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The Relationship Between Family Communication Patterns, Conflict Strategies, and the Development/Management of Eating Disorders

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Murray State University Honors College

HONORS THESIS

Certificate of Approval

The Relationship Between Family Communication Patterns, Conflict Strategies, and the Development/Management of Eating Disorders

Ana Moyers
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Organizational Communication & Leadership

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The Relationship Between Family Communication Patterns, Conflict Strategies, and the Development/Management of Eating Disorders

Submitted in partial fulfillment
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Abstract

Eating disorders persist as one of the most prominent psychological and physiological illnesses among young adults and adolescents. Nonetheless, most research in the field focuses on external factors that influence the development of these disorders such (i.e., social media and an idolized body image). There is less research to investigate the role of an individual's environment, more specifically the family dyad and communication related to such eating disorders. The family unit remains, often, the primary means of socialization for individuals during developing years, thus, this study seeks to expand on how current family communication and family climate contribute to eating disorders by examining the relationship between family communication patterns and conflict strategies in the context of eating disorders/disordered eating behaviors utilizing grounded theory, more specifically, selective and axal coding, to determine this relationship as the phenomenon and its conditions to determine 4 emerging themes told through participant exemplars. The qualitative study entails interviewing and surveying participants in order to assess themes between specific family communication patterns and conflict strategies as well as deep "heart-of-the matter" contextual interview data, to construct a deep understanding/narratives of how eating disorders are communicated in interactions and to construct themes that may be helpful, going forwards, in the eating disorder context.

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Literature Review

The family dyad persists as the primary source of socialization for individuals; familiar norms, values, and means of communication are dictated by extrinsic and intrinsic variables that, by definition, define the family dyad. Baxter (2004, 2011) and Leeds-Hurwitz (2006) further defines the role of the family in socialization by defining the 'talking family' as "how families are socially constructed, negotiated, and legitimated in the discourse of relational parties." By this notion, family serves as the fundamental means for human development, only to be furthered through accompanying the means of society, with respect to individuals' social foundation, holding the potential to either aid in the development of mental illnesses (i.e., eating disorders) or serve as preventative measures of such. Johnson, Cohen, Kasen, & Brook (2002) suggest that "patients with severe eating disorders have elevated rates of physical illnesses, psychiatric disorder, suicide, and mortality" (p. 545). Eating disorders are defined as an abnormal fixation on food, body weight, body image, thinness, etc., conceptualized by its antecedent conditions that contribute to risk levels associated with the likelihood of developing an eating disorder, including the connection between the family dynamic and communication, more specifically, family communication patterns and conflict styles as stressors, serving as triggers for at-risk adolescents and patients at risk of relapse (Anxiety & Depression Association of America (ADAA).

Classification of Eating Disorders (Determined by the Anxiety& Depression Association of America (ADAA)

Eating disorders can be characterized into five classifications, as determined by the Anxiety & Depression Association of America: Anorexia Nervosa, Binge Eating Disorder, Rumination Disorder, Other Specified Feeding & Eating Disorder (OSFED), and Unspecified Feeding & Eating Disorder (UFED). Anorexia nervosa is characterized by the restriction of food intake which results in weight loss or an inability to maintain healthy weight for individuals' height, age, stature, etc.; symptoms include significant loss of weight, isolation from support systems (i.e., family, friends, activities, etc.), preferring layered clothing to hide the individual's body, a preoccupation/obsession with nuances of food (i.e., calories, quantity of intake, dieting,), and engaging in binging behaviors, considered its own eating disorder, however, incorporated by the ADAA as a potential symptom of anorexia nervosa. Bulimia nervosa is defined by binging behaviors followed by an uncontrollable "need" to dispose of intaken food through induced vomiting; evidence of binging disorders includes frequent visits to bathrooms, consumption of excess amounts of food during a limited time-interval, consumption of excessive amounts of water or breath-freshening products to mask evidence of purging (inducing vomiting), and developing dental breakdown. The second ADAA-characterized eating disorder is binge eating disorder (BED) which is defined by the organization as a disorder that is centered on the consumption of excessive amounts of food during a limited time, often quickly and to the point of producing physical discomfort, typically promoting the development of bulimia as a supplementary eating disorder stemming from a sense of lack of control over the act of eating, used as a countermeasure to the excessive food consumption.

> BED is one of the newest eating disorders formally recognized in the DSM-5. Before the most recent revision in 2013, BED was listed as a subtype of EDNOS (now referred to as OSFED). The change is important because some insurance companies will not cover eating disorder treatment without a DSM diagnosis. (ADAA, 2022).

Other specified feeding & eating disorders (OSFED), previously referred to as Not Otherwise Specified (EDNOS), is considered a classification that encompasses other disorders that do not inherently meet the criteria or symptoms to be classified into the other two eating disorders. The symptoms of this "all-encompassing" disorder are a culmination of various eating disorders such as purging, binge eating, while also engaging in excess exercise, etc. However, in contrast, the "newest" eating disorder classification, of avoidant restrictive food intake disorder (ARFID), previously referred to as selective eating disorder, follows the restrictive eating behaviors of anorexia, however, differs in the means for such restriction; ARFID focuses on a variety of means for its development such as an apparent disdain for certain food or food groups, an obsession with health and well-being, or trends that become all-encompassing under the pretense of self-betterment; where most children undergo a period of "picky eating," individuals with ARFID see the retention of such patterns into adulthood or the development of such during adulthood. Common identifiers of ARFID are restriction of food, similar to anorexic restrictive behaviors, picky eating that continues to worsen, limiting the variance in diet, fears of choking or vomiting, therefore, food intake is limited to avoid such fears, a lack of body dysmorphic behaviors or fear of weight gain, and the consumption of items that are not considered food-based, also referred to as Pica. The fifth classification of eating disorder, by the ADAA, is rumination disorder, characterized by an inherent need/want to regurgitate; these individuals do not make it apparent in engaging in such behaviors, and unlike bulimia, in which vomiting is

induced, rumination does not involve the expelling of food. Differing from the other six classifications, Unspecified Feeding or Eating Disorder (UFED) focuses on the societal and personal effects that the disorder has on the individuals; the behaviors vary across the eating disorders by which this disorder, like OSFED, cannot be characterized into just one disorder. This disorder is often diagnosed by physicians when the means for which the development of the eating disorder is unidentifiable or lacks clarity.

Stress as a Trigger for Eating Disorders & Disordered Eating Behaviors

Stress, as a result of, daily and major, life-altering/inconveniencing events correlates to unfavorable/unwanted psychological and behavioral in adolescents (Compas, Howell, Phares, Williams, & Giunta, 1989; Wagner, Compas, & Howell, 1988). Stress produces abnormalities in eating patterns due to adverse reactions/emotions that result in either the restriction of food intake or the over-consumption of such; while normal in small intervals (i.e., restrictions or over-consumption resulting from stress lasting temporarily), eating disorders develop when the temporary turns to permanence, engaging in a cycle of destructive behaviors with unproductive or nonexistent coping mechanisms. Rosen, Compas, &Tacy (1993) determined that results produced a correlation between stress and disordered eating behaviors, in addition to incorporating depression as a contributing factor. As cited from (Rosen, Compas, &Tacy, 1993):

> The only truly prospective risk study to date was by Attie and Brooks-Gunn (1989). These scholars attempted to predict eating disorder symptoms in adolescent girls 2 years after an initial assessment by controlling first for Time 1 symptoms and then entering a battery of Time 1 predictor variables, including measures of psychopathology at baseline. This study was more appropriate for questions of prediction over time.

This study sets forth evidence that supports the assertion that stress, stemming from various areas of daily life/interactions, including those of the family, is a contributing factor to disordered eating behaviors as means of coping with such stress. Going further to create the association between stress, emotional inconsistency, taking form in psychopathology, and the development of eating disorders as a result of emotional inconsistency, as a result of family stress and ill conflict management.

However, Rosen, Compas, & Tracy (1993) identified two limitations to the Attie & Brooks-Gunn (1989) study: the influence of stress and psychopathological factors in the development of eating disorders and the temporal nature of the variables were not studied in full. However, Rosen, Compas, & Tracy (1993) studied girls, recruited from three independent secondary preparatory schools in the Northeastern United States, who were asked to complete a questionnaire, in a longitudinal study, with questionnaire I completed in January and questionnaire II completed in May. The subjects completed various surveys (i.e., Eating Attitudes Test,) that sought to uncover the relationship between stress and psychological symptoms, to eating disorder symptoms. The study found that there was not a salient correlation between psychological symptoms and eating disorder symptoms to the development of eating disorders as originally predicted. However, rather that it was the third factor tested, stress, that had a greater correlation to the likelihood of the development of eating disorders and disordered eating behaviors. This determined that there is an interdependence between eating disorder symptoms and stress. Stress was found to have a direct correlation to developing eating disorder symptoms; additionally, a similar relationship was determined between eating disorder symptoms and stress, suggesting that regardless of which variable occurred primarily, each possesses the potential to develop/influence the other. The study sets forth the foundation for the

current study in determining that while pre-existing psychological illness, harm, or conditions directly influence the development of eating disorders, the greater contributing factor, also preexisting as a contributing factor of such psychological conditions determined to cause eating disorders, is stress.

Looking, more specifically, at stress as a variable in eating disorder development/maintenance and treatment, stress within the family unit possesses salience in such behaviors. Cowan (1991) identifies that family stressors are categorized into two categories: normative and nonnormative family stressors. Normative family stressors are those originating from normal changes in family life through time (i.e., birth, death of the elderly, marriage into a family, etc.); non-normative family stressors, contrastingly, are difficult to predict as these are stressors that arise without warning, often a result of life's own unpredictability, and may not occur the same in across family units (i.e., serious illnesses, death, divorce, financial hardships due to unforeseen circumstances, etc.). However, it is important to acknowledge that these normative and nonnormative family stressors hold the ability to cross into each other as seen in the example of divorce being categorized as nonnormative, however, there may be symptoms of distress in a marriage, leading to divorce, that, then, would be considered normative. Yet, the salience of these differences comes together in its morphogenesis, the tendency that families are sure to change regardless of the type of stressor. Another means of categorizing family stressors came from Adams (1975) who determined that family stressors can either be temporary or permanent, furthering with another dimension of family stressors as either voluntary or involuntary; this relativity of timeliness and the voluntary nature of stressors determines family reaction and severity of impact when looking at family communication patterns and conflict strategies. This frequency and permanency of family conflict, and its stressors, persists as a

constant in the prediction of the likelihood of an individual developing an eating disorder and the management of sed eating disorder once it is present and, later, identified.

The ABC-X Model of Stress (1949)

Hill (1949) determined that there are systemic variables that impacted the family experiences as to whether the family units handled the stressors of family members returning from World War II well or not. The model is named after the four factors that Hill determined influence family stress: stressful events or situations (A), family resources (B), family perceptions (C.), and stress and crisis (X).

A stressful event or situation (A) is defined as "an occurrence that provokes a variable amount of change in the family system" (McKenry & Price, 2000, p. 6). This is to suggest that any event or situation that has the potential to invoke change possesses the same potential to cause stress. In terms of family dynamics, the change is referred to as a change to the family's structured routine, and when such routines are disrupted by change, stress occurs; in this disruption, pre-established roles or expectations of how the family is to function are lost or forced to be altered to reestablish harmony. It is important to note that change can be either positive or negative and that positive change holds the same means to produce stress, as the stress is centered in the change (stressful event or situation) rather than its framing of positive or negative.

Family resources (B) are traits, abilities, and qualities of individuals within the family system, the system itself, and the environment that surrounds the system used to address the stressful event or situation (McCubbin & Patterson, 1985). Family resources are able to be pulled in order to mediate a problematic situation; for instance, an individual within the family system loses their job, however, other individuals in the family are able to mediate the situation by helping out financially. However, where situations become problematic is when the family

system and its parts do not hold the resources necessary to mediate the negative impact of (A), creating vulnerability to a disruption in the system, and by extension, stress.

Family perception (C) is the family's "appraisal, assessment, or definition of the event or situation," (Segrin & Flora, 2011, p. 209). There is a variance in how different individuals appraise conflict and stress and, by such, a variance in how family units appraise stress. Segrin & Flora determine that the families in which are able to better navigate stressful events and situations are those that are able to reframe, and appraise, the conflict or stress as positive, allowing families to clarify issues, decrease the emotional burden, and encourage normality.

The X factor, in Hill's ABC-X theory, represents the stress or eventful occurring and experienced by the family as a product of the event, resources, and family perceptions. The stress created and experienced by the family is their reaction to the event, filtered through the resources and perceptions (Segrin & Flora, 2011, p. 209). It is important to view stress and family stressors as a continuum which relies heavily on framing to take meaning; not all stress is negative and may be required to push the family system further, encouraging the cease of unfavorable behavior due to unwanted change (stress).

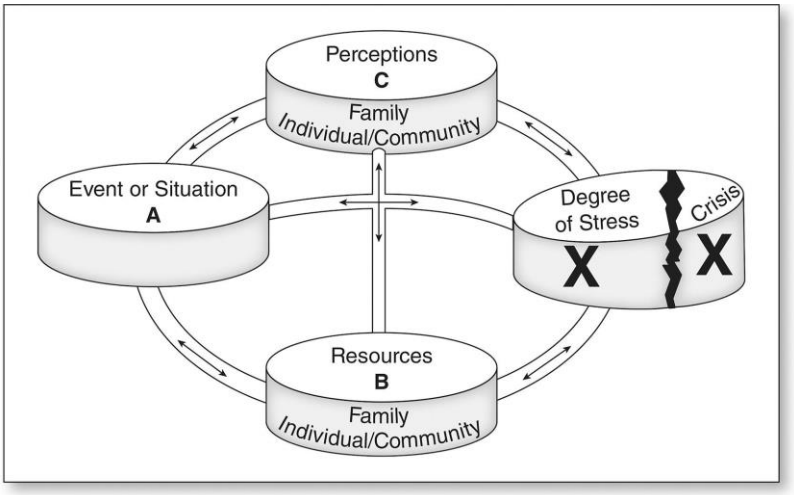

Figure 1: Hill's (1949) ABC-X model of family stress.

Note: Taken from SAGE publications

Family Communication Patterns

Families, as complex entities, possess their own means of operation and communication as systems, as there are various interacting agents that influence the unit and its cohesion. Littlejohn & Foss (2008) determined characteristics of the family unit: interdependence, families are more than the sum of its parts, and there exist systems within systems. Families and their members hold an interdependence founded on the effect that any given individual holds in regard to the unit. The authors found that the actions of one individual in the family have a significant effect on the actions/feelings of the other members of the family system. Adler, Rosenfeld, & Proctor II (2018), determined characteristics of the family unit: interdependence, families are more than the sum of its parts, and there exist systems within systems. Families and their members hold an interdependence founded on the effect that any given individual holds in regard to the unit. The authors found that the actions of one individual in the family have a significant effect on the actions/feelings of the other members of the family system. "If, for example, one family member leaves home to marry, or a parent loses a job, or feuding siblings stop talking to one another, the system is no longer the same. Each event is a reaction to the family's history, and each event shapes future interaction" (Adler, Rosenfeld, & Proctor II, 2018, p. 304). In this interdependence, while parts of the family system are unique in nature, possessing their own beliefs, thoughts, and personalities, the family, as a unit, is greater than the sum of these individual parts. There is an understanding that can only be reached through looking at the system through the interaction of its units together in forming the system; when parts interact with one another, they establish a new means of communicating that is bound by such interaction, no longer bound only to an individual's communication and intent, but one that is a culmination of all individuals' intent/communications. Therefore, individual communication

patterns are likely to change when engaging in group/family interactions. Additionally, families are systems that are present in larger systems; Adler, Rosenfeld, & Proctor II (2018) found that subsystems exist within family units, giving the example of within a heterosexual family of four, there are six possible subsystems: mother and father, mother and son, mother and daughter, father and son, father and daughter, and daughter and son; with the number of subsystems varying dependent on the individual family system. Each subsystem produces its own set of norms and means of interaction that differentiates from other subsystems within the dyad or system.

Additionally, Koerner & Fitzpatrick (2006) identified two categorizations of communication in family communication: conversation and conformity. Conversation orientation prioritizes open, productive communication in which each participant feels empowered in participating in a positive communication climate about topics, issues, conversations, etc. Families that are considered high in conversation orientation interact openly, often, and authentically, facing few limitations to their communication/interactions. For instance, "conversation-oriented families enjoy telling family narratives and strengthen their bonds by doing so" (Thompson & Schrodt, 2015). Conversely, families with low conversation orientation do not engage in communication frequently and typically view most communication as negative or as a lesser means to a goal rather than a means to attain such goal. Families found to possess a higher conversation orientation produced individuals with greater, more well-rounded, and confident interpersonal communication skills applicable in future interactions. Koerner & Fitzpatrick's second characteristic of family communication is that of the presence of conformity in family interactions/communication. Conformity-orientation refers to the emphasis placed on the uniformity of values, beliefs, rules, etc. within the family unit. High-conformity-oriented

families prioritize the group-think mentality that is centered in common attitudes and responses, discouraging thinking that seeks to contradict the precedent set forth by the family. These families are categorized by their hierarchical nature in which certain family members (i.e., parents or elder members) possess greater authority over the units in the system and, thus, possess greater decision-making power. In contrast, low-conformity-oriented families prioritize independence, free-thinking, expression, and individuality within their system, encouraging individuals to engage in communication that questions the status quo while expressing their thoughts in an open, positive communication climate, similar to that of conversation orientation. This is not to say that low-conformity orientation encourages a lack of respect and adherence to authority within the family unity, but rather that instead of holding a mentality in which in order to be productive as a system, the units must adhere to the precedent of superior governing agents (i.e., family members with more authority); the system is organized in such a way that each unit possesses authority that when communicated within the system's parts results in open dialogue aimed towards the same goal with mutually-satisfying operations.

Conversation and conformity orientations interact to form four family communication patterns: consensual, pluralistic, protective, or laissez-faire; each with varying levels of conversation and conformity orientation. Consensual families rank high in both conversation and conformity. According to Adler, Rosenfeld, & Proctor II (2018), "Communication in these families reflects the tension between the pressure to agree and preserve the hierarchy, and an interest in open communication and exploration," (p. 305). In this pattern, the individuals would feel a sense of safety in communicating their thoughts and feelings about a subject due to authority figures interacting with open minds and understanding while holding an understanding that the formalized decision will fall to the authority figures. Pluralistic families are high in

conversation orientation but low in conformity orientations; in this family communication pattern, communication is open without limitations, however, decisions would be developed on the basis of group discussion in which opinions are surveyed by their own merit in an ongoing, supportive, collaborative process. Individuals in consensual or pluralistic families develop confidence and flexibility in communication while refraining from engaging in verbally aggressive or passive-aggressive verbiage as they are met with open, healthy communication patterns. Contrasting consensual and pluralistic family communication patterns, the protective family pattern ranks lower in conversation orientation while scoring higher in conformity orientations, prioritizing obedience to authority with a reluctance to share thoughts on the basis of such obedience and limited discussion. Laissez-faire families, however, hold both low conversation and conformity orientations marked by a limited interaction between the units of the system, seen through disassociation, emotional distancing, and communication marked by indifference. Noeller (1994) stated that "coercive parenting seems to give only negative messages to young people about themselves and their own worth" (p. 56). Thus, Individuals in protective or laissez-faire family communication patterns develop, in contrast to consensual and pluralistic, a lack of confidence and flexibility in communication identified through emotional suppression in adhering to the hierarchical value system.

Family Communication Patterns and Eating Disorders

Botta & Dublao (2002) determined that looking at family communication patterns specifically centers on the verbal interactions between those in family systems through the dimensions of conformity and conversation orientation. Various studies have concluded that there is a relation between family communication patterns and the development of eating

disorders; Blouin, Zuro, and Blouin (1990) concluded in their study that families which limit expression and conformity orientation, also categorized into either protective or laissez-faire family communication patterns, ranking low on conversation orientation, have seen a greater development of bulimia nervosa in their family system. Killian (1994) furthers the conclusion found by Blouin, Zuro, and Blouin (1990) by suggesting that these families with low priority on expression also rank lower in open communication, an indicator of either the laissez-faire or protective family communication patterns. Similarly, Kog and Vandereycken (1989), in their research, asserted that families with anorexic and/or bulimic individuals showed avoidance tendencies when managing conflicts within the family system more than those without eating disorders. Therefore, there is a relationship between family communication patterns, under the conformity orientation, and the development/handling of eating disorders within the family unit. Noller, Seth-Smith, Bouma, and Schweitzer (1992) found that more "democratic" parenting, prioritizing autonomy, free will, and open communication, results in a positive self-view among individuals with and without eating disorders; while, opposing this, those with a coercive parenting style, focused on control, conformity, and adherence to the family hierarchy and power dynamic, will tend to foster an environment of negative self-view and worth. Applied to family communication styles, conversation-oriented communication styles, (i.e., consensual & pluralistic), tend to foster open, positive communication, resulting in this secure sense of self-view; in opposition, those centered in conformity orientation, (i.e., protective or laissez-faire), result in the opposite result, a diminished self-view. By extension, this negative self-view persists as a variable capable of initiating or prolonging the development of eating disorders. Bruch (1982) suggests that there is a trend that families with anorexic individuals seemly held/hold weight on conformity to the family values and roles determined by the hierarchy; relatively,

Head and Williamson (1990) declared that, similar to Bruch's (1982) findings of conformity, when looking at bulimia nervosa, those with an eating disorder seemly had a family background of communication patterns centered in restriction and control by the parents, mirroring the disordered eating behaviors that developed as a result. There appears to be a supported relation between the behaviors exhibited by those with eating disorders and the family communication pattern to which these individuals were exposed during their developmental years.

Conflict Strategies

Blake and Mouton's (1964) two-dimensional grid of concern for self and others depicts five conflict strategies: competing-dominating, collaborating-integrating, compromising, avoiding, and accommodating-obliging (Rahim, 1983; Thomas & Kilmann, 1974). The competing conflict strategy presents high in self-concern and low in concern for others, prioritizing self-interest, and a "win-lose" mentality. Secondly, the collaborating conflict strategy presents high in both concern for self and concern for others; this strategy is marked by a balance between assertiveness and collaboration, with priority given to a "win-win" mentality seeking mutual satisfaction. The compromising conflict approach takes on an "I win, you lose; you win, I lose" mentality, signified by a give-and-take style in which both parties accept responsibility to concede on facets of their self-interest to determine a resolution between each self-interest. The compromising strategy is often unassertive, but collaborative in communication due to the goal of achieving compromise. The accommodating conflict strategy ranks highly in concern for others but low in concern for self, with communication marked by its collaborative but unassertive nature in an "I lose, you win" framing. Contrastingly, the avoiding conflict strategy presents low in both concern for self and concern for others in which the goal is centered on neither collaboration nor assertiveness but in avoiding conflict altogether.

Constantine's Model of Family Conflict, Attachment, and Depression (2006)

Constantine (2006) determined that one means by which family conflict increases the risk of developing depression and stress (i.e., a prominent trigger in eating disorders) is through a weaker attachment to parents. The purpose of Constantine's 2006 study focused on hypothesizing the degree to which parental attachment affects family conflict and depression. Segrin & Flora (2011) illustrate the significance of Constantine's findings that high family conflict resulted in a stark decrease in familiar trust and communication, increasing alienation from the parent or family unit. It is this apprehension and tension between parent and child that sets precedent for the development of depression and stress which, additionally, persists as a trigger for the development of eating disorders.

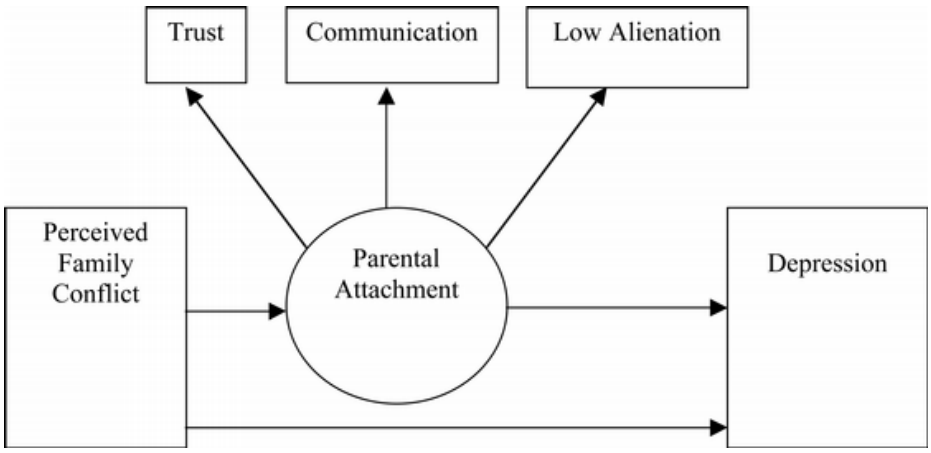

Figure 2: Constantine's model of family conflict, attachment, and depression.
Note. Taken from Constantine, M.G. (2006). Perceived family conflict, parental attachment, and depression in African American female adolescents. *Cultural Diversity and Ethnic Minority Psychology*, 12, 697-709. Published by the American Psychological Association.

Family Conflict & Eating Disorders

A study conducted by Vesna Vidovic et.al., (2005) investigated family cohesion, flexibility, and communication, between adolescent girls and their mothers, in regard to eating disorders. Families perceived to hold lower family cohesion and flexibility were seen to have had greater apprehension in communication with their parents, more specifically, the mother. The results of the study confirmed the existence of differentiations between subtypes of anorexic and bulimic individuals, and, simultaneously, similarities in bulimia originating out of anorexia and anorexia nervosa in which conflict avoidance and denial towards the restrictive behaviors of anorexia, and its ability to intersect into bulimic and other disordered eating behaviors, resulted in the favorable view towards the need for family cohesion and communication. However, it is important to note that conflict, like stress, can hold positive results and, thus, must be viewed as a primarily normal component of human and family interaction; where the separation between conflict as normality and conflict as a stressor, or variable, in the development of eating disorders, is in the framing of such as inherently negative. Unresolved conflict, more specifically within the family system, becomes dysfunctional and increases stress for adolescents, later to manifest in emotional invulnerability and consistency, mental health issues, and severe psychological and psychological issues, as supported by Botta & Dumlao (2002) who determined, "[...] when it is not resolved in an adequate manner, increased conflict becomes dysfunctional and may lead to psychopathology for the adolescent," (p. 204). Noller's et. al (1992) determination of self-view being determined by either the democratic or coercive parenting style, gave means to the connection between the conversational-oriented family communication patterns resulting in a positive self-view compared to the conformity-oriented family communication patterns resulting in a negative self-view which exists as a prevalent

trigger for eating disorders. In this, the connection can also be made that mismanaged conflict, or conflict strategies falling under the same conformity orientation (i.e., competing-dominating and avoiding), will produce the same negative self-view that exists as a variable for eating disorder development/mishandling. Dare, Le Grange, Eisler, & Rutherford (1994) and Shugar & Krueger (1995) concluded that anorexic families tend to fall under the avoidance conflict strategy as bulimic families fall under competing-dominating conflict strategies through outbursts of conflict. Anorexic individuals exhibit restrictive behaviors that are a result of the family conflict strategies focused on avoiding conflicts in which the child internalizes an inherent need of withholding feelings associated with their eating disorder in the fear of creating conflict that will ultimately be disregarded. Thus, these families tend to see individuals developing accommodating-obliging conflict strategies to deal with the avoidance of their family system, adhering and submitting to the wants and needs of the family. Family communication patterns and conflict strategies in the scope of the family environment maintains a prevalence in the development/effective or ineffective management of eating disorders, setting forth the framework for this study. In order to further understand the established framework, the following research questions are asked:

RQ1: How do family communication patterns influence the stress of eating disorders?

RQ2: How do family conflict strategies influence the stress of eating disorders?

Methods

Qualitative research divulges the human experience, is used to develop an understanding of complex phenomena, and its interacting entities/relationships. (Strauss & Corbin, 1991).

Data Collection

Seventeen participants (P) were gathered through the use of an Institutional Review Board (IRB) approved recruitment statement with the majority of the sample size originating from Murray State University students. After signing the consent form, outlining the structure, content and processes of the interview, participants engaged in an estimated 1 hour interview surrounding their experience with family communication patterns, conflict strategies, eating disorders, and the relation between the three, in which questions were asked surrounding family communication, conflict within the family and strategies used in mediating such conflict, and participant eating disorder history. The recruitment goal was to recruit individuals to share their experiences with family communication patterns, stress, conflict strategies, and the development/management of eating disorders, giving participants the opportunity to share their experiences in order to further the research in the field of health, interpersonal, and family communication. Participants met the criteria if they held any inclination of having/have had an eating disorder or disorder eating habits. The sample size was not limited by any demographic or psychographic information. 17 interviews resulted in 421 minutes of material. Interviews ranged from 20 minutes to 60 minutes.

Interviews were conducted in a behind-closed-doors setting in which data was collected by completing an audio-recorded, semi-structured interview, transcribed verbatim. An interview guide was created in order to guide conversation in regard to various aspects of dating disorder development/management and their experiences with family communication and conflict. For

instance, “do you believe your family has/had an open, positive communication mindset?,” “if there was ever conflict in your family, how would you describe the way it was handled in your family?” “did you ever have to minimize yourself in an attempt to resolve the conflict or please your family?” and “how has your family life/family communication affected your eating habits?” were sample questions asked to participants. Table 1 represents the breakdown of participant sample demographics. Table 2 represents the breakdown of specific eating disorders held by the participants.

Table 1 Demographic Characteristics of Participants
(*N* = 17)

Characteristics	*n*
Gender	
Male	0
Female	17
Age (years)	
18	5
19	3
20	5
21	2
>21	2
Ethnicity	
Caucasian	16
African American	0
Hispanic	0
Other	1
Education Level	
College Freshman	6
College Sophomore	5
College Junior/ Senior	6

Table 2: Specified Eating Disorders
(*N* = 17)

Identified Eating Disorders	*n*
Identified Eating Disorders	
Anorexia Nervosa	4
Bulimia	3
Rumination Disorder	1
Other Specified Feeding & Eating Disorders (OSFED)	0
Unspecified Feeding & Eating Disorders (UFED)	6
Cross-Identified	3

Data Analysis

Interviews were tested utilizing grounded theory, derived from the phenomenon it represents, (Strauss & Corbin, 1991, p. 23). Grounded theory uses discovery, development, systematic data collection, and the analysis of such data pertaining to a phenomenon. Axial coding, a set of standards for analysis in which data is categorized through coding paradigms to discover connections between these categories, was used to identify causal conditions (i.e., conditions that lead to the phenomenon) and the actions/interactions that occur within the phenomenon of the relationship between family communication patterns, conflict, strategies, and the development/management of eating disorders. In addition, in the methodology, selective coding was utilized in interpreting data collection to expand on axial coding through the refinement of connections (themes) found through the categorizations, filling gaps in understanding through the validation of relationships between such categories and phenomena; selective coding allowed the research data to be interpreted through the identification of the data as a storyline by which the relationships serve as primary actors. For instance, the connection between family conversation-oriented family communication and effective eating disorder management and the connection between conformity-oriented family communication and ineffective management of eating disorders resides as the phenomenon, under the paradigm model, in which the causal conditions of stress, family communication patterns, and conflict strategies (variables that leads to the development of eating disorders) interact with the context of the family environment, family conflict/stress, and eating disorders, with intervening conditions of the family (i.e., the family authority/hierarchy, trust, communication, level of alienation, etc.), and an outcome of either effective or ineffective management of eating disorders and conflict/stress. Grounded theory analysis produced four emerging themes: (T1) Conformity-

oriented family communication patterns (i.e., protective & laissez-faire) increase family stress and the stress of eating disorders, resulting in the ineffective management of the eating disorder (i.e., anorexia & bulimia as the predominant eating disorders), (T2) Conversation-oriented family communication patterns (i.e., consensual & pluralistic) decreased family and eating disorder stress, resulting in effective eating disorder management, (T3) The management of stress and its conditions (i.e., trust, communication, low alienation) through the use of collaborating-integrating, compromising, and accommodating-obliging conflict strategies result in the effective management of eating disorders, and (T4) The management of stress and its conditions through the use of competing-dominating and avoidance result in the ineffective management of eating disorders.

Findings

Research question one asked how do family communication patterns influence the stress of eating disorders. Two themes emerged from the influence of family communication patterns on the stress of eating disorder management: T1 & T2. Research question two asked how family conflict strategies influence the stress of eating disorders, resulting in two additional themes: T3 & T4.

Conformity-Orientation, Laissez-faire Family Communication Pattern, & Ineffective Eating Disorder Management (T1)

Conformity-oriented family communication patterns (i.e., protective) and the laissez-faire family communication pattern, were found by participants to have an increased impact on family stress and the stress of eating disorders, resulting in the ineffective management of the disorder. Participants whose families engaged in protective and laissez-faire family communication patterns reported a negative association with conflict and their ability to communicate/disclose

within the family unit. The protective family communication pattern, ranking low in conversation-orientation and high in conformity-orientation, prioritizes the family hierarchy and power dynamic over positive dialogue and conversation; in this pattern, family members that engaged in protective communication prioritized the "I am right, you are wrong," mentality in which power is asserted over the child which produces high alienation from the family and low disclosure, as seen in *Figure 2*, and participants illustrated an diminished self-worth due to continuous scrutiny by the family due to a competing-dominating communication pattern; these individuals internalized the reality that because they hold a position on the bottom of the family hierarchy, then, as a result, their opinion/thoughts/beliefs did not matter in the grand scheme of family operations, creating a viewpoint on disclosure, within the family system, as relatively negative. For instance:

> Instead of expressing concerns and then getting reasoning for those concerns, which is typically how I need that to be addressed. She (i.e., the mother) more so yells, and she tells me what to do, and she doesn't really hear what I have to say or what anyone else has to say. It's kind of like her way or the highway type of deal. Which was very like hard on me growing up because like I've been told that I'm very quiet and I am receiving therapy now. And my therapist said, 'I think this is why you're quiet: because you were screamed at your whole childhood by your mom. And since you were screamed at your whole childhood, and you saw what happened whenever you stopped yourself' (P7)

As a result, the individuals chose to withhold private information from the family in order to protect their self-worth. It was later identified, by a medical professional (i.e., the participant's therapist) that this competing-dominating pattern in which the participant was met with continuous discourse when disclosing or interacting with the family was the cause of self-

isolation/censorship in which it is easier to withhold then to engage with the family which was later brought into future relationships/interactions. Individuals who described increased levels of alienation in association with the protective family communication pattern due to a strict priority on the family power dynamic, stripping family members lower on the hierarchy (i.e., the child) of their autonomy in family decision-making and communication, stated that an increased alienation from the family produced an increased vulnerability to depression, many of which self-diagnosed themselves as being in "a depressive state" due to a lack of communication on daily and controversial issues, perpetuating the eating disorder/disordered eating. Participant nine demonstrated a relationship between this alienation and the internalization of the stress associated with depression, see *Figure 1 & 2*, to the perpetualism of their disorder, as seen in the exemplar below:

> Whenever I was really struggling with like depression and suicidal thoughts, I didn't say a single word. And I did end up attempting suicide and my mom just didn't understand why. And it's just because I just hid everything super well because we were low income and she had to work like two jobs, three jobs sometimes to keep us all afloat. So a lot of my problems were very internalized, which did make conflict kind of happen I guess, more often, because she felt like she couldn't trust me, and I felt like I couldn't trust her to be able to go to her because if I did, she would use it against me and say like, 'Oh, well, I'm not a good enough parent. Because you think I don't care about you enough. And that's why you're doing all this.' (P9)

Individuals often felt a need to minimize themselves, and their needs, in order to adhere to the family hierarchy and the decisions set forth by the family power dynamic; due to this self-minimization, individuals developed disordered eating behaviors in an attempt to cope from the

stress produced from a lack of communication within the family system. These behaviors included, but were not limited to, restriction, binge eating, constant rumination over food and nutrition, calorie counting, excessive exercise, etc.

Similarly, the laissez-faire family communication pattern produced the same result, ranking low in both conversation and conformity-orientation; this pattern focused neither on conversation nor an adherence to family structure, power dynamic, or the family hierarchy and the shared beliefs that result. In this, there is little to no communication/expectations of interaction regarding any topic, serious or pleasantries, within the family system; participants that identified with having families that conformed to the pattern of the laissez-faire family were found to also possess elevated levels of alienation in parental attachment and low levels of the expectation of family interaction.

This alienation is similar to that of the protective family communication pattern, which produced an increased family stress which when internalized by the individual led to the development of disordered eating habits and, in most cases, later, progressed into an eating disorder. The individuals within the family system are left to deal with daily stressors and inconveniencing events individually without an adherence and loyalty to the family or a need/want to communicate with the family entities. In regards to stressors, both normative and non-normative, messages in family communication suggested that the laissez-faire approach reinforced the notion that there is decreased dialogue, if any at all, and, thus, when faced with normative and non-normative stressors, see *figure 1*, the perceptions of the family would be that of avoidance, referencing the low conversation and conformity orientation, diminishing the available resources (i.e., family support) to the individuals within the family system, and when in interdependence with stressors, results in the stress transforming into a crisis mismanaged into a

break in the family system, either outright or taken form as resentment of the interacting entities. Individuals also reported having increased anxiety, holding a "walking on eggshells" mentality, when conversing within their family, regardless of the topic at hand; with many expressing a fear of asking permission to socialize or engage in activities outside of the family. This mentality served as the precedent for a lack of disclosure and comfortability surrounding conflict resolution in the family system, allowing the individuals to either self-isolate and further perpetuate the disordered eating or perpetuated an ability to illustrate a positive, normal face to the family system while the individual, in reality, is affected by severe psychological and physiological illnesses/strain, as illustrated in the below exemplar.

> I became quiet to not be seen and to kind of blend in for a while. Like whenever I got older and got to college, I would just do what she (i.e., the mother) wanted at times just to survive. I would have panic attacks at the end of each semester because I had to go home. And so, it's like a lot of things to where I have to constantly just be on guard whenever I go home. And so, growing up in that situation, where I had to just be quiet and blend in and do whatever she wanted, it was very difficult and just very mentally draining. (P7)

The narrative persisted that conformity-oriented or laissez-faire families produce children that have high alienation from the family unit due to an increase of stress by which a lack of positive communication, aimed at creating understanding and a mutually satisfying relationship/resolution, resulting in a negative perception of family conflict, and a break into crisis, (*Figure 1*). Participant 7 illustrated a high alienation from the family as there was an avoidance of communication or conflict in order "to survive." Thus, the individual developed metaphorical walls (barriers) to protect themselves from the dominating nature of the mother, and the laissez-faire pattern of the family communication resulted in a break in trust, leading to

increased alienation, and limiting communication; as a result, identical behaviors of alienation and restriction were seen in P7's eating disorder (i.e., anorexia/UFED). The participant reported engaging in behaviors such as an extreme restriction of food, counting calories, and binge eating when restriction proved futile; these behaviors were developed as a response to the communication pattern in which the individual interacted among (i.e., protective & laissez-faire), and mirroring the behaviors seen in the family communication as appropriate and acceptable as a means to cope. The constant among participants was the emphasis on an increased alienation and the internalization of conflict and negative emotions that was the result of conformity-oriented family communication patterns, prioritizing the family power dynamic and preservation of the "I win, you lose," mentality with little regards for what the child is feeling within the family system and its functions.

Conversation-Orientation & Effective Eating Disorder Management (T2)

There is a predominant theme that exists between the conversation-orientation family communication patterns (i.e., consensual & pluralistic), and effective eating disorder management. Conversation-oriented family communication patterns, consensual & pluralistic, are marked by an open, communication climate focused on democratic communication in which individual autonomy is maintained within the family unit. Consensual family communication patterns, ranking high in both conversation and conformity orientation, suggests that priority is placed on both establishing a positive, communication climate founded in the individual's autonomy to share ideas, thoughts, and beliefs openly to obtain mutual understanding and a feeling of active listening and participation from all parties interacting in the family unit. Pluralistic, ranking high in conversation and low in conformity orientation, prioritizes

conversation with less regard given to the family hierarchy or power dynamic. Participants possessing these family communication patterns exhibited better coping mechanisms when undergoing or seeking treatment for an eating disorder. These individuals established that while the eating disorder may not have originated as a direct cause of family issues, stress, or communication, the positive conversation-oriented communication pattern allowed them to feel a sense of safety in conversing about controversial topics (i.e., politics, stress, academics, etc.) however, more specifically, in regards to eating disorders and disordered eating habits, allowed individuals to maintain their sense of self and satisfy inherent needs for social/belonging and self-actualization of the person. The below narrative exemplifies this:

> Usually when there's conflict in my family, it's handled pretty normally I guess in terms of how we talk it through and sort of, you know, each person will provide their own perspective on what's happening and we'll kind of go from there. There have been times whenever my family will, like, raise their voices at each other; it's not something that's frequent. And generally, my family's communication is very open. We're comfortable telling each other things and, you know, asking each other for advice or emotional support and things like that. When I confided in my parents that I was struggling with an eating disorder or something like that, I felt like they tried to have an open conversation with me about it and try to figure out where to go from there. (P4)

These individuals felt increased comfortability engaging in open dialogue surrounding the topic of managing an eating disorder and present/potential triggers that were/are either the developmental cause or result of the developmental cause of the disorder in a mindset focused on feeling heard and understood. Parents/family members that engaged in these positive, communication-oriented communication patterns instilled confidence and positive self-worth in

their children, reassuring the notion that the family persists as a means of satisfying an individual's needs. Instilling positive self-worth into a child, especially during pivotal developmental years, through positive, reinforcing messages, better prepares the individual to face challenges outside of the family system; in addition, the consensual and pluralistic family communication patterns reinforced the notion that even in failure or hardship, the child held an opportunity to engage with the family to discuss situations and issues, without fear of alienation or judgment, and these individuals, in response, possessed an increased sense of confidence in disclosing a need/want for help/treatment as it would be met with support and conversation surrounding a positive outlook on beginning treatment or establishing a means within the family system, itself, to effectively manage the eating disorder intrinsically. The below exemplar portrays this behavior:

> I think the big thing is that my mother is very non-judgmental and is just there to listen; my mom would step in and help translate what the issue was. And I was always a very picky eater. So, when I was younger, my mom would kind of stop making meals for me, and she would just let me have control and make whatever I wanted. But when that was too many options, or too many steps, then I just wouldn't eat. And I think that was probably a big part of that. (P6)

In the case of Participant six, the individual was able to maintain autonomy over decisions in an open communication climate which allowed the individual's needs of disclosure, belonging, and communication to be satisfied, as Participant six was able to have full autonomy over what they ate; instead of the mother meeting their disordered eating with frustration at the individual refusing the meal made for the entirety of the family, she met the situation with negotiation (i.e., compromising & collaborating-integrating) to allow the participant to choose a meal that they

would be willing to eat, as the overarching goal of the interaction was to get them to eat, regardless of what it was that they ate. In this focus towards maintained autonomy, the mother integrated the child into the decision-making process, encouraging them to combat the disordered eating behaviors of the disorder through holding autonomy over their own food choices, assuming the choice satisfied basic human nutritional needs. Participants whose families engaged in conversation-oriented family communication patterns (i.e., consensual & pluralistic) set a standard of conversation-oriented communication marked by a positive communication mindset; therefore, when looking at the disclosure of the individual's eating disorders and/or a need/want for treatment, these patterns created a family environment that supports disclosure, communication, and interaction in the hopes of reaching resolution.

Behaviors associated with consensual and pluralistic family communication patterns are open dialogue, self-awareness, disclosure, a willingness to talk about issues and seek treatment, diplomatic resolution, etc. Participants who identified with having a family engaged in communication-oriented family communication patterns suggested that due to an openness surrounding communication, the family stress, as assessed through the ABC-X model of stress & Constantine's Model of Family Attachment and Depression (*Figure 1 & 2*), there was limited family stress and stressors with most stressors being normative, those occurring naturally. Examples included sibling disagreements, marriage, retirement, etc; all of which were described by participants as naturally occurring and lasting a limited or fixed amount of time. Additionally, it was concluded that, because the conversation-orientated family communication patterns allowed individuals within these families to be better prepared with the coping with the stress of normative stressors but also that of non-normative stressors (i.e., those occurring unnaturally and often unexpectedly), with examples including: death, divorce, financial

instability, etc. Those that felt a sense of autonomy in decision-making within the family went forth to determine that in being able to communicate with their family openly about these more difficult, and often life-altering, stressors resulted in a positive resolution to arising conflicts and positive coping in regard to normative and non-normative stressors along with family stress.

Management of Stress Through Collaborating-Integrating, Compromising, & Accommodating-Obliging Conflict Strategies & Effective Eating Disorder Management (T3)

Interviews illustrated the theme of the management of family and eating disorder stress through the use of collaborating, compromising, and accommodating-obliging conflict strategies and effective eating disorder management. Collaborating-integrating conflict strategy, ranking high in concern for the self and others, granted participants that sense of autonomy in the family relationship that is needed in order to feel safe in disclosure. Participants whose families engaged in the collaborating-integrating conflict strategies stated that when conflict arose, often it was short-lived as the management of such was done quickly in a process of conflict identification, discussion, and collaboration in order to come to a resolution that is mutually satisfactory as each family member is able to communicate their needs/wants/expectations/perspectives without discourse. In this, individuals within these families were found to possess a decreased likelihood of developing an eating disorder as there is reduced family stress, or if development occurred, effective management to stress; more specifically, participants indicated that children in families with this conflict strategy had reduced likelihoods of developing anorexia and bulimia. These eating disorders are associated with behaviors in restriction and purging due to a failure to restrict; considering collaborating-integrating involves a mutual emphasis on the self and others,

restrictive behaviors are not typically present in this style as the style is centered in positive, open dialogue, and thus, there is a reduction of these specific eating disorders when families engage in this conflict strategy. It was also concluded that those individuals who developed an eating disorder through external factors, other than family communication and conflict management, nonetheless, reported positive eating disorder management in regard to the collaborating-integrating conflict strategy. The exemplar below demonstrates this openness to conflict resolution:

> Usually when there's conflict in my family, it's handled normally I guess in terms of how we talk it through and sort of, you know, each person will provide their own perspective on what's happening and we'll kind of go from there. I mean, I think since then, I've realized that if I'm stressed, I mean, depending on the context, I don't know. If I'm stressed, I should acknowledge that I shouldn't try to bury it. So, it's not like basking in the stress, but just assessing it is what I tried to do whenever I noticed myself feeling anxious like that and wanting to engage in disordered behaviors. (P4)

Participant four, self-diagnosed with anorexia, illustrated that the openness that their family had in regard to conflict affected how they managed stress going forward. Possessing confidence in having the ability to openly communicate feelings and expression led to an internalization of positive outlooks on conflict and the development of positive coping strategies for stress and the stress of eating disorders. The openness of the collaborating-integrating conflict strategy allowed the participant to self-access when feeling stressed and determine alternative means of coping without giving in to disordered behaviors/thoughts/feelings associated with the eating disorder.

Similarly, the compromising conflict strategy, ranking high in both the self and other, results in a mutual “I win, I lose; you win, you lose,” mentality due to one individual giving in to

the other. Participants that determined that their families engaged in compromising in order to establish a resolution to a conflict, showed a comfortability in disclosing information surrounding their eating disorders and the management of such. Those in the compromising conflict strategy showed an increased interest in coming to a mutual decision that satisfies both parties, in which both give in in order to take. In this, the family is seen as a system that works in tandem within its entities for resolution; participants felt that regardless of potentially having to give in and relinquish some of their individualistic needs/wants (i.e., full autonomy over meal plans, eating schedules, self-isolation practices, etc.) in order to come to the recommended resolution (i.e., eating disorder management/treatment); it was worth it as the perception of the resolution was that decisions were made in the best interest of both parties through mutually collaboration, ending in compromising, and the participant was more likely to accept the resolution and treatment if they felt as if they retained a reasonable sense of autonomy. The compromising conflict strategy, encouraging an open communication climate, showed a reduced likelihood of developing anorexia or bulimia for the same reasons as that of the collaborating-integrating conflict strategies. Yet, many, despite the positive communication climate, illustrated a reluctance to disclose solely on the basis of normative stress (i.e., the stress that comes with disclosing private information), non-normative stress (stress that came from messages within the family or externally), and due to a reluctance to violate the expectation of interpersonal relationships or the family (i.e., disappointing their families). The following exemplar illustrates this framework:

> Um, I grew up as a kind of mediator between family members. I think it's pretty common for eldest daughters, and families with multiple siblings. Now that I've moved out, I found that I've kind of gotten out of that role. But every time I go home for break, I find

> myself very easily slipping back into it because as opposed to having me going between family members and communicating between them like throughout the year, now it's all condensed into the one month that I'm home. (P3)

The participant determined that, despite having a mostly open communication climate in the family, it was the stress of having to adhere to the role of being the oldest daughter, and the fear of violating such a role in the fear of disappointing a supportive, positive family, that produced the reluctancy for disclosure within the family, despite the compromising tone within family communication when engaging in conflict. Conversely, the openness of this conflict strategy allowed these individuals to overcome the initial apprehension and move forward with disclosure and the thought/discussion of treatment. In these families, the conversation surrounding individuals receiving treatment for eating disorders was viewed positively; in other words, the conversation was centered in the everyone-wins mentality, leading to the individual receiving the treatment needed in an open fashion. The exemplar below demonstrates this positive view on treatment in regard to the family's positive conflict resolution:

> In terms of like supporting me on the days where food is really hard for me to eat. Yes, they (i.e., family) have been very supportive. Like for example, if mom made dinner and it was a nightmare, she would be very supportive in the sense that okay, don't understand what's happening right now, but she would recognize like, I want you to eat something. What else can I make that you will eat? I think she gets it a little bit more than my dad if I like wake up on a Saturday. Don't eat lunch. We're getting near dinner time but we're not having to sit down to dinner and I'm hungry. Mom would be willing to like sit in the kitchen with me for 15 minutes and name 'You could eat this.' 'I don't want that.' 'Why

> don't you want that?' 'Oh, because of this reason.' 'Okay. Well, if that's the reason, then you could have this instead'. (P3)

The compromise was viewed as a mutually beneficial solution in order to encourage treatment. The openness of communication and the end being that of the child eating something, despite the disordered behaviors, made for increased comfortability in the child to advocate for what they needed in order to move forward. The treatment was centered in what both parties could do in order to satisfy the needs of the individuals without judgment or disappointment; for the patient with the eating disorder, the need was the treatment for the eating disorder, and for that of the parents, the satisfaction of needs would be that of the need to relinquish control under the mentality that the conflict is non-normative, and in that, will require compromising on all ends.

Participants who possessed families that engaged in the accommodating conflict resolution focused more on the family entities rather than themselves, falling under the conversation-orientation and almost rejecting the conformity-orientation, with the focus of resolution being on the feelings and needs of the child rather than their individualistic needs/wants. In this conflict strategy, participants were observed to have to possess a greater confidence in disclosure to their family as there was/is an established expectation that the family will formulate a resolution that would be focused on the child and what they are expressing. Additionally, there was confidence that conflict would be resolved in these families which decreased family stress and stressors that serve as triggers for eating disordered behaviors. Participant three illustrates this as well, as the mother took the responsibility to accommodate the behaviors of the child in order to assist in treatment; when met with hesitation from the child in regards to meals, the mother did not respond with dominating communication, aimed to assert dominance, but rather leaned into the accommodating-obliging conflict strategy to tackle the

source of the conflict (i.e., the eating disorder and the child's reluctance to consume food). Those with accommodating families were found to hold a decreased likelihood of developing anorexia and bulimia disorders (i.e., restrictions, calorie counting, purging, excess exercising, laxatives, etc.). Additionally, in individuals that held the accommodation conflict strategy a similar phenomenon existed; however, it differentiated in that, in the case of the child, accommodation would often be used as a response to the family's communication rather than the family utilizing the strategy. In this case, in which the individual (i.e., the child) was the entity that engaged in the accommodating-obliging conflict strategy, the research illustrated that these individuals typically did so in order to please the family in which, then, the conflict style would fall under conformity-orientation rather than conversation-orientation. In this case, T3 would be found to hold an additional component in that, if the child was to utilize accommodation, the individual would be giving up the majority of their needs/thoughts/wants in order to accommodate the parents communication, often seen with parents that adhere to the competing-dominating family communication pattern or to the avoidance conflict strategy that relies on conformity-orientation for family functions, which limits the autonomy of the child in decision-making within the family, and, as a result, diminished the child's security in disclosing struggles regarding their disordered eating habits or eating disorders and the child's security in self-image. Participants showed that when their parents engaged in behaviors such as: "I am right, you are wrong," "You are the child, you listen to me," "You're stupid," etc. they sought to accommodate through alienation in order to avoid a conflict or further perceptualize the perceived conflict. In this case, the concern is reversed as the child is placing emphasis on the satisfaction of the needs (i.e., happiness, family security, family cohesion, etc.) of the family while displacing their own, resulting in the internalization of such negative messages either verbalized by the family or of

those externally, but internalized, nonetheless, due to a lack of support and communication outwardly expressed by those that provide the primary means of socialization for the individual. The alienation created from the child engaging in the accommodating conflict strategy was found to slightly increase the likelihood of the development of anorexia, bulimia, and other specified and unspecified eating disorders. The following exemplar demonstrates this alternative theme in regard to the child possessing the accommodating-obliging conflict strategy as a response to the parents' conformity driven conflict strategies:

> In fact, I kind of think I wasn't in the wrong for some stuff at all. But I still like in order to resolve things I do take the blame and I say like, I have to be the one to say like I'm sorry and resolve things that way and kind of be the bigger person, which does suck because I would really love for my mom and I to be able to talk and work things out and recognize that both of us had like a part in things. But it just kind of feels like at this point. It's just me taking the initiative, which is difficult to realize that like my mom is not going to come around. I'd say that I internalized a lot of my problems. So, I felt like I was the issue. And so, it was a little bit of a self-harm tendency for me to restrict food because I felt like I deserve to be punished for not being a good enough kid or not doing things perfectly. And then in another aspect, I'd say like, it was in an attempt to like please other people. (P9)

In this case, the participant developed the accommodating conflict strategy in order to cope with the stress of an eating disorder and family stress. The individual felt as if they had to take the initiative to give in to the needs of the parent to satisfy conflict, under the assumption that the parent would not be the one to do it themselves. The alienation from the internalization of the stress, especially in response to a need to be "the bigger person," to accommodate the other

person, perpetuated the eating disorder. Regardless, of the small margin of participants that fell into this type of accommodating conflict strategy, the majority of participants whose family possessed this conflict strategy were seen to relinquish control and the adherence to the family hierarchy in order to satisfy the requirements of the child through the open dialogue present during conversation-oriented family communication patterns, resulting in the theme of the accommodating conflict strategy and the effective management of eating disorders.

Management of Stress Through Competing-Dominating & Avoidance, & Ineffective Eating Disorder Management (T4)

Participants viewed competing-dominating and avoidance as ineffective in eating disorder management. Competing-dominating is marked by the "I win, you lose" mentality in which the priority is placed on authority and family cohesion. Messages and language associated with the competing-dominating included: "I am right," "This is what I want," "I am older, so I know more," etc. This strategy is marked by language centered in establishing authority over the other which, when internalized by the child, creates a negative environment that creates an increased apprehension and stress that, when looked through the ABC-X model of Stress (*Figure 1*) & Constantine's Model of Family Attachment & Depression (*Figure 2*), commentary from family and its members that are in the competing-dominating conflict strategy resulted in a breaking of trust and communication which results in increased alienation, increasing an individual's likelihood of developing depression, which along with stress, persists as a triggering factor for the development of eating disorders. Experiences include families exhibiting language that is passive aggressive, aggressive, fighting words, harmful, etc. aimed at establishing harm to the other individuals within the interaction and the family unit. These messages were, then,

internalized and resulted in apprehension towards conflict, in general and also within the household. This directly affected their willingness to engage in active conversation with their families, many expressing that they had a negative view on conflict due to family communication, suggesting that many did not ever disclosure to their families that they suffered/are suffering from an eating disorder due to assumptions that disclosure would be met with discourse/harmful communication as previous conflict was met in by similar means. In interactions within families with competing-domineering conflict strategies, children were determined to possess conflict strategies that developed as a means to mediate such reactions, including accommodation-obliging and avoiding. The majority of participants, who identified with a competing-dominating family, determined that in order to cope with the domineering language used during conflict, there was an increased need to minimize themselves in order to avoid the conflict as there was not a foreseeable resolution as conflicts remained fluid into future conflicts. The exemplar below illustrates this:

> Because it was like whenever you gain that much weight that quickly it's you already don't feel good about yourself. You already don't. And then to have someone who is supposed to love you no matter what. Sit there and tell you that you're not skinny enough and that you're not pretty enough. It hurts because they're supposed to love you no matter what. And if they can't love you. Whenever you gain extra weight, how is anyone else close to you? And at that point in time. I didn't know the things I know now. And so, to me, that's all I wanted was that Yeah. And so basically just by not talking about it and like then reinstituting it that I need to like lose this weight quickly. It made it a lot easier. (P7)

Participants, that had families who utilize(d) the competing-dominating strategy, narrated that family members who used this strategy, possessed negative self-view due to continuous scrutiny in the commentary within the family unit. In regards to eating disorders, the perceived lack of resolution resulted in a lack of disclosure surrounding the individual's eating disorder and its management; those, within, these family were found to have a distinct relationship between the competing-dominating conflict strategy and an increased likelihood of the development of anorexia or bulimia as the behaviors associated with these disorders are prominent within the family and its communication, only further perceptualizing the eating disorder. This perpetuation is shown through the following exemplar:

> I guess probably a little bit because it didn't force me to ever like to confront it until I just realized it on my own. So, if it would have been, you know, like able to talk about it openly in my home and I would have been able to like catch it. Earlier than I probably would have like stopped having those thoughts or those behaviors earlier on because it would have been brought to my attention earlier instead of perpetuating the eating disorder. (P2)

The lack of communication, marked by this strategy, aided in the perpetuation of these disorders as it was concluded that the apprehension towards communicating with their families made hiding eating disorders or disordered eating habits easier as there was/is little to no communication surrounding these topics, or, if there was, the communication was hostile or dismissive. The competing-domineering conflict strategy, unlike the conversation-orientated family communication patterns, produced a negative communication climate in which individuals had diminished autonomy and self-worth in communicating their needs which resulted in the internalization of negative emotions, such as stress, and triggers associated with

eating disorders. Therefore, there is a negative theme between the competing-domineering conflict strategy and the ineffective management of eating disorders.

The avoidance conflict strategy, marked by low concern for both the self and others, is centered in an inherent want/need to resolve conflict through the avoidance of these conflicts. Participants, who had families that possessed avoidance conflict strategy, illustrated decreased comfortability in engaging in daily pleasantries (i.e., daily conversational topics), however, illustrated increased anxiety in communicating surrounding complex issues or stressors, including that of an eating disorder. Families that fall under the avoidance conflict strategy possess a negative conflict view that is passed down and internalized by the children, increasing the apprehension that already exists surrounding conflict. It was concluded that the avoidance conflict strategy produced an increased likelihood of the development of anorexia among participants. The internalization of a negative view on conflict through its mismanagement, is done so through the use of avoidance, as illustrated by the exemplar below:

> So of course, we just didn't talk about it. And then, because I feel like we didn't talk about it (i.e., the eating disorder & disordered eating behaviors), that made it super easy for me to look it up online and find pro anorexia sites and stuff. Like that. That kind of fueled it. I was just super unhappy and looking for a way to cope with that. I would say that we communicated the way that we do. Just because my mom's parents do not communicate well. Her mom was emotionally unavailable, and her dad was physically abusive. So, because she experienced that she brought a lot of that to our family. And there was just a lot of brokenness and just bad habits where I feel like she doesn't even recognize that they're bad because they're better than what she grew up with. (P9)

The messages presented during the mother's childhood, spilled over into the childhood of the, now, child, resulted in a pattern of disordered thoughts and conflict avoidance within the family system. This is further presented in the internalization of messages surrounding food, eating, and diet within the family. As damaging messages surrounding dieting and food within the family system, especially with an avoidance conflict strategies and conformity-oriented family communication patterns, internalized by the child results in the development or perpetuation of eating disorders. The lack of communication present in the avoidance conflict strategy eliminated an individual's sense of autonomy to bring forth conversation surrounding the impact of such damaging messages; the individual, instead of contesting the damaging messages, will internalize the messages as well as the feelings resulting from them, by which the result is an adherence to such messages based on a lack of positive discourse to its opposition. This internalization of these harmful messages as reality is demonstrated through the following exemplar:

> It really grossed me out because I was like, 'Oh, my mom hates her body. So, I hate this aspect about my body. 'Other than my mom saying that she hated her legs, and that was a hyper fixation for me, I needed to make sure that my legs were as small as possible because I didn't want to have ugly fat legs. She hugged me one time was like, 'You got to be careful, you're getting kind of thin.' But for me having never been called that by my mom before and being told that one day I was going to be fat like my grandma, it reinforced the message further. Like just really harmful language like that. (P9)

The connection between the increased likelihood of anorexia development and avoidance is in the avoidance of expression that occurs within a problematic situation and the avoidance behaviors (i.e, restriction) that is associated with that particular eating disorder, illustrating a will

to restrict or detach oneself from adverse effects and emotions of conflict. Anorexics appeared to be more reluctant in expression and favored accommodating-obliging to their parents. However, the avoidance conflict strategy did not find a sole connection between the conflict strategy and anorexia. The results illustrated no distinctive eating disorder that produced the greatest connection to avoidance, providing the framework for the development/mismanagement of at least one participant that identified with 1 of the 5 specified eating disorders in the research. Those that identified with bulimia suggested that the avoidance conflict strategy increased the internalization of conflict in which purging is used in order to cope with the conflict, and overwhelming emotional distress that occurs in response, within the family that appears unresolved due to avoidance. Additionally, then, looking at the avoidance conflict strategy through the scope of the participant engaging in the strategy, individuals (i.e., children) that held the avoidance strategy did so in a response to a family strategy rooted in conformity-orientation such as the competing-dominating, centered in authority. Participants expressed that they avoided conflict in response to a family that responded to conflict with aggressive/harmful language and messages; these individuals reported that it was easier to minimize themselves in an attempt to please their families or appease the conflict rather than seek out resolution, as escalating the conflict was foreseeable had there been interaction. In this, adverse apprehension and messages are internalized by the individual without an outlet for expression/relief. The lack of expression/relief drives individuals to seek coping mechanisms to cope with, not only the family conflict, but the emotions driving the eating disorder, regardless of the specified disorder. Avoidance, like the competing-dominating conflict strategy, produces a negative, closed communication climate in which individuals' autonomy in expression is limited either through self-alienation or through the alienation imposed by the family system, increasing the likelihood

of the development of eating disorders or, if an eating disorder is present, the ineffective management of eating disorders.

Discussion/Conclusion

The purpose of this study was to further research focused on eating disorders and health communication to encompass an under-researched component of eating disorder management, the connection between family communication and conflict management and its influence on the stress of eating disorders. The research produced four themes: (T1) The conformity-oriented family communication pattern (i.e., protective) and the laissez-faire family communication pattern increase family stress and the stress of eating disorders, resulting in the ineffective management of the eating disorder (i.e., anorexia & bulimia as the predominant eating disorders), (T2) Conversation-oriented family communication patterns (i.e., consensual & pluralistic) decreased family and eating disorder stress, resulting in effective eating disorder management, (T3) The management of stress and its conditions (i.e., trust, communication, low alienation) through the use of collaborating-integrating, compromising, and accommodating-obliging conflict strategies result in the effective management of eating disorders, and (T4). The management of stress and its conditions through the use of competing-dominating and avoidance results in the ineffective management of eating disorders. Vidovic's et.al., (2005) study emphasized the effect that low cohesion and flexibility holds on the likelihood of developing eating disorders among female adolescents, more specifically, exploring that in regard to the mother-daughter dyad. This current study furthers on the premise of Vidovic's et.al., research to include the family communication patterns that results in lower or higher family cohesion and flexibility, and its influence on not only the stress and development of eating disorders, but the

management of them if already present within the entirety of the family. Overall, the research concluded that it is the difference between conversation-oriented, conformity-oriented family communication patterns, and the laissez-fare family communication pattern, in relation to the ability of the family system to manage conflict, engaging in one of the five conflict strategies outlined by Blake and Mouton (1964), and the stress that is created before, during, and after conflict that holds the greatest themes/predictors on/of the development/effective or ineffective management of eating disorders. Family communication patterns centered in conformity-orientation (i.e., protective) and the laissez-fare family communication pattern limit the autonomy of the individuals within the family system in decision-making and conflict resolution centered in family cohesion which increases normative and non-normative stressors that, when resolved ineffectively, serve as triggers for eating disorders and disordered eating behaviors. The limitation of autonomy leaves the individual seeking such autonomy by alternative means in which, in many cases, is found in the unhealthy behaviors of eating disorders as such behaviors are viewed as means to reestablish the control lost in the family system. Conflict strategies that fall under the categorization of conformity-orientation or possess characteristics associated with negative communication climates (i.e., competing-dominating & avoidance) produce the same results as the conformity-oriented family communication patterns and the laissez-faire family communication pattern in the limitation of expression of those within the family system through negative, damaging messages centered in authoritarian approaches founded in the protection and adherence to the family hierarchy and a cohesive set of values, beliefs, and means of interaction by the family authorities supporting the themes set fostered in the findings. In this, the creation of such an environment and the ineffective management of conflict, and the stress that results from it, was found to be the prominent factor of the development/mismanagement of eating

disorders. Ineffective conflict management that does not result in long-lasting resolution will increase in such disorders and behaviors.

Conversation-oriented family communication patterns (i.e., consensual & pluralistic) create a positive, communication mindset in which individuals within the family system feel empowered in self-expression in which family interactions are aimed at formulating mutually satisfactory resolutions that are long-lasting. Open, communication climates were credited with decreasing the likelihood of the development/mismanagement of eating disorders; participants, when asked if they felt as if positive communication climates would have eased or assisted in building their confidence to withstand the stressors and triggers of their eating disorders, determined that positive communication climates eased the stress/apprehension that surrounded disclosure of the eating disorder and a need for treatment. Those that felt as if the family communication environment allowed them expression with retained autonomy, without the risk of discourse, disclosed more openly about issues in their lives, more specifically, those of the eating order. Conversations were patient with emphasis placed on active listening, on behalf of all involved parties, in order to create a mutual understanding; because of this, if eating disorders were present within the family system, they were effectively managed through empathy and open dialogue. Individuals felt as if there was no risk in discussing such topics because history has/had proven that conflict was met with the conflict strategies centered in this conversation orientation (i.e., compromising, collaborating-integrating, & accommodating-obliging). The themes that emerged from the data, determined that, overall, it is the family's ability to handle conflict, and its stress, effectively through conversation-oriented family communication patterns previous to the development/management of eating disorders that will produce effective management of the conflict of eating disorders when/if presented, later, in the family unit. Family systems that

engaged in these strategies and patterns established the standard of open, positive communication that built the confidence of individuals in their ability to articulate to the family their needs without escalating the conflict. Messages and language marked by positivity, framed in such a way as to suggest mutual satisfaction, in collaboration, compromise, or accommodation, reinforce that the conflict will be met with a resolution and the conversation, when in progress, will be met with respect and patience towards the individual disclosing. Individuals, in conversation-oriented family communication patterns, held less apprehension towards the discussion of eating disorders within the family system; participants who felt confident in communicating within their family, showed a decreased internalization of negative messages as these negative messages/inconveniencing events or situations were openly discussed, or, perhaps, if not openly discussed were met with open discussion once the child brought forth the conversation of conflict or issues held by them. Applied to eating disorders and disordered eating behaviors, it is the openness to discuss multifarious topics and issues that resulted in either the decrease in likelihood of the development of eating disorders or the effective management of such, if an eating disorder is present. The less negative internalization of messages that an individual engages is, the more positive conflict and the resolution of such is viewed; creating an open, communication climate within the family system limits the internalization of negative messages/behaviors as there is an established outlet for the expression of negative emotions/thoughts (ie., the family system). However, when there is a lack of supported expressions, individuals persist to internalize the negativity/inconveniences of daily life/interactions seeking expression within themselves; as a result, individuals formulate coping mechanism to replace the expression unavailable within the family, taking shape in disordered eating behaviors or as eating disorders.

While the study was able to identify four emerging themes/narratives, there were limitations to the study; the majority of the sample of participants were gathered from a university in the southern part of the United States. The limited sample size produced a skew towards individuals between the ages of 18-22 years old, in which the possibility exists that someone outside of the scope of the sample would have a difference in experience with family communication patterns, conflict strategies, and the development/management of eating disorders, more specifically, regarding the generation differences that contribute the family communication patterns and conflict patterns. Additionally, the sample demographics skewed towards a 17:0 ratio female: male ratio in the interview data collected, meaning there was a predominantly female point of view/perception. Additionally, there was a large skew in the participant demographics towards the Caucasian viewpoint as the ratio of Caucasian individuals to those of other ethnicities was 16:1, which limits the scope of the data in regard to ethnic/cultural diversity. Future research should seek to assess a greater sample size, with more diverse demographics, in order to further justify the results as truly universal as eating disorders are not mutually exclusive to the female nor Caucasian population. This study furthers on research already in the field of health communication, family communication, and eating disorders to look specifically on the family environment, comprised of communication, messages, and language, through the family communication patterns and conflict strategies used within the family system to prove the substantial influence and correlation of each pattern and strategy, through either conversation or conformity orientation, to the development/effective or ineffective management of eating disorders through emerging themes presented among individuals affected by such disorders.

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