participating in this research and they include emotional discomfort or distress. To prevent or deal with these risks the following steps will be taken: a list of mental health specialists within the city of Lethbridge is included in this consent form to support you emotionally and psychologically. In order to prevent any stress regarding being seen in an interviewing location, the location of the interview will be at the University of Lethbridge for individuals living in Lethbridge, or via Skype for individuals living outside of Lethbridge.

The potential benefits of your participation in this research is that, while there are no known benefits to participating in this research, your participation may improve our understanding of disordered eating behaviours and related factors of improving symptomology. The results of the study may help to encourage other individuals with an eating disorder, or with disordered eating behaviours, attitudes, and experiences, to work together with their pet to ameliorate their symptoms.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will not be utilized in the research.

To make sure that you continue to consent to participate in this research, I will continually ask you for consent, from obtaining consent to the screening process, to gaining written consent about entering the study. When you enter the study, I will go over the consent prior to the individual interview process. After the individual interview, I will again gain verbal consent from you to ensure that you feel comfortable remaining in the study.

In terms of protecting your anonymity, you will be permitted to self-select a pseudonym and will have the contact information of my research supervisor, my own contact information, and the contact information for the University of Lethbridge Research Ethics Board. Your identity will also be kept confidential from any other members of the research team including the supervisory committee.

Your confidentiality and the confidentiality of the data will be protected by consent, with the exclusion of disclosure of abuse of a child, or of an elder or dependent, as well as the

threat to harm themselves or others. Data will be collected utilizing a digital recorder which will be kept on my person or in a locked cabinet with the exception of when it is being utilized in an interview setting or during a transcribing session. Further notes may be made with paper and a pen during the interview process. These notes will also be utilized to probe a participant during the interview, and will be kept in a locked cabinet until the end of the transcription. All locked cabinets will be located in locked offices. Furthermore, all recordings will be placed on a password protected laptop which will also be kept in a locked room.

Other planned uses of this data include being disseminated in journals, within a written thesis, at professional conferences and potentially at community events.

Data from this study will be disposed of. Once the transcription is complete, the electronic data will be destroyed/deleted. Upon concluding the research, the printed data will also be destroyed. Copies of the consent form will be kept for five years.

It is anticipated that the results of this study will be shared with others in the following ways: journals, written thesis, professional conferences, and community events.

In addition to being able to contact the researcher [and, if applicable, the supervisor] at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting Dr. Scott Allen, the Chair of the Faculty of Education Human Subjects Research Committee at the University of Lethbridge (403-329-2425).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

---

*Name of Participant*

---

*Signature*

---

*Date*

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***