

THESIS

DYNAMIC DISORDERS:
NARRATIVES OF EATING DISORDERS AND THE
FATHER-DAUGHTER RELATIONSHIP

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ABSTRACT

DYNAMIC DISORDERS: NARRATIVES OF EATING DISORDERS AND THE FATHER-DAUGHTER RELATIONSHIP

Eating disorders affect women all over the world, particularly adolescents, at a rate which has grown in the last several decades. As obesity becomes one of the most battled health risks, those seriously underweight are ignored, praised, and/or forgotten, and as the fear of obesity grows, so does the incidence and prevalence of eating disorders. Previous research on eating disorders has focused on the family system and/or the mother-daughter dyad for their etiological significance, but relatively little attention has been given to the father's place in the family system or the father-daughter dyad in this context. Using Bronfenbrenner's (1979) ecological model as a lens, this thesis expands the literature of eating disorders by asking questions about the father-daughter relationship and the father's role(s) in the development, maintenance, and recovery of their daughter's eating disorder experiences. Narrative interviews, which record daughters' perceived experiences of the father-daughter relationship in the context of their eating disorders, were collected from women who self-identify as having an eating disorder. Analysis of the daughters' narrative accounts reveals six themes that define the

father-daughter relationship and daughters' experiences of their eating disorders. Throughout the narratives, daughters communicatively construct their relationships with their fathers through the dialectical tensions of closeness/distance and openness/closedness. Interestingly, daughters do not communicatively construct their relationships with their fathers based on interactions about food, weight, or appearance but rather around issues of quality interactions, support, and closeness, as daughters construct the father-daughter relationship as an evolving emotional experience. Eating disorders, then, are perceived as relational artifacts of the father-daughter relationship, marking certain relational turning points. Within the narratives, fathers potentially enable the development of the eating disorder through actions and inactions *nonrelated* to daughters' food intake, appearance, or behavior and potentially further enable the performance of the eating disorder through their silence and passive reactions to their daughters' disorders. However, fathers have the potential to aid in the recovery process with care, support, and expressed closeness, and when fathers do actively participate in their daughters' recovery, the relationship and the recovery process can both benefit from their active participation. These findings highlight the need for further research on fathers (and other father-figures) in this context. Future studies should examine and compare narratives of both fathers and daughters in this context to gain a more complete picture of the father-daughter relationship experience. In addition, future studies should inquire about the family's influence on eating disorders but also the eating disorder's influence on family interactions. Finally, future research should conduct studies with relational dialectics and relational turning points as their main focus in families with eating disorders.

DEDICATION

This work is dedicated to my four wonderful grandparents:

John Gregory, Laura Rose, Milton, and Imogene (Jean).

They pushed me on the swing-set, traveled with me to magical places, challenged my brain with puzzles and games, and taught me how to fly. Most importantly, they taught me by example that, above anything else, family is the most important part of life.

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CHAPTER 1: INTRODUCTION

The Problem of Eating Disorders

While historical research suggests that eating disorders, both anorexia nervosa and bulimia nervosa, have been in existence since ancient times, there has been an explosion of the two disorders in the last several decades (Polivy & Herman, 2002). Eating disorders were originally thought to only affect upper-middle class, white women in western societies¹, but in the 21st century, eating disorders affect women all over the world, particularly adolescents, at a rate which has been growing for the past 40-60 years (Harrison & Cantor, 1997; Steiner & Lock, 1998). Steiner and Lock (1998) further assert that although eating disorders are more prevalent in western cultures with a Caucasian majority, the growing body of research from around the world suggests that eating disorders are a growing global problem as well.

As obesity becomes one of the most battled health risks at the top of the public health agenda, those seriously underweight are marginalized, ignored, praised, and often forgotten. Similarly, as the fear of obesity grows, so does the prevalence of eating disorders (Austin, 2000). Pike and Rodin (1991) argue that as societal concern with dieting and weight increases, the normative nature of weight concern among women will also continue to increase. In fact, research concerning the etiology of eating disorders has continued to grow in the United States, Australia, Belgium, Canada, Italy, Scotland, England, Denmark, Germany, New Zealand, Egypt, Spain, Greece, and Japan over the last several decades.

Despite such growing cultural and global diversity, women and adolescents are still overrepresented in the identified distributions of eating disorders (Stice, 1994). In fact, the highest incidence of eating disorders is seen in adolescent and young adult girls (Pike & Rodin, 1991), as women account for 90% of all eating disorders (both anorexia and bulimia) according to the American Psychiatric Association (2000).² Thus, body dissatisfaction and disordered eating are issues “faced predominantly by the female population” (Green & Pritchard, 2003, p. 216).

Body dissatisfaction in general then, is a growing normative concern for women of all ages (Al Sabbah et al., 2009), and many adolescent girls and young women who are dissatisfied with their bodies diet despite their already healthy weight (Dunkley, Wertheim, & Paxton, 2001). For the female population, adolescence is an especially risky time for body concerns, as it is the most common time of onset for both anorexia and bulimia (Gralen, Levine, Smolak, & Murnen, 1990). Moreover, as young women grow into adulthood, disordered eating behaviors can continue to grow in severity (Neumark-Sztainer, Eisenberg, Fulkerson, Story, & Larson, 2008). As Wertheim, Mee, and Paxton (1999) explain, adolescent and young adult females are more likely to aspire to a body size smaller than their own.

In high schools around the country, 40%-60% of young women report dieting to lose weight with a variety of different methods, including but not limited to, vomiting, laxatives, diuretics, and diet pills, and among junior high girls, 30%-40% report weight concerns (Steiner & Lock, 1998). In a sample of third to sixth grade children, Jacobi, Schmitz, and Agras (2008) found that 45% expressed a desire to be thinner, and 37% of those had already tried to lose weight. The authors also reported 31.8% of the ten year old

girls in their sample admitted they were afraid of becoming fat. Reports of children as young as five years old expressing concern with body image and fear of becoming fat are on the rise (Gowers & Shore, 2001; Loth, Neumark-Sztainer, & Croll, 2009) with children as young as 12 presenting a diagnosable eating disorder (Kirsh, McVey, Tweed, & Katzman, 2007).

Eating Disorders Defined and Explored

The American Psychiatric Association's (2000) *Diagnostic and Statistical Manual of Mental Disorders* defines eating disorders as severe disturbances in one's eating behaviors including, but not limited to, excessive fasting, repeated episodes of binge eating, or inappropriate compensatory behaviors. Their definition excludes cases of obesity or feeding issues and eating disorders which are diagnosed in infancy or early childhood. Eating disorders are currently divided into three diagnostic categories: anorexia nervosa and bulimia nervosa, the two most commonly known, and eating disorder not otherwise specified (EDNOS), a category for coding disorders that do not meet the specific criteria for either anorexia nervosa or bulimia nervosa (American Psychiatric Association, 2000). Polivy and Herman (2002) suggest that all three types of eating disorders are simply different manifestations of the same disorder since the core symptomology is the same for all of them. Such core symptoms include being female (Fonseca, Ireland, & Resnick, 2002); body dissatisfaction (Fonseca et al., 2002; Polivy & Herman, 2002); preoccupation with food, weight, and shape (Gowers & Shore, 2001; Polivy & Herman, 2002); and certain ego deficits (Polivy & Herman, 2002).

Anorexia nervosa is categorized by four diagnostic criteria: (1) the individual refuses to maintain a minimally normal body weight for age and height, usually less than

85% of the expected weight; (2) the individual has an intense fear of gaining weight or becoming fat, which is exacerbated by weight loss, even though the individual is already underweight followed by an increased concern about weight gain as weight continues to decrease; (3) the individual experiences body weight and shape in a disturbed way, wherein some individuals feel as if they are globally overweight while others feel as though they have problematic areas of their body that are too fat; (4) in post-menarcheal women, the individual suffers from amenorrhea, or the absence of three consecutive menstrual cycles (American Psychiatric Association, 2000). When an individual meets most of the diagnostic criteria, but not all of the specifications, they are diagnosed with EDNOS.³ Medical complications stemming from anorexia nervosa are severe. According to the American Psychiatric Association (2000), “the semistarvation characteristic of this disorder can affect most major organ systems and produce a variety of disturbances” (p. 586), and over 10% of anorexia nervosa cases end in mortality as a result of starvation, electrolyte imbalance, and suicide.

In contrast to anorexia nervosa, *bulimia nervosa* is categorized by five diagnostic criteria: (1) the individual recurrently suffers from episodes of binge eating which are classified by consumption of an amount of food that is substantially larger than most people would eat in the same period of time and under similar circumstances and a sense of a lack of control over eating behaviors; (2) the individual uses recurrent compensatory behaviors to prevent weight gain from binges such as fasting, excessive exercising, self-induced vomiting (up to 80-90% of sufferers use this method), or the misuse of laxatives (one-third of sufferers use this method), diuretics, enemas, or other medications; (3) binge eating and compensatory behavior episodes occur at least twice a week for three

months; (4) self-evaluation is highly linked to perceived body shape and weight; (5) the disturbance does not occur exclusively during episodes of anorexia nervosa⁴ (American Psychiatric Association, 2000). When an individual meets most of the diagnostic criteria, but not all of the specifications, they are diagnosed with EDNOS.⁵

Of the two disorders, bulimia nervosa is the most prevalent (Gowers & Shore, 2001), with diagnosed patients outnumbering anorexia nervosa patients 2 to 1 (Polivy & Herman, 2002). Young women suffering from bulimia nervosa are also harder to detect because they usually maintain normal body weight, and their purging episodes happen in private settings. Medical complications stemming from bulimia nervosa are also severe. The American Psychiatric Association (2000) claims frequent fasting or purging behaviors can cause severe medical problems. Obviously, these two disorders pose serious threats to the adolescent female population, but because there are many causes reported in the literature, preventative measures are side-lined for a preferred focus on curative measures.

Indeed, the incidence of both anorexia nervosa and bulimia nervosa has increased dramatically over the last 50 years (Polivy & Herman, 2002; American Psychiatric Association, 2000) with an estimated prevalence of 3% - 10% for at risk females between the ages of 15-29 years. However, according to Polivy and Herman (2002), incidence and prevalence estimates vary from source to source because young women who suffer from eating disorders are often reluctant to reveal their disorder. In addition, Botta (1999) further asserts that many cases go undiagnosed every year due to the secretive nature of eating disorders. Austin (2000) writes, "Eating pathology that does not meet criteria for a psychiatric disorder affects much larger proportions of the population" (Austin, 2000, p.

1249). Polivy and Herman (2002) also claim, subclinical disordered eating, which includes weight loss behaviors such as extreme dieting, calorie counting, fasting, crash dieting, and vomiting, usually outnumbers diagnosed eating disorders 2 to 1. Screening studies in North America and Europe utilizing a number of instruments found that 10% - 25% of adolescent girls and young women score above the cut-off for disordered eating behaviors, and behavioral studies report 10% - 20% of adolescent girls induce vomiting and abuse diuretics, laxatives, ipecac, and diet pills (Austin, 2000). Therefore, these subclinical populations could affect much larger proportions of society (Austin, 2000; Botta, 1999).

Adolescence is a crucial risk period for developing shape and weight concerns (Wilksch & Wade, 2010). As Benedikt, Wertheim, and Love (1998) claim that most adolescent girls who demonstrate weight and shape concerns are in the “normal” weight range according to their BMI, and they conclude that the number of girls who report extreme weight loss techniques is greater than the number of girls who are overweight. Extreme weight loss techniques can result in significant harm to the adolescent body. Fonseca et al. (2002) report that eating disorders and extreme forms of dieting can cause both psychological (decrease in self-esteem, poor concentration, and sleep disturbances) and physical (menstrual irregularities and growth retardation) damage to the adolescent body. Extreme dieting is also associated with other risk taking-behaviors such as alcohol, tobacco, narcotics, and suicidal tendencies (Fonseca et al., 2002).

Of those who eventually seek treatment for their eating disorder, only 40-50% of girls treated for anorexia and 50-60% of girls treated for bulimia completely recover (Loth et al., 2009). For those that do recover, Steiner and Lock (1998) report

psychological and social impairment remain even after weight recovery. Consequently, the rest of those treated for their respective disorders never fully recover because of the high relapse rate (Loth et al., 2009), and it is reported that 3% - 10% of all eating disorder cases result in mortality (Steiner & Lock, 1998). These statistics do not include cases that never seek treatment.

To summarize, both anorexia nervosa and bulimia nervosa have continually grown in incidence and prevalence over the past several decades not only in the United States but also around the world (Austin, 2000). As a growing global concern, women and adolescents are affected by eating disorders at a disproportionate rate (Harrison & Cantor, 1997; Steiner & Lock, 1998). Moreover, weight and shape concerns are so commonplace in US-American society that body dissatisfaction is now seen as normative (Pike and Rodin, 1991). Eating disorders, though, are multifaceted and associated with multiple risk factors, and with 3% - 10% of eating disorder cases resulting in mortality (Steiner & Lock, 1998), there is a need for further research in this area.

This study hopes to explain the role of the family system in the development and recovery of an eating disorder focusing specifically on the role of the father. I examine the eating disorder phenomenon from the lens of an ecological model, and from this perspective, the father emerges as a missing member in the family system of young women suffering from eating disorders as well as a missing component of the ecological model; however, the mother emerges in the literature as a dominant focus in the father's absence. The exclusion of the father from the literature combined with the tendency for mother blaming is problematic because of the importance of the father in their daughters' overall psychological development (Bronstein, 1988a; Lamb & Tamis-Lemonda, 2004;

Phares, 1996) and in their daughters' abilities to navigate between systems in the ecological model (Bronfenbrenner, 1979).

Preview of Chapters

This project aims to answer the more general question of the paternal role in the development, maintenance, and recovery of daughters' eating disorders. Chapter 2 will first review the relevant literature on the importance of fathers in both normal and abnormal child development, the family as it is important to the development, maintenance, and recovery of eating disorders, and Bronfenbrenner's (1979) conception of the ecological model, which will serve as a lens for this project. The specific research questions (which will also be discussed in Chapter 2) are addressed using an interpretive approach to analyze narratives, young women's written stories of their experiences struggling with an eating disorder. Chapter 3 will then explain relevant methodology and the specific methods used to conduct the study. Following methods, Chapters 4 and 5 will include the analysis of the project. Chapter 4 will discuss the codes and themes that emerged from narrative accounts that explain how the nature of the father-daughter relationship is communicatively constructed by the daughter. Chapter 5 will then examine the themes and codes from participant accounts that demonstrate how specific communicative roles the father performs enable the performance of the eating disorder. Chapter 6, as the discussion chapter, will synthesize the three research questions, explain limitations, and address the overarching question of this project, which is to discover the paternal role in the development and recovery of eating disorders, in an attempt to fill the gaps in the family portrait found within the ecological model. Finally, Chapter 7 will

conclude the project with key findings, theoretical, methodological, and pragmatic contributions as well as suggestions for future research.

ENDNOTES

¹ As a researcher concerned with power and the consequences of colonization, I have deliberately chosen to leave both “white” and “western” lowercase throughout the document. I believe those words carry enough power already without also receiving capitalization in this project.

² Reported cases of eating disorders in males account for approximately one-tenth of those that occur in females (American Psychiatric Association, 2000).

³ In addition to the four diagnostic criteria, the American Psychiatric Association (2000) defines two subtypes of classification for anorexia nervosa. The Restricting Type is characterized by dieting, fasting, and excessive exercise where weight loss is accomplished through a very restricted and limited diet with minimal food intake. The Binge-Eating/Purging Type is characterized by binge eating behaviors and subsequent self-induced vomiting or the misuse of laxatives, diuretics, and enemas. Some patients included in this subtype do not binge but do regularly purge after small amounts of food consumption.

⁴ “Not only occurring during episodes of anorexia nervosa” means that the individual is not underweight when these episodes occur. Bulimia nervosa patients are typically within the normative weight range for their age and height, though some may be slightly over or under weight. If the patient is significantly underweight when they meet the rest of the diagnostic criteria, they are diagnosed with anorexia nervosa instead of bulimia nervosa (American Psychiatric Association, 2000).

⁵ In addition to the five diagnostic criteria, the American Psychiatric Association (2000) defines two subtypes of classification for bulimia nervosa. The Purging Type is characterized by routine self-induced vomiting or the misuse of laxatives, diuretics, and enemas. Unlike individuals with the purging type of anorexia, Purging Type bulimics maintain a minimally normal body weight. The Non-Purging Type is characterized by other inappropriate compensatory behaviors such as excessive exercise and fasting.

CHAPTER 2: LITERATURE REVIEW

An Ecological Perspective of the Eating Disorder Phenomenon

Since there has not been a consensus between researchers pinpointing the etiology of eating disorders, I propose an ecological model as the framework for which to examine this specific societal problem. Sociocultural pressures are present in the family, through peers, and in the media. Such messages manifest through relationships with other people and through interaction with the media and become internalized when they are reinforced by people in their surrounding environments (Stice, 1994). If we can increase awareness in families to make them conscious of these sociocultural reinforcements, then we might be able to decrease the problem of eating disorders. Wertheim et al. (1999) argues, the “*greater the number of sociocultural agents that are promoting thinness ideals and advocating dieting, the more likely that a child will adopt such attitudes and behaviors*” (emphasis in original, p. 172). The family exists as a bubble in a world that demands people are thin, and when the family contributes to the number of sociocultural agents promoting thinness, it is more likely an eating disorder will occur. If we can decrease the number of influential sociocultural agents through familial messages, we could decrease the number of adolescent women affected by eating disorders.

It is, therefore, essential to understand that the adolescent woman and her family exist at the center of an ecological model of eating disorders. The ecological environment is “conceived as a set of nested structures, each inside the next. . . . At the innermost level is the immediate setting containing the developing person” (Bronfenbrenner, 1979, p. 3).

Bronfenbrenner's (1979) model of social context has at its center the individual (the adolescent woman) surrounded at the closest concentric circle by the family system. With an ecological model, the individual experiences her social environment in layers: first as a self, second through interaction with the family, third through social interaction with institutions and peers, fourth with the media, and finally with sociocultural norms and the ideology of her culture (Austin, 2000). Since the family is the closest layer to the center (the individual), the family has the most potential to influence eating attitudes and behaviors through its influence on development. Bronfenbrenner (1979) defines development as "the person's evolving conception of the ecological environment, and [her] relation to it" (p. 9). An ecological framework for eating disorders recognizes that there are multiple familial, sociocultural, and mediated etiological agents working in unison to encourage disordered eating behaviors. This is Bronfenbrenner's (1979) "theory of environmental interconnections and their impact on the forces directly affecting psychological growth" (p. 8). However, within the ecological model, there are prevention points to be identified, such as the family.

Parents have the most influence over their children's behavior because they are the "primary socializing agent" (Crowther, Kichler, Sherwood, & Kuhnert, 2002, p.149) of their children's behaviors. Ackerman (1984) defines the family as "a household in which the behavior of any one person is at all times a function of behavior of all other members" (p. 16). Galvin, Dickson, and Marrow (2006) claim that the family is essentially a group, and groups are bound together as a social system by their communication. In addition, Ackerman (1984) argues that the family provides individuals with their generating principles, which he defines as "extremely deep-seated, often

unconscious, fundamental attitudes out of which we form our perceptions and, hence, they govern our experience of ourselves and the world” (p. 7). Even though the individual is a meaningful contributor to the family system, Broderick (1993) claims that the individual learns behaviors (including pathological functioning) from the family unit.

Galvin et al.’s (2006) explanation of openness, the process of boundaries and permeability in the family system, is helpful in understanding the importance of the family in an ecological model. Although families have boundaries, they are still permeable to outside influence from the community, but through boundaries, the family system can work to achieve healthier eating patterns in all members of the family unit. Broderick (1993) asserts that the family system always has boundaries of a varying degree of permeability. The system acquires resources from the surrounding community, but the system also has to be selective about outside influence so as to prevent contamination from the community. These boundaries can also prevent contamination of the family’s collective worldview. The family then is the first intervening variable in the development of eating disorders. Applying a family systems perspective allows us to consider that “eating disorders are not only an individual illness but also a ‘valid diagnoses of the family system’” (Prescott & Le Poire, 2002, p. 62). By developing a new worldview, the family can enact boundaries that will successfully challenge the communication patterns that contribute to disordered eating.

Broderick (1993) also suggests that families extend their boundaries through the use of a channeling process to protect family members who are away from the house. Essentially, family members channel other family members, specifically children, into safe situations and settings that maintain similar worldviews of the family system. In the

same way that parents channel their children away from antisocial behaviors and into prosocial behaviors such as recreational or extracurricular activities, parents can also channel their children's attitudes about eating and body satisfaction. Al Sabbah et al. (2009) explain this process as follows:

The prime context where the child lives and develops is the family. It is in this context that the cognitive, social and emotional development starts. The family is the cornerstone for promoting healthy behaviors and is an important source of social support. Parents are the main source of children's health care information; therefore parents can play an important role in reinforcing positive influences and filtering out negative influences on their children. (p. 2)

Families therefore have the potential to curb the problem of eating pathology by channeling their children into activities that make them feel better about their bodies and their capabilities. Effective communication between parents and adolescents is associated with greater social competence and better relationship quality (Henry, Sager, & Plunkett, 1996). Moreover, bonding and family connectedness are important to adolescent adaptation because they provide "an emotional foundation from which adolescents can explore the world" (Henry, 1994, p. 452). Thus, affirmations of any kind increase self-esteem, which potentially decreases eating pathology.

In this way, parents can be the guarding force between their daughters and disordered eating, which can be reduced with positive familial reinforcement. Henry (1994) found that adolescents who are more satisfied with their family disclose more emotional information with their parents, are more compliant with family expectations, and most importantly, have a greater quality of life. Also, parental connectedness and support, which includes praise, encouragement, and physical affection, are indicators of adolescent adaptation and positive development in youth. Parental support is also linked to general competence, identity achievement, and self-esteem (Henry, Robinson, Neal, &

Huey, 2006). Boundaries are one of the reasons that children exposed to multiple eating disorder risk factors do not develop the disorder. Henry (1994) argues that “interventions can be developed and utilized that seek to enhance adolescent well-being through strengthening family resources within the overall family system and parental-adolescent subsystems” (p. 447). Thus, the family has the potential to establish protective factors through their use of boundaries (McVey, Pepler, Davis, Flett, & Abdoell, 2002).

While there are multiple risk factors for eating disorders reported in the literature, to date, there have not been any conclusive results as to a direct cause and effect relationship of disorder development. Thus, from the last five decades of research, risk factors have been named from studies as “influences that increase the likelihood that disordered eating will occur” (McVey et al., 2002, p. 76). There are several other risk factors besides the family explored in the literature on eating disorders: individual personality traits, peer influence, mediated images, and sociocultural norms. However, as families are socializing agents at the center of all of the eating disorder influences, they are uniquely positioned to communicate positively about body image and sociocultural pressures.

Overall, Bronfenbrenner’s (1979) ecological model is useful when examining eating disorders because it allows the researcher to move beyond exclusively blaming the media, peer influence, sociocultural influence, or the family environment and helps the researcher examine the eating disorder phenomenon more broadly. Bronfenbrenner (1979) conceived of the ecological environment “as extending far beyond the immediate situation directly affecting the developing person” (p. 7). Environments that influence behavior and development cannot be explained in a linear sense; rather they have to be

explained from a systems perspective. In an ecological model of eating disorders, causation is multifaceted, produced by the combination of a multitude of eating related messages and feelings coalescing in different sets of circumstances that are all unique to the individual at the center of the concentric circles.

Despite its relevance to eating disorders, the ecological model has not been used extensively on this topic. Researching eating disorders from an ecological model allows for a more complete portrait of the eating disorder phenomenon. The father's role in families with daughters suffering from eating disorders, for example, is missing from the ecological model already provided by eating disorder research. Since the family is in the closest concentric circle in the ecological model to the adolescent woman suffering from disordered eating behaviors, the literature can benefit from a more thorough picture of the family system in which an eating disorder is present. I hope to contribute to this literature by studying fathers of daughters with eating disorders.

Why Fathers Matter in Child Development

Literature addressing the role of fathers in child development suggests that fathers are important to the overall development of their children (Bronstein, 1988a; Lamb & Tamis-LeMonda, 2004). As Phares (1996) asserts, present fathers (rather than absent ones) contribute to both normal and abnormal child development in meaningful ways. However, Phares (1996) also notes that a relatively low percentage of studies concerned with developmental psychopathology include(d) fathers in their measurements and results due to a large focus in the past on the absent father in developmental psychopathology. Bronstein (1988b) reports that once fathers were included in the research on child development, results demonstrated that fathers were important contributors to their

children's overall development, they explored the potential to be involved in their children's lives, and actively sought to be involved in the childrearing process. Lamb and Tamis-Lemonda (2004) concur, arguing that fathers play an integral role in the development of their children, are often salient in the lives of their children, and affect the course of child development for either the better or worse.

Despite the fact that mothers still spend more time with their children, are still more accessible to their children, and have more responsibilities for child care than fathers (Phares, 1996), men are becoming increasingly more involved in child care, and the amount of time fathers spend in household tasks and childcare has increased significantly since the late 1970s (Bronstein, 1988b). The percentage of time fathers spend with their children, are accessible to their children, and the percentage of child-care responsibilities fathers hold have also increased significantly in the last two decades (Phares, 1996). Catalyst (1988) writes, "There can be little doubt that the trend for mothers *and* fathers to nurture their children, as well as to work outside of the home, will continue to grow" (emphasis in original, p. 336) as more men are embracing an active role in the family for personal satisfaction and psychological wellbeing. Because of this growing trend, more fathers are calling for alternative work schedules, parental leave policies, employer-supported child care programs, work and family seminars, and time off to care for their sick children. Yogman, Cooley, and Kindlon (1988) attribute the increased involvement of fathers in the home to larger sociocultural changes taking place in western societies, such as the women's movement and an increase in dual-earner families; however, they explain that men are also seeking emotional closeness with their

children “as part of a men’s movement toward fuller personhood” and as a rejection of the narrowly defined role of family provider.

While Bronstein (1988a) reports that across a number of studies and throughout several cultures, fathers have been found to participate less than mothers in basic care giving for their children, they do spend more time than mothers in play with their children, mostly physical and arousing play. Lamb and Tamis-LeMonda (2004) agree that even though mothers spend more time with their children than fathers, the types of play fathers engage in with their children (i.e., boisterous, stimulating, and emotional) are more salient for their child’s development. Father-child interactions contribute to the intellectual development of the child, and “both boys and girls who had highly involved fathers showed higher levels of verbal intellectual skills” than children with less involved fathers (Phares, 1996, p. 67). In addition, father’s warmth was positively related to how children perceived their own academic confidence (Phares, 1996).

Lamb and Tamis-LeMonda (2004) claim that fathers affect their children in a positive way when they have supportive and nurturing relationships with their children. The authors further assert that children with involved fathers are characterized by “increased cognitive competence, increased empathy, less sex-stereotyped beliefs, and a more internal locus of control” (p. 8); however, when paternal involvement was forced, adverse effects on children were duly noted. In addition, children who have “secure, supportive, reciprocal, and sensitive relationships” with their fathers are more likely to have better psychological development than children with less satisfying paternal relationships (p. 10). Moreover, Phares (1996) reports evidence that “it is *quality* rather than *quantity* [of time] that seems to have a greater impact on children’s wellbeing”

(emphasis in original, p. 18). For infants and toddlers, low father-daughter closeness contributes to a difficult temperament in daughters, and for adolescents, there is a correlation between feelings of closeness with their father and self-esteem (Phares, 1996). Phares (1996) reports, “Adolescent girls who perceived their father to be warm and supportive . . . showed higher levels of self-esteem than their peers” (p. 81). Pleck and Masciadrelli (2004) claim that daughters who report that their father spent adequate time with them as children also report better mental health in adulthood, and having the adequate amount of paternal involvement in childhood subsequently predicted self-esteem and life satisfaction in adulthood. McVey et al. (2002) also claim that fathers’ support might help to promote healthy levels of self-esteem as well as healthy eating attitudes for young adolescent daughters. Consequently, intervention studies that have increased paternal involvement have evidenced positive changes in child behavior (Pleck & Masciadrelli, 2004). Thus, Bronstein (1988a) writes, “In their interactions with their children, fathers have taught, demonstrated, or encouraged physical competence, adventurousness, confidence in asserting opinions, learning of new information, and mastery of new skills” (p. 120).

Because anorexic and bulimic families are characterized in previous research by poor conflict-resolution and rigid hostility, it is important to ask how paternal roles change and influence children in highly conflicted families in contrast to those discussed above. Cummings, Goeke-Morey, and Raymond (2004) report that marital conflict and quality are correlated with child development, adjustment, and overall functioning. The authors also report, “Fathering and father-child relationships are more vulnerable to negative effects of marital discord than are mothering and mother-child relationships”

and are accompanied by more negative effects on child adjustment (p. 197). However, if fathers were supportive to children in response to marital conflict, there were “reduced negative reactions from children, with children’s behavioral distress, in particular, being no greater than the responses found in reaction to resolved conflict” (p. 210).

In addition, Cummings et al. (2004) assert that father-child relationships suffer when there is low marital satisfaction and high marital conflict. In cases of interparental conflict, father-child attachments suffer more than mother-child attachments, children are more distressed by a father’s expressions of discord in marital conflict, and children respond more negatively to a father’s expressions of conflict even when the mother exhibits the same conflict expression. High marital conflict tends to result in poorer overall *paternal* parenting, specifically for daughters in households with high marital conflict (Cummings et al., 2004). Fathers were “more globally negative” to their daughters, used more authoritarian parenting styles with daughters, and as marital conflict increased, distressed fathers were more likely to disengage from their relationships with their daughters (Cummings et al., 2004, p. 200).

The role of fathers in eating disorders. Adolescent psychosocial adjustment is therefore directly related to paternal involvement according to Lamb and Lewis (2004), who suggest “fathers use more imperatives, attention-getting utterances, and utter more complex sentences than mothers do” (p. 285). Fathering traits such as talking and responding to, teaching, and encouraging children to learn, “predicts children’s cognitive and linguistic achievements” (Lamb & Tamis-LeMonda, 2004, p. 4). Even after controlling for economic differences, Lamb and Lewis (2004) report, paternal involvement in routine childcare of daughters was correlated with their daughter’s higher

grades in school and less stereotypical views about adult gender-roles. If fathers are able to mediate their daughters' views of gender roles and even of stereotypes, which often suggest women should meet the thin ideal, then their omission in the literature concerning eating disorders is consequential.

Broadly, fathers play a significant role in the overall psychological and psychosocial development of their children. Marta's (1997) study conducted in Italy argued that even though the family structure is "matrifocal," the father is just as important in child development and risk behaviors. However, fathers are omitted from developmental psychopathology literature in the United States (Phares, 1996) for similar reasons why fathers were thought to be unimportant to child development in Marta's (1997) study, which she explains succinctly:

Mothers play a predominant role in the family and in the life of adolescents while fathers are less closely involved in the family. Thus, Italian families appear to be 'matrifocal,' with the mothers over-involved in the rearing of their children and also in the transmission of social norms, while fathers, having abdicated their role as mediator between the private and social realms, find themselves in a no-man's land or else in search of a new role, still to be defined. (p. 474)

The results of Marta's (1997) study are reported as follows:

Both parents play an important role in the well-being of their adolescent children. The late adolescent in his or her struggle to achieve identity, looks for resources in relationships with both mother and father so that each plays either an enabling or a constraining role in the adolescent's development. (p. 483)

Because of similar tendencies in US-American families, I assert that fathers in US-American families should be just as important as mothers in their enabling or constraining roles concerning eating disorders.

However, some US-American studies have reported that there is no relationship between fathers and their daughters' eating disorders. Wertheim et al. (1999) found that

mothers were more likely to help their daughters diet, participate in the diet with their daughter, and criticize their daughter's weight, but they did not discuss the role of the father in these exchanges. Is the father a silent member of the family? In Wertheim et al.'s (1999) study, they claim "father influences did not add significantly" (p. 183) to the daughter's eating attitudes and behaviors. Phares (1996) reports that fathers of daughters with eating disorders appear to be more emotionally uninvolved in their daughters' lives than fathers in control groups. Does that mean the father's silence is not significant to the mother-daughter relationship or to the daughter's relationship with food? According to an ecological model, the father is still present in the family system, so his voice, or the absence of his voice, should still factor into the mother-daughter subsystem and the larger family system.

Other studies report a correlation between father-daughter interaction and the daughter's eating disorder; however, research on the father's role in the development of eating disorders is sparse. Marta (1997) found that "fathers, traditionally and culturally less involved in child-rearing, emerge as important parents in situations of risk for the adolescent" (p. 484). Moreover, Kirsh et al. (2007) claims, "Unconditional support from father has been found to attenuate the negative influence of stress on disordered eating among young adolescent females" (p. 352). Finally, McVey et al. (2002) found that high levels of paternal support could moderate school-related stress and negative peer-related events. In fact they found, "high levels of involvement and unconditional support from fathers is the most optimal" to reduce the risk factors associated with disordered eating (p. 90).

While parental support has the potential to prevent low self-esteem and poor eating attitudes, low *paternal* support, in particular, is highly correlated with disordered eating (emphasis added, McVey et al., 2002). Wertheim et al. (1999) found fathers' comments about daughters' weight were related to daughters' body dissatisfaction, and Smolak, Levine, and Schermer (1999) found paternal communication was correlated with daughters' attempts to lose weight, concerns about being fat, and body-esteem. Humphrey (1989) found "fathers of anorexics and bulimics were relatively more watching and managing as well as belittling and blaming toward their daughters; the daughters, in turn, showed more sulking and appeasing toward them" (p. 213). Fathers and daughters in the control group, however, demonstrated more helping, protecting, trusting, and relying on each other.

Humphrey's (1989) study also concluded that there were further differences in anorexic and bulimic father-daughter interactions. Fathers of anorexic daughters demonstrated more pseudo affection (nurturing), control (managing), pseudo help, and negation (ignoring), which their anorexic daughters responded to with pseudo self-disclosure and submission. Fathers of bulimic daughters demonstrated more pseudo understanding and control (managing), which their bulimic daughters responded to with ambivalent self-assertion and sulky resentment. These studies highlight the father's potential to influence their daughter's eating disorder experiences, but they also highlight the need for more research on the father's role in the development, maintenance, and recovery of eating disorders.

Mother blaming. As absent fathers have typically been blamed for their children's abnormal development, present fathers have largely been ignored in research

(Phares, 1996). Quality of fathering was ignored from the child development literature because it was believed that competent mothering “was the key to children’s successful social, emotional, and cognitive development” (Bronstein, 1988b, p. 6). The lack of research on fathers “reflects the perceived importance of the mother as the primary parent and the relegation of fathers to a secondary status vis-à-vis the mother” (Phares, 1996, p. 7). Because of the focus on mothers in eating disorder literature, the father’s role has been ignored; this omission of fathers from the research concerning eating disorders has been encouraged by a strong focus on mothers’ roles within the family, which Phares (1996) terms mother blaming. Mother blaming is defined as “a sexist bias toward studying maternal contributions to children’s emotional/ behavioral problems while ignoring possible paternal contributions” (p. 95). Phares (1996) argues that studies which “only hypothesize maternal culpability for children’s problems must be questioned and thoroughly investigated” as “research on father’s roles in normal child development has shown that fathers have a significant impact on their children’s development” (p. 107). Fathers behaviors are ignored or excused while mothers are held responsible by society at large and researchers for their child’s wellbeing. Phares (1996) claims that this exclusion of fathers is ironic because “although the role of fathers in normal child development was unjustly ignored, the lack of attention to fathers also kept them safe from being blamed for their children’s psychological problems” (p. 99). I agree with Phares (1996) when she asserts that fathers should be included in our research to the same degree that mothers have been in the past. The following is a brief summary of the eating disorder literature exploring the mother-daughter relationship.

The role of mothers in eating disorders. Researchers have traditionally focused on overall family functioning¹ or the mother-daughter subsystem when examining eating disorders. Overall family functioning as well as specific parental behaviors are positively linked to adolescent well-being (Henry et al., 2006). The “presence of dominant or overprotective parents, particularly mothers, is a consistent theme” in the eating disorder literature (Kagan & Squires, 1985, pp. 267-268). Mothers are the primary source of health information for their children, and mothers also have a strong influence on their adolescent daughter’s attitudes about eating behaviors (Al Sabbah et al., 2009). Moreover, Gowers and Shore (2001) claim that mothers are responsible for the “transmission of cultural values regarding weight, shape and appearance” (p. 237). Thus, mothers’ eating and weight concerns are associated with daughters’ eating and weight concerns, and the degree to which daughters diet is related to their mothers’ attitudes and behaviors concerning weight in their daughter (Benedikt et al., 1998; Gowers & Shore, 2001; Pike & Rodin, 1991).

In fact, many mothers actively encourage their daughters to lose weight even when they are not overweight (Benedikt et al., 1998; Pike & Rodin, 1991). Mothers who are dissatisfied with their own bodies and demonstrate extreme weight loss behaviors such as vomiting, fasting, and skipping meals are also more likely to have daughters who engage in extreme weight loss behaviors (Benedikt et al., 1998; Gowers & Shore, 2001). Pike and Rodin (1991) found that mothers of eating disordered daughters had a longer history of dieting than controls and showed subclinical symptoms of eating disorders themselves. This finding insinuates that, to a certain extent, disordered eating behaviors,

could be modeled from the mother's dieting behaviors, but while mothers model disordered eating behaviors, they also place direct pressure on their daughters to be thin.

In Pike and Rodin's (1991) study, mothers of disordered eating daughters were more critical of their daughters than they were of themselves. The mothers did not believe they needed to lose more weight than their peers, but they thought their daughters should lose more weight than their daughters' peers. These mothers also rated their daughters as significantly less attractive than the daughters rated themselves. Finally, mothers of daughters with eating disorders wanted their daughters to lose more weight than mothers of controls.

In addition, mothers of anorexia nervosa patients frequently use destructive communication with their daughters because the mother-daughter dyad exhibits poor conflict resolution (Lattimore, Wagner, & Gowers, 2000). Maternal control and intrusiveness as well as maternal dominance are characteristic of the anorexic mother-daughter dyad (Kog & Vandereycken, 1985; Latzer, Hochdorf, Bachar, & Canetti, 2002). Similarly, mothers of bulimia nervosa patients consider their daughters to be more overweight than control mothers, and they report restricting their daughters' food intake and encourage dieting more than control mothers (Crowther et al., 2002; Pike & Rodin, 1991). Mothers of bulimics actively encourage weight loss in their daughters by restricting food intake and pushing excessive exercise and dieting (Moreno & Thelen, 1993). Even perceived negative messages from the mother about her daughter's body was correlated with bulimic symptomology (Kanakakis & Thelen, 1995).

These previously mentioned studies have simply ignored the role of the father, which is problematic because the research shows an incomplete family portrait as well as

an incomplete ecological model of associated risks. Presumably, this exclusion is because the mother is thought to be more central in the family and also because of the “gender stereotyped nature of dieting” (Gowers & Shore, 2001, p. 237) or because of the assumption that adolescent children feel closer to their mothers rather than their fathers (Al Sabbah et al., 2009). However, the fact that the father is ignored as if his reactions, perceptions, and input (or lack thereof) were negligible is a problem from the perspective of an ecological model. Lamb and Tamis-Lemonda (2004) claim that fathers are thought to be children’s link between the family and the outside world because “fathers’ unique communicative styles directly teach children about the linguistic and communicative demands of social exchanges” (p. 9). According to Marta (1997), the father is unique to the development of the adolescent because he serves as mediator between the private and social realms. From an ecological perspective, the father is a mediator between the family system and its surrounding systems.

Eating Disorders as a Familial Phenomenon

Polivy and Herman (2002) argue that eating disorders result from the “convergence of several facilitating factors” (p. 205), and even though there is not one identifiable causal factor on which to focus, there are stronger and weaker contributing factors to the problem. The family is the primary socializing agent for the child as this is the context where the child grows and develops (Al Sabbah et al., 2009) and should therefore have more influence in regards to eating disorder development and/or protection from eating disorders. Dunkley et al. (2001) found the media ideal to be the least influential in disordered eating symptomology followed by the boy ideal, self ideal, friend ideal, and finally mother ideal and father ideal. If the mother and father ideal were

found to be the most important ideal to adolescent girls, then it follows that the family should be more influential in encouraging or discouraging endorsement of the thin ideal and sociocultural norms. Thus, the family can be considered to be at the heart of the eating disorder problem because parents influence disordered eating behaviors in four distinct ways: (1) psychosomatic characteristics of the family system, (2) parental influence over self-esteem and self-worth, (3) familial modeling of eating behaviors, and (4) verbal encouragement to diet and lose weight.

Psychosomatic characteristics. Minuchin, Rosman, and Baker (1978) claimed that families with daughters suffering from eating disorders demonstrated certain psychosomatic traits in their family interactions. Over the years, researchers have further developed these characteristics for both anorexia nervosa and bulimia nervosa families. Latzer et al. (2002) define the psychosomatic family environment as one that is “unable to provide a sense of security, availability, and attunement to child’s needs” (p. 583), which contributes to the etiology of specific eating disorders. Family dysfunction in these families predisposes girls to disordered eating “through its direct effect on negative self-esteem” (Fonseca et al., 2002, p. 442). Latzer et al. (2002) found that eating disorder patients score significantly lower than controls on a personal growth scale, especially when related to family encouragement because both anorexia and bulimia patients perceive their families to be less cohesive, less adaptable, more rigid, and exhibiting poorer communication than controls (Hoste, Hewell, & le Grange, 2007; Vidovic, Juresa, Begovac, Mahnik, & Tocilj, 2005). As demonstrated below, both anorexia nervosa and bulimia nervosa are associated with “self-reported pathological family functioning on five dimensions: the family style for problem resolution (problem-solving), transmission

of information (communication), differentiation of tasks (roles), experience of emotions (affective responsiveness), and general functioning” (Fornari et al., 1999, p. 439); however, the manifestation of the dysfunction in anorexic and bulimic families differs according to previous research.

Anorexia nervosa. Families with an anorexic daughter have been described in the research as very rigid and overly organized (Hoste et al., 2007; Humphrey, 1986; Steiner & Lock, 1998; Vidovic et al., 2005), overprotective (Hoste et al., 2007; Humphrey, 1986; Vidovic et al., 2005), and exclusive (Kog & Vandereycken, 1985). These families are also cohesive and enmeshed (Fornari et al., 1999; Hoste et al., 2007; Humphrey, 1986; Kog & Vandereycken, 1989; Vidovic et al., 2005), wherein anorexia may present itself as a failure to individuate from an overly enmeshed and overprotective family (Humphrey, 1986). Vidovic et al. (2005) report that rigid cross-generational alliances are common in these families, and in their study, Kog and Vandereycken (1985) found “a stronger coalition between each parent and the anorectic daughter than between the parents as marital partners” (p. 168), which is exacerbated in divorced families. Thus, the anorexic family appears to be a “tightly knit structure, with interpersonal boundary problems” (Kog & Vandereycken, 1989).

Anorexic families are also conflict avoidant (Fornari et al., 1999; Humphrey, 1986; Kog & Vandereycken, 1989; Vidovic et al., 2005) to the point where they are poor or lacking in conflict resolution skills (Hoste et al., 2007; Humphrey, 1986; Vidovic et al., 2005) as well as lacking in constructive communication in conflict situations (Lattimore et al., 2000). Anorexic daughters tend to react to parental intrusion with submission (Humphrey, 1989; Kog & Vandereycken, 1985), but they do not have a good

relationship with their parents (Kog & Vandereycken, 1985). In return, “parents ignore and negate her genuine self-expressions and developmental needs” (Humphrey, 1989, p. 213) while they “present a façade of perfection, self-sacrifice, and love” (p. 206). Anorexic daughters are therefore characterized by dependency and insecurity in their family systems (Kog & Vandereycken, 1985).

Bulimia nervosa. Parents with a bulimic daughter have been described differently in the research. Bulimic families are highly disorganized (Crowther et al., 2002; Fornari et al., 1999; Humphrey, 1986; Kog & Vandereycken, 1989; Pike & Rodin, 1991; Vidovic et al., 2005), and they report more general family dysfunction (Crowther et al., 2002; McNamara & Loveman, 1990) and negative family interactions when compared to non-bulimic controls (McNamara & Loveman, 1990). They are characterized by high levels of conflict and open hostility (Crowther et al., 2002; Fornari et al., 1999; Humphrey, 1986; Kog & Vandereycken, 1989; McNamara & Loveman, 1990; Pike & Rodin, 1991; Vidovic et al., 2005) with parents and daughters in bulimic families engaging in mutual belittling, blaming, and sulking (Humphrey, 1989). Daughters tend to react to parental intrusion with hostility (Kog & Vandereycken, 1985) and report overall poor communication skills in their families, including problem-solving skills (McNamara & Loveman, 1990).

Because bulimic families are chaotic, conflicted, and critical (Pike & Rodin, 1991; Steiner & Lock, 1998), they enact low levels of family support (Fonseca et al., 2002), affection (Humphrey, 1989) nurturing, caring (Vidovic et al., 2005), and responsiveness to emotions (Pike & Rodin, 1991). Bulimic daughters perceive their parents to be over-involved in their lives to the point that they find it difficult to establish

and maintain separate identities from their parents, but this over-involvement is absent of affective responsiveness (McNamara & Loveman, 1990). These families are less helpful, trusting, and nurturing than controls (Pike & Rodin, 1991). Unlike anorexic families, bulimic families demonstrate a lack of cohesion or connectedness (Crowther et al., 2002; Fonseca et al., 2002; Fornari et al., 1999; Humphrey, 1986; Kog & Vandereycken, 1989; McNamara & Loveman, 1990; Vidovic et al., 2005), poorer expressiveness overall (Crowther et al., 2002), and a low tolerance of expressiveness in daughters (Humphrey, 1986; McNamara & Loveman, 1990).

While it is clear that families influence eating disorder behavior, in one case study reported by Lieberman (1989) there was no other explanation for eating disorder development in one family's four children:

This family appears to have patterns of being enmeshed, rigid, and lacking in conflict resolution. All four children have been involved in the parental conflict. Overprotectiveness does not seem to be a constant or consistent feature. The family was isolated from its surrounding culture as first generation immigrants. There was no obvious special meaning attached to food, nor was there a hyperconsciousness of appearances. . . . Each child in this family is privy to secret communication from one or both parents. Each child has been enlisted into a coalition by each of the parents who are in conflict. (pp. 103-104)

In this case, the family is the only source for the development of the eating disorders because of the isolation of the family from the outside world. This family is truly representative of Minuchin et al.'s (1978) psychosomatic family system.

Self-esteem. In families that do not demonstrate psychosomatic family characteristics, parents still have the ability to directly influence self-esteem and self-worth, which are important protective factors against eating disorders. Young adolescents determine their self-worth from a variety of factors (including appearance, social acceptance, scholastic and athletic achievement, and behavioral conduct), which mostly

stem from family interactions (Kirsh et al., 2007). Family connectedness is viewed as one of the most important protective factors against disordered eating, and parental involvement and communication between parent-child dyads increases connectedness as well as increases the quality of parent-child relationships (Al Sabbah et al., 2009). Parental warmth is also directly linked to adolescent self-esteem, sociability, secure attachments, and low depression (Gittleman, Klein, Smider, & Essex, 1998), and parental encouragement of autonomy is associated with decreased dieting behavior (Polivy & Herman, 2002). Thus, parental support and adequate parent-adolescent communication are positively correlated with self-esteem and social adjustment while they are negatively correlated with deviant and delinquent behaviors (Marta, 1997).

Moreover, parent-child communication is linked with social competence, autonomy, positive attitudes toward academics and work, achievement, and self-esteem, which are all negatively correlated with disordered eating (Al Sabbah et al., 2009). Marta (1997) found that adequacy of communication was most important between parents and adolescents during the high stress phase of adolescent individuation from the family:

The perception of being encouraged and supported, of being able to ‘count on’ someone, helps the entire family re-negotiate rules and roles and allows adolescents to launch themselves into the external world, aware that they are neither alone nor suffocated in an undifferentiated world. (p. 483)

More importantly, Al Sabbah et al. (2009) report, negative relationship and lack of communication with parents are linked to dissatisfaction with weight as well as depression, misconduct, and poor mental health. One-fourth of the girls in their study felt that they were unable to communicate with their mothers about problems, and over half of the girls did not feel comfortable communicating with their fathers; consequently, adolescents’ perceptions of difficulty in communicating with their parents, especially

with the father, was significantly associated with body dissatisfaction (Al Sabbah et al., 2009). Loth et al. (2009) found that their participants

remembered the time when their eating disorder first developed as a challenging time resulting from a difficult transition, personal struggle, or negative influence in their life and reported feeling as though an increase in family support might have helped them to navigate this transition more successfully. (p. 150)

Therefore, adolescents who report lower levels of family communication, parental caring, and parental expectations are at a higher risk for developing eating disorders (Loth et al., 2009; Polivy & Herman, 2002).

Modeling. In addition to harms to self-esteem, parents can demonstrate sociocultural norms through the modeling of dieting behavior. Studies have shown that parental weight concern, disordered eating behaviors, and negative family communication about eating and weight are correlated with disordered eating (Crowther et al., 2002; Gowers & Shore, 2001). Kog and Vandereycken (1985) report significantly more eating disorders in first degree relatives (fathers, mothers, sisters, and brothers) of patients with both anorexia and bulimia, which suggests that a family member suffering from an eating disorder is often used as a model in these families. In fact, maternal history of an eating disorder is most linked to eating disorders in daughters (Field et al., 2008). Wertheim et al. (1999) explain how food modeling can lead to disordered eating behaviors in adolescent women:

Food abstaining behaviors such as crash dieting are generally more extreme, potentially health-compromising forms of weight loss attempts, as compared with general dietary restraint. Given the additional dangers of food abstention as a weight loss method, it is unlikely that many of the parents who encourage their daughters suggest that they do so by completely abstaining from food for periods of time. Nonetheless, these sorts of behaviors are likely to be observable if the parents are doing them because they involve missed meals, and daughters may learn about such methods and interpret them as condoned by parents. (pp. 182-183)

Family mealtime is also a significant time for modeling eating behavior. Loth et al. (2009) found that rules placed on mealtime, food, and the availability of food were highly correlated with eating disorders. The authors argue that food rules

undermine a child's ability to respond to their own feelings of hunger and satiety. . . . Parental control during mealtime has been found to send children the message that their weight status is undesirable and that they are not in control of their eating habits. (p. 150)

Modeling is reported from patients with both anorexia and bulimia. Anorexia nervosa patients primarily report maternal modeling of weight concerns, as mothers of daughters with anorexia were more concerned with their own thinness than anyone else's and ranked themselves as not thin enough (Kog & Vandereycken, 1985). Bulimia nervosa patients also report modeling during mealtime. Crowther et al. (2002) concluded that bulimia patients report more stress and control during family mealtime, as food was used more for punishment and reward compared with repeat-dieters and non-bulimic controls. Moreover, the authors also found the strongest predictors of bulimic symptomology to be control of food intake and rules of family mealtime.

On the other hand, family meals can be used as a protective boundary guarding against eating disorder symptomology. Neumark-Sztainer et al. (2008) found that girls who report more frequent family meals in adolescence are less likely to develop eating disorder symptoms than those who report fewer family meals. In fact, among girls, frequent family mealtime in adolescence played an important protective role in eating behavior and lowered the prevalence of extreme weight control behaviors. In addition, they found that family meals were also correlated to higher psychosocial well-being. Loth et al. (2009) contend that parents can make mealtime a positive learning experience by

making family meals together a routine in the family: “Youth who reported eating more frequent family meals, experiencing a more positive atmosphere at family meals, placing a higher priority on family meals, and having more structured family meal settings were less likely to report unhealthy weight control behaviors” (p. 150).

Verbal encouragement. Parental modeling of dietary restraint does not appear as influential, however, as verbal encouragement to diet and lose weight (Wertheim et al., 1999). Family pressure to be thinner contributed to overall body dissatisfaction in disordered eating samples (Goodman, 2005; Green & Pritchard, 2003), and parental encouragement to diet is associated with greater dieting and increased body image concerns (Dunkley et al., 2001; Gowers & Shore, 2001; Green & Pritchard, 2003). Loth et al. (2009) found that their participants were directly affected by their family’s emphasis on weight and body image, which created “an environment in which young people also place a strong emphasis on these attributes” (p. 150). Adolescent women who have parents that tease them about their weight and shape “demonstrated higher levels of body dissatisfaction, social comparison, internalization of the sociocultural ideal of thinness, and lower levels of self-esteem” (p. 150). In addition, Smolak et al. (1999) found that parents of fourth grade girls who encouraged their daughter to control her weight were more likely to have a daughter who dieted frequently.

Families with anorexic as well as bulimic daughters demonstrate these encouragement behaviors. Polivy and Herman (2002) write, anorexia nervosa patients report familial encouragement of their disorder because they are often praised by family members for slenderness, self-control, and discipline when the disorder develops, and this type of encouragement from family members generally remains once the daughter has

become severely emaciated. Bulimia nervosa patients also report perceived pressure from family members to lose weight in childhood and adolescence (Moreno & Thelen, 1993), and 53% of bulimic women report that they began their binge and purge episodes after pressure from their family to lose weight (Stice, 1994). When compared with controls, bulimics report more pressure from family members to lose weight and more critical comments from family members about weight and shape (Crowther et al., 2002; Moreno & Thelen, 1993). According to Moreno and Thelen (1993), bulimic families hold more negative attitudes toward overweight people and emphasize thinness more than controls.

Despite the strong influence of the family system in the development of eating disorders, the family system exists among other systems. Adolescents with eating disorders usually report negative events regarding their family, their peers, and their school atmosphere (Kirsh et al., 2007). Rather than naïvely assert that there is one cause or ultimate answer to the eating disorder phenomenon, I agree with Harrison and Cantor's (1997) assertion that all of the risk factors mentioned above combined with other sociocultural and mediated risks "collectively set the stage for the development of disordered eating" (p. 41). Narrative stories from daughters suffering/recovering from eating disorders is one unique way to examine the perceived ecological nature of their eating disorder experiences.

Eating Disorder Narratives

Each family member constructs their own understanding of functioning within the family system (Henry et al., 2006), but the understanding of the parents is not what ultimately leads to the daughter's disordered eating habits. Henry (1994) argues that "adolescents' perceptions of specific parenting behaviors that occur within parent-

adolescent subsystems” are directly related to adolescent adaptation to their surroundings. Bronfenbrenner (1979) has also argued that in the ecological model “what matters for behavior and development is the environment as it is *perceived* rather than as it may exist in ‘objective’ reality” (emphasis in original, p. 4). Indeed, Wertheim et al. (1999) found daughters’ reports of family interactions to be more predictive of eating behaviors than the reports of parents, which suggests that daughters’ perceptions of familial interactions are more important to the development of their disorders than parents’ perceptions. Narrative accounts, as a record of daughters’ perceived experiences, are therefore an important method for capturing a portrait of the father-daughter relationship and daughters’ experiences with eating disorders.

Fisher (1987) claims, “humans are essentially storytellers” (p. 64), and the elements of stories represent human life through their “communicative expression of social reality” (p. 65). In addition, he argues that the “narrative impulse is part of our very being because we acquire narrativity in the natural process of socialization” (p. 65). Lieblich, Tuval-Mashiach, and Zilber (1998) expand on Fisher’s assertion when they write, “People are storytellers by nature. Stories provide coherence and continuity to one’s experience and have a central role in our communication with others” (p. 7). Bosticco and Thompson (2008) claim that at a very basic level, people tell stories to help them understand the world, their daily experiences, and their own identity.

Thus, narratives are “a way of relating a ‘truth’ about the human condition” (Fisher, 1987, p. 63) as they help us understand our own lives as well as the lives of others. Lucaites and Condit (1985) expand this notion further as they write, “The function of such narratives is not to present a pleasurable tale for its own sake . . . but rather to

illuminate the factual nature of the universe as a means of providing information for human use” (p. 93). Narratives are useful for the “discovery, revelation, and presentation of a truth” (Lucaites & Condit, 1985, p. 93) about certain human experiences. Thus, narratives are useful to social science researchers because they reveal human descriptions, explanations, and allow for predictions about certain human experiences (Fisher, 1987).

Sharf and Vanderford (2003) and Fisher (1987) agree that narratives capture reasons, values, and motives for certain actions regarding illness. “Such stories give legitimacy to the often unacknowledged expertise of patients” (Sharf & Vanderford, 2003, p. 15) as patient narratives serve to challenge previous research and biomedical knowledge that ignored the voices and experiences of the patients themselves. Narratives use “subjective language to talk about the internal, nonverifiable experience of illness, of being in dis-ease” (Sharf & Vanderford, 2003, p. 11). Fisher (1987) claims that narration is also useful in giving order to human experiences, relating those experiences to others, forming communities, and defining one’s life. Sharf and Vanderford (2003) expand on the usefulness of narratives as they highlight five uses of illness narratives in the field of health communication: sense-making, asserting control, transforming identity, warranting decisions, and building community.

First, illness populations use *narratives for sense-making*. Narratives serve to create meaning out of seemingly random events, people, and actions as they allow us to make our own connections and understandable patterns. For those individuals whose lives have been altered because of their illness experiences, narratives “enable us to cope with chaotic or confusing conditions” (Sharf & Vanderford, 2003, p. 16). In addition,

sense-making might not be the same for two people with similar illness experiences, which is important for women with eating disorders, as their respective environments might be different before the onset of their disorders. The authors add that sense-making “frequently involves assigning responsibility and sometimes blame” (p. 19). Being able to generate one’s own story allows the narrator to experience agency in her own life.

Second, *authorship of self-narrative allows those suffering with illness to reassert a degree of control* that may have been stripped away in the process of becoming sick, seeking medical help, negotiating medical space with families, etc. Simply, the act of ordering events in one’s life is an act of control. Creating a narrative also allows the one with an illness to emphasize certain aspects and contributing factors of the illness. By labeling causes for symptoms and behaviors concerned with one’s illness, individuals regain some semblance of control over their own lives.

Third, Sharf and Vanderford (2003) describe the storytelling process as “an approach to self-knowledge” (p. 21), as *narrative accounts function to record shifts in identity*. Both positive and negative experiences of illness can result in identity shifts, as we are different before illness, in illness, and after illness. In addition, the narrative process illuminates “various facets of [the narrator’s] identity” (p. 23). Similar to an altered identity, the authors explain how illness affects relationships: “Another kind of challenge revealed through narrative analysis is the way in which illness alters relationships, an inherent dimension of identity. While renegotiation of relationship roles tend to be gradual, the impact can still be quite dramatic” (p. 22).

Fourth, *narratives explain the decision-making process*, as they reveal the narrator’s reasoning for actions, both in routine activities and concerning their health.

Narratives are also a means for the narrator to justify why certain decisions have been made and why future decisions will be made. Sharf and Vanderford (2003) explain, “In telling about their experiences of sickness, narrators are able to position themselves” as narrative accounts

describe conflicts and explain problems, including the difference between the way things were in the story and the way the storyteller desired them to be. They disclose a storyteller’s attitudes and judgments about events, actions, people, motives, types of relationships, and goals. As a result, stories reveal (implicitly or explicitly) the way the teller thinks the world ought to operate. (p. 25)

Finally, *narratives can also foster a community* as individuals share their personal stories with those who are going through similar experiences of illness. Communal sharing of stories can also increase awareness and public advocacy concerning an illness population. As Bosticco and Thompson (2008) claim, individual stories can be compiled as a means to link the experiences of multiple individuals to a central event.

Because narratives are integral to the self and to the self’s relationship with other selves, narratives serve specific purposes for illness populations, health-care providers, and researchers in health communication. First, stories are a means by which people find meaning in the things that happen to them and (re)define their sense of self and self-image. In fact, Lieblich et al. (1998) claim that narratives “*are* people’s identities” (p. 7). Second, understanding narratives can help health-care providers determine diagnosis and understand prognosis. Finally, for researchers, narratives provide key information about a particular health problem or an illness population (Bosticco & Thompson, 2008). Moreover, Elliott (2005) asserts that narratives can uncover “meanings [people] attach to their experiences” (p. 17). Therefore, narrative interviews are a legitimate means to

“interpret and understand human relations” (Fisher, 1987, p. 89) in the realm of eating disorder behavior and father-daughter communication.

Broussard (2005) used narratives in her study about bulimic women’s experiences with their disorders. She claimed, “Very few investigations have been published that have given an understanding of the experiences of bulimic women *from their perspective*” (emphasis added, p. 45). In her study, 13 women who self-identified as being actively bulimic described their experiences and feelings concerning their bulimic behaviors. She then used thematic analysis and exemplars to illustrate the four findings that emerged from the 13 narrative accounts of bulimia. First, all of the women in the study felt as though their behaviors served to isolate themselves from others. Second, all of the women in the study described sensations of fear, and third, the women described being in a mental or psychological battle of rationalization. Finally, the women described their compensatory behaviors (i.e., purging after a large meal) as a resolution to pacify the brain and guilt from eating. Broussard’s (2005) study shows the usefulness of narratives in this context.

Since the father’s communicative role in child development is of growing importance (Bronstein, 1988b; Catalyst, 1988), the aim of this study is to begin to fill the gap concerning fathers’ communicative roles in the development of disordered eating behaviors not only in the family system but also in the broader ecological model of risk by using narratives. The overarching goal of this project is to discover the paternal role in the development, maintenance, and recovery of eating disorders because of the importance of the father in the daughters’ overall psychological development and in the

daughters' abilities to navigate between systems in the ecological model. With this goal in mind, I present the following research questions:

RQ1: How is the nature of the father-daughter relationship communicatively constructed by the daughter?

RQ2: How do the communicative roles the father performs (silence, passivity, vocal) enable the performance of the eating disorder?

RQ3: How do the communicative roles of fathers of daughters with anorexia nervosa differ in performance from the communicative roles of fathers of daughters with bulimia nervosa?

ENDNOTES

¹ It is important to note that reports of family functioning may or may not be representative of the entire family system, as many fathers were not included in these previous studies because they were unavailable for participation at the time of study.

CHAPTER 3: METHOD

Methodology

Because there is relatively little research addressing the father-daughter dyad in the eating disorder literature, I conducted preliminary primary research as a way of understanding how women perceived the role of their father in their eating disorder through their own personal narratives.

Methodological Orientation

My research commitments derive from an interpretive approach to health communication (Dutta & Zoller, 2008). Interpretive scholarship itself derives from what Craig (1999) describes as the sociopsychological tradition in communication research. In this tradition, communication is a “process of expression, interaction, and influence,” which “produces a range of cognitive, emotional, and behavioral effects” (Craig, 1999, p. 143). In this study, I aim to examine how the communicative expression, interaction, and influence of the family can subsequently lead to the cognitive, emotional, and behavioral development of eating disorders in adolescent women.

According to Dutta and Zoller (2008), interpretive scholars “seek to understand *how* meaning is constituted and contested through interaction” (emphasis added, p. 6), and scholars who apply the interpretive approach in health communication “engage in documenting detailed descriptions of health meanings and the processes through which they are constructed and enacted” (p. 6). In this study, I examined *how* messages were communicated between the father and the daughter. To accomplish this task, this project

employed narrative interviews to detail the etiological significance of disordered eating messages and how they became meaningful between the father and daughter in these households. Moreover, the interpretive perspective “focuses on how reality is socially constructed” (p. 12). I examined how the reality of eating disorders was socially constructed within these families, particularly within the father-daughter dyad. Finally, the interpretive perspective emphasizes the researcher as human instrument, so it is important for the reader to first understand my position as a researcher to better understand the nature of the instrument and the data collection and analysis choices that were made for this project.

Researcher Position

I decided to become a researcher because I thought I could change the world. I now understand that incremental achievements in research lead only to more inquiry. Eventually inquiry benefits society, but I knew going into this project that I was not going to change the world tomorrow or even next year. I know now, however, that my research has the potential to make life better for the groups of people I aim to study. So, I am a researcher not because it will benefit me in any way (although I have grown over the course of this project), but because it will eventually benefit our understanding of illness and communication and how they mutually influence one another.

I hope that my research can, at some point in my lifetime, help health-care professionals better diagnose and treat adolescent women with eating disorders. I also hope to expand the literature so that fathers are included for a more complete family portrait and a better understanding of the ecological model of eating disorders. More importantly, though, I hope that my work can eventually lead to a prevention-first

perspective for eating disorders. Too much focus is placed on curative measures (though my aim is not to decrease or discredit these measures), when a complete ecological model may eventually help health care professionals prevent eating disorders instead of treating them.

More than these hopes though, I came to this project with a realistic grasp on how much I could actually change the world and the lives of young women confronting the ever-present issues of body image and body satisfaction. I am, first and foremost, a young woman who struggles with the normative nature of body dissatisfaction, and a major influence on my position as a researcher stems from my own experiences with anorexia nervosa. Although I was never formally diagnosed, I spent a year of my life struggling with the constant fear of gaining weight. My own father played an integral communicative role in the development and recovery process of my own eating disorder, which was a motivating impetus to this study.

Because of my own experiences, I understand the risks of studying such a fragile population. Research on eating disorder studies suggests that “social desirability may motivate respondents to deny potentially shameful behaviors in certain assessment formats (i.e., interviews) so that others will perceive them more positively” (Lavender & Anderson, 2009, p. 546). It was important, therefore, for the participants in this study to have complete anonymity and confidentiality while writing their narratives. Presentation and societal norms can be problematic in face-to-face interviews with this population, especially when describing family relationships; participants are more likely to respond honestly if the format provides greater anonymity (Lavender & Anderson, 2009). In

addition, perception is an important aspect to the development of eating disorders. As a result of these factors, this study uses narratives as its primary source of data.

Method

Henry et al. (1996) argue, “The family system is experienced differently by each individual in the family, who constructs his or her own reality” (p. 284). Because of their ability to convey the perception of the participants, this study is grounded in narratives, in the form of life stories of the adolescent women. Bosticco and Thompson (2008) claim, “The basic elements of a story consist of an individual (or individuals) and movement through a series of developments over time” (p. 39). Fisher (1987) asserts that narratives “enrich our understanding of communicative interaction” as they are “stories we tell ourselves and each other to establish a meaningful life-world” (p. 62). Elliott (2005) describes three key features of narratives in research: they are chronological, which helps the researcher determine sequence of events; they are meaningful, which helps the researcher determine what is important to the individual; and they are inherently social, which helps the researcher determine the narrator’s relationship to the other people in their social environment.

Narrative interviews are also less threatening than face-to-face interviews, which allows respondents to answer questions without having their story interrupted (Elliott, 2005) and provides each participant with the space to structure their answers to the depth and breadth of their choosing. Allowing the participants to explain their situations in their own time, in their own way, provides a richness in the data, as every eating disorder case has its own unique variance in causality due to numerous risk factors. For these reasons, I provided a web-based recruit script to potential participants in the study (detailed below)

that explained the nature of the research project, but I did not have any additional contact with the participants in this study to ensure their confidentiality and their anonymity.

Data Collection

Originally I sought to work with five eating disorder treatment clinics in Denver, Boulder, and Fort Collins, Colorado, but I was ultimately unable to work with them for several reasons. First, The Eating Recovery Center in Denver, The La Luna Center in Boulder, and the Eating Disorder Treatment Program at the Children's Hospital in Denver declined to participate in the study, as they thought their patients were too vulnerable and the study might interfere with their patients' care. Second, the La Luna Center in Fort Collins and the Eating Disorder Center of Denver agreed to read a research proposal, but they could not provide me with a contact person or a timeframe in which they would approve (or disapprove) the proposal. There was no guarantee the clinics would be willing to work within the timeframe of the project.

Given these constraints, I decided to recruit participants from an online support group setting where I would be in charge of posting the survey and collecting the survey data without having an unidentified third party to track down. This new method of data collection also guaranteed that I would be the only person who could access the responses. The original hope was to post the recruitment script on an online support group forum associated with an eating disorder clinic because it would guarantee the participants had resources if they were disturbed by the questions; however, I discovered that I would still have to rely on a third party moderator to post the script, gather names of those interested, and then send those names to me. In addition, the posts on their forums were months apart and sporadic, so there was no guarantee that potential

participants would see the script within the timeframe of the project. Because of the above mentioned factors (and IRB's guidance), I decided to recruit from a public, online support site, SupportGroups.com. However, after six days of data collection, the website blocked my username and email as well as deleted all of the posts in each of the four support groups because a user had complained that I was spamming their support group instead of providing support and guidance.

Because of the complications with data collection, and on IRB's advice, I decided to recruit participants from the Colorado State University campus. Dr. Helen Bowden, who works with Hartshorn Health Center's Counseling Services as group coordinator of the Body Image/Nutrition Support/Recovery Group, agreed to pass out paper copies of the recruit script to her clients in the support/recovery group. Participation was still voluntary and anonymous, as the women in the support group had the choice to access the survey or not.

Dr. Jennifer Bone, Basic Course Director in the Department of Communication Studies, also agreed to email all of the SPCM 200: Public Speaking instructors asking them to pass on the recruit script to their students either via email or their RamCT shell. The email specified to the instructors that participation/non-participation would not affect student grades in the class in any way. As with SupportGroups.com, interested individuals were then able to link to the online survey to participate in the study. Participation was not discussed in the classroom, so participation remained anonymous and voluntary.

Standardized qualitative narrative interview schedules were then made available through Survey Monkey for participants recruited from (1) SupportGroups.com's

anorexia, bulimia, EDNOS, and eating disorder online support groups, (2) Dr. Helen Bowden's Body Image/Nutrition Support/Recovery groups affiliated with Counseling Services at Colorado State University, and (3) Colorado State University's SPCM 200: Public Speaking classes.

Description of research sites. SupportGroups.com and Colorado State University served as the two research sites for this project.

SupportGroups.com. SupportGroups.com is a growing public online support groups community that offers a variety of over 200 publicly available support groups including, but not limited to, cancer, pregnancy, smoking, migraines, and unemployment, which are divided into the four broad categories of addiction, cancer, mental health, and treatments/medications. For the purposes of this study, there were four specific pro-recovery support groups available: anorexia support group, bulimia support group, eating disorder not otherwise specified (EDNOS) support group, and a more general eating disorder support group.

Each support group provides links to other resources (e.g., information about the specific disorder, treatment programs, and contact information for health care professionals) for its members. For the eating disorder support groups, the links to other resources were provided by EatingDisordersOnline.com, which claims to be committed to the community, treatment, and recovery of eating disorders.

EatingDisordersOnline.com provides up-to-date information about treatment centers, resources, and answers to frequently asked questions for members searching for more information. EatingDisordersOnline.com also provides a directory of support groups, articles, blogs, statistics, treatment, and recovery links (not affiliated with

SupportGroups.com). They endorsed SupportGroups.com's eating disorder support groups as being helpful to "individuals who want to connect during life's challenging times." In addition, EatingDisordersOnline.com claimed that SupportGroups.com is a place to "share experiences, evaluate information, and get support during times of need, illness, treatment, and recovery." The users of SupportGroups.com believed this statement to be true based on their commitment to sharing their experiences with other members of their respective online communities.

Anyone with a working email address is able join SupportGroups.com. Once they create an account, the user can join and participate in the many groups and forms of support the website offers. When I joined on January 29, 2011, the anorexia support group had 250 members and 1,027 posts; the bulimia support group had 280 members and 1,015 posts; the EDNOS support group had 42 members and 196 posts; and the eating disorder support group had 693 members and 4,249 posts. Based on group totals, it was evident that new members joined SupportGroups.com on a daily basis. In addition, all of their posts, discussions, videos, and tips were publically available on the website, and according to the date and time stamps of posts, members of each support group posted journals and discussions as well as commented on the posts of others daily. Within each support group, members were able to post their thoughts, write journals, participate in discussions, and share videos with other members of the support group. In addition to sharing their own thoughts about their struggles, members were able to read and support other members by commenting on the posts, journals, and videos of other members. Members shared support tips with other members in their support group, including

detailed articles, podcasts, websites, and newsletters that had worked for specific members.

Based on user involvement, participation, and commitment to other members, it was clear that the users believed that their support group was a credible site for support, recovery, and community. The posts of individual members in the eating disorder support groups were genuine, heartfelt posts about their lives and struggles with their specific eating disorder. When members supported each other, they usually signed their comments with genuine advice, warm wishes, and hopes for the future. Based on my observations, the participants genuinely wanted the support and advice of other members. Moreover, based on the reactions¹ to my recruit script posted in the anorexia support group, it is clear that the members take the support group's purpose of support and recovery very seriously.

Colorado State University. There were two specific groups recruited from Colorado State University: Dr. Helen Bowden's clients struggling with body image and nutrition and Communication Studies public speaking students.

Body image and nutrition counseling is affiliated with Colorado State University's Counseling Services, which is part of the larger CSU Health Network. Specifically, Counseling Services is committed to mental health for the students at CSU. Their website states, "Seven of the top ten health issues presented by college students are psychological in nature. Because of this, CSU health Network has decided to take a progressive approach to mental health care issues." Dr. Helen Bowden is one of the counselors in this area. In addition to body image and nutrition, Counseling Services offers individual and group treatment in the following areas: stress and sleep, alcohol and

other drugs, suicide prevention, sexual health, and stress management. The CSU Health Network website specifies that students are provided “an initial visit with one of the counseling staff, follow-up care or referral as needed and help during a crisis.” This includes both individual and group counseling programs. Visits to Counseling Services are free of charge to students (tuition and fees cover the costs).

Body image and nutrition counseling focuses on normal eating habits, which is defined by the CSU Health Network’s website as

being able to eat when you are hungry and continue eating until you are satisfied. It is being able to choose food you like and eat it and truly get enough of it – not just stop because you think you should. Normal eating is being able to use some moderate constraint in your food selection to get the right food, but not being so restrictive that you miss out on pleasurable foods.

Anyone who deviates from or struggles with normal eating practices (i.e., over-eating, eating with restrictions not based on medical condition, under-eating, not eating, eating but purging, etc.) is eligible for individual or group body image and nutrition counseling. Other than focusing on normal eating, the CSU Health Network website also provides general information about eating disorders: “Eating disorders such as anorexia, bulimia, and binge eating disorder include extreme emotions, attitudes, and behaviors surrounding weight and food issues. They are serious emotional and physical problems that can have life-threatening consequences.” Having this information on the website might encourage students to seek counseling if they are struggling with eating disorders, and since it is free of charge, there is less of a deterrent for students to seek treatment.

The Department of Communication Studies offered 51 sections of SPCM 200: Public Speaking taught by 27 different instructors in the spring semester of 2011 when this study requested participants. Of the 1,186 students enrolled in public speaking during

this request, 495 were male (42%), 691 were female (58%), 389 were freshmen (32.8%), 485 were sophomores (40.9%), 185 were juniors (15.6%), and 127 were seniors (10.7%). They also represented 108 different majors across the Colorado State University campus, which included agricultural business, biological science, creative writing, equine science, finance, human development and family studies, mechanical engineering, natural resource tourism, pre-construction management, psychology, sports medicine, writing, zoology, undeclared, etc. Because of the broad nature of the course and the diversity among the students enrolled in the course, this sample was also more representative of the general public, as they are not all struggling with an eating disorder.

Participants. Participation in the study was voluntary, confidential, and completely anonymous. The participants were a sample of 15 women (n=4 from supportgroups.com and n=11 from Colorado State University). Seven women identified themselves as struggling with anorexia nervosa, five women with bulimia nervosa, two women with EDNOS, and one woman self-identified as struggling with bulimirexia, which is a combination disorder (not recognized by the American Psychiatric Association's (2000) *Diagnostic and Statistical Manual of Mental Disorders*) that cycles between extreme under-eating and extreme overeating accompanied by compensatory behaviors. All of the participants were between the ages of 18-35. These women volunteered to participate in the study after reading the recruit script (an online request for participants posted in their respective support group for those on supportgroups.com, a paper copy passed from Dr. Helen Bowden to the clients in her Body Image/Nutrition Support/Recovery Group, and an announced/posted recruit script for the public speaking students). The participants from supportgroups.com should have already been

accustomed to sharing their thoughts about their disorder through writing online, so the research procedures should have been comfortable for them. The participants from the Body Image/Nutrition Support/Recovery Group were already comfortable speaking about their experiences with eating disorders in front of both their counselor as well as other members in their group, so they should have also been comfortable with the format of the questions. Finally, even though the public speaking students are not accustomed to sharing their experiences with eating disorders, their self-identification as someone struggling with or recovering from an eating disorder makes them important participants in the study.

Procedures. First, I uploaded the standardized qualitative narrative interview questions (Appendix A) to Survey Monkey one week prior to the beginning of recruitment. Survey Monkey was used for this study because it guaranteed that I was the only person who could access the responses once they were submitted. More importantly, Survey Monkey provided the option not to track the IP addresses of the responses, which allowed me to further guarantee confidentiality and anonymity. In addition, Survey Monkey was ideal because of the ease of building the survey and posting it free of cost while still ensuring security to the participants, and it also ensured the participants ease when answering the questions because of its user-friendly format.

Second, I sought permission from SupportGroups.com, as per their guidelines, by emailing them a request for permission to post the recruit script to each of the four support groups. A copy of the recruit script was printed in the body of the email (a copy of this email can be found in Appendix B). There was no response to my initial email

requesting permission. I tried to email them for permission two more times before I proceeded with recruitment, as per IRB's request.

In order to post the recruit script, I created an account with SupportGroups.com, which entailed providing them with a username, password, and working email address. Once I had an account, I joined the anorexia, bulimia, EDNOS, and eating disorder support groups. I posted the scripted recruit message (Appendix C) in each of the four support groups. Within the recruit script, I disclosed that I had struggled with an eating disorder in the past in order to establish commonality and credibility with the participants. I observed the posts in each support group, and after a couple of days when the recruit script was no longer visible, I posted the recruit script a second time to each of the four support groups to maximize the number of members who saw the recruit script. The goal was to post the recruit script to each support group about twice a week (depending on the activity of the participants) for four weeks. This process was impossible, however, as SupportGroups.com blocked me from their website (banned my email address and deleted all of my posts) after only six days because a user complained that I was spamming the support group and not providing guidance and support.

With an n=4, I contacted Dr. Helen Bowden, group leader of the Body Image/Nutrition Support/Recovery Group affiliated with Counseling Services at Colorado State University. We met on March 9, 2011 to discuss my research project and the procedures of passing out the recruit script and taking the survey. She agreed to pass out the recruit script to all of her clients over a two-week period beginning March 21, 2011, as she only sees each of her clients once every two weeks.

I also met with Dr. Jennifer Bone, Basic Course Director in the Department of Communication Studies about disseminating the recruit script to all of the SPCM 200: Public Speaking instructors. On March 8, 2011, Dr. Bone and I worked together to craft an email to all of the SPCM 200: Public Speaking instructors with information about the project and instructions on how to deliver the information to their classes. Dr. Bone then sent the email from her account to all of the SPCM 200: Public Speaking instructors (a copy of this email is provided in Appendix D). We left it to the discretion of each of the instructors as to whether or not they would pass on the recruit script to their students as well as how they would discuss it with their class(es).

A link to the narrative interview was provided in the recruit script for all participants. The survey was already open, so potential participants were able to respond immediately once the recruit script was made available to them. The first page of the interview available to the participant was a cover letter (Appendix E) that had to be acknowledged before the participant could access the rest of the questions. The cover letter detailed the nature of the research, guidelines for participating, interview procedures, contact information, as well as risks and benefits of participation. By clicking the button at the bottom of the cover letter, the participant acknowledged the cover letter, thus giving their consent to participate in the study.

After a predetermined time period for each group (six days for SupportGroups.com, three weeks for the public speaking students, and two weeks for Dr. Helen Bowden's clients), access to the survey was closed via Survey Monkey on April 2, 2011. The narrative interviews were collected and marked with identification numbers based on the date and time of their responses. The narratives were then stored digitally

through Survey Monkey (to ensure the original documents were kept secure), electronically as a downloaded file, and as a hard-copy for the data coding process. During this process, I had no direct contact or correspondence with any members of SupportGroups.com or with any of the respondents who chose to respond to the narrative interviews for the purpose of preserving their autonomy and anonymity.

Measuring instruments. A standardized narrative interview schedule was provided to all participants to ensure comparable data. There were 13 questions in total that would have taken the participant a maximum time of one hour to complete. Two questions asked about basic demographic background (age and ethnicity), and two questions asked about the background of the eating disorder. Nine open-ended questions then addressed the nature of the research questions: four concerned the nature of the father-daughter relationship; three addressed communicative roles of the father that either enable or constrain the eating disorder; and one concerned the overarching goal of the research project by asking about the father's role in the development, maintenance, and recovery of the eating disorder. One final question asked the participants to add any information they felt was important to their situation. There were no questions specifically designed to address the third research question, which sought to differentiate between the communicative roles of fathers with daughters suffering from anorexia nervosa and fathers with daughters suffering from bulimia nervosa. After the narrative interview questions were closed on Survey Monkey, I compared the themes that emerged from each set of narratives to address the third research question.

Data Analysis

Reading the narratives first-hand also allowed me to examine their accounts of relationships with their family, their father, and their health in a way that I would not have been able to reading the work of other authors. The individual participant's perceptions of her family unit helped explain family circumstances that contributed to her disordered eating behaviors. Narratives that revealed the participant to be under the age of eighteen were not considered as part of the data because their status as minors would not have allowed them to provide consent for themselves, and it was not possible to gain the consent of their parents. In addition, narratives where the participant did not have a father-figure were not considered in the data because those narratives were irrelevant to the research questions. Finally, narratives that were incomplete or did not complete at least half of the narrative questions were excluded from the data, as their narratives did not present a portrait of the father-daughter relationship.

To answer the research questions, I adapted Strauss and Corbin's (1990) method of grounded theory for coding the narratives. First, I open-coded each thought unit in a different color throughout the narratives. Each color represented a different thought unit, and the colors remained consistent throughout all of the narratives. Second, using Strauss and Corbin's (1990) constant comparative method, each narrative was compared to the rest of the narratives to discover trends and differences that emerged from the thought units. Third, the trends and differences were then labeled as themes (groups of consistent codes) emerging from the narratives. The narratives were then re-evaluated to check that all the themes were present in each narrative. The similarities and differences that emerged from the narratives became the overarching themes explored in the following

analysis chapters as they answer the research questions. The next chapter will address the first research question and discuss the codes and themes that emerged from the narratives that explain how the nature of the father-daughter relationship is communicatively constructed by the daughter.

ENDNOTES

¹ One member of the anorexia nervosa support group directly responded to my posted recruit script on the discussion board of that group through the “comment” function. She commented again when I posted the recruit script to the discussion board a second time. Her messages to me revealed that she believed I was spamming their support group when the purpose of the group was support. Because of the parameters of the study, I did not respond to her comments in any way, and based on discussions with IRB, her comments cannot be reprinted in this text.

CHAPTER 4: THE NATURE OF THE FATHER-DAUGHTER RELATIONSHIP

This chapter discusses the narrative themes that address the first research question: How is the nature of the father-daughter relationship communicatively constructed by the daughter? The participants' narratives reveal four narrative themes that help to answer this question: characteristics of the father as described by the daughter, characteristics of the daughter, father-daughter patterns of talk, and characteristics of the father-daughter relationship (see Figure 4.1). These themes have been organized in this chapter to best explain their relationship to one another and address how the nature of the father-daughter relationship is communicatively constructed by the daughter.

The first theme, *characteristics of the father as described by the daughter*, consists of three codes: fathers' health and happiness, addiction and abuse, and fathers' work and accomplishments. The second theme, *characteristics of the daughter*, is comprised of two codes: daughters' willingness to engage and daughters' acceptance. The third theme, *father-daughter patterns of talk*, is built by six codes: frequency of talk, personal talk, general talk, general talk as strategic, talk about daughters' food and behavior, and evolving patterns of talk. Together the first three themes provide a picture of the father and daughter as separate people coming together as a dyad in talk. These three themes combine and work to inform the final theme, *characteristics of the father-daughter relationship*, which is defined by six codes: frequency and presence, roles of the father, emotions experienced, support, fathering quality, and evolution in the relationship.

The fourth theme, combined with the previous three themes, works to address how the father-daughter relationship is communicatively constructed by the daughter.

In Figure 4.1 below, the four themes can be seen to influence one another and therefore define and characterize the father-daughter relationship. On the left and right sides of the figure, the father and daughter are represented as two separate individuals with their own separate characteristics, priorities, and interests. They come together as relational partners through talk (or lack thereof) with one another, in the center. Through talk and interaction, the relational partners define their dyadic identity, the father-daughter relationship. The arrows in the figure represent the flow of change, as incremental changes in father characteristics, daughter characteristics, or father-daughter talk can then lead to changes throughout the father-daughter relationship. Below, I explain each of the narrative themes further.

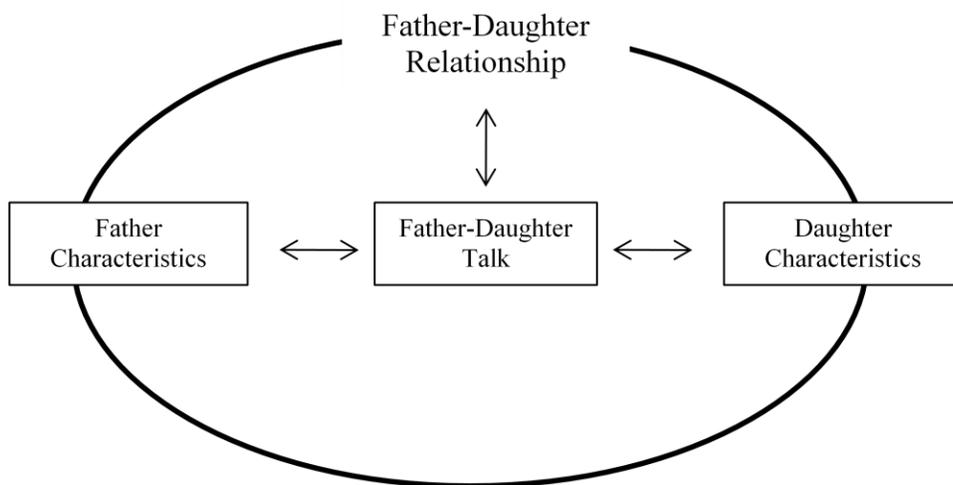


Figure 4.1. Interdependent Relationships between Narrative Themes

Characteristics of the Father as Described by the Daughter

Within their narratives, daughters address their fathers as people outside of the father-daughter relationship as well as fathers inside the relationship using three codes that speak to the nature of the father-daughter relationship as well as to the daughters' eating disorders. Daughters describe their fathers' health and happiness, alcohol/drug addictions, and abuse in the relationship. Interestingly, daughters also claim their fathers are hard working men, which informs their conceptions of their fathers as people. The descriptions below address their fathers as people outside of the father-daughter relationship as well as fathers inside the relationship.

Health and happiness. Daughters were occupied with their fathers' health and happiness in several ways. The following three data exemplars¹ demonstrate how perceptions of fathers' health practices can serve as both points of connection and separation in the father-daughter relationship.

“I feel like I can identify with him better because he is trying to lose weight”
(Participant 5).

“My dad is almost 50 [. . .] and has recently beat cancer. [. . .] I have had this for so long I don't remember what it was like before” (Participant 6).

From the narratives above, it is apparent that participants 5 and 6 feel a connection with their fathers because of their fathers' health situations. Participant 5 is better able to identify with her father because of his new health practices with weight loss whereas participant 6 focuses more on overcoming health problems in her narrative. There is hope in her writing that if her father could overcome cancer, she can also overcome her health problems, namely her eating disorder. On the other hand, participant 20 emphasizes her father's poor health choices in her narrative. She describes the ways her father does not

take care of his body, which becomes important for her justification of her own health practices and her eating disorder later in her narrative. She offers,

“He has a disability and is very poor health because he smokes, takes many medications, doesn't eat healthy or exercise. [. . .] He expresses that he is unhappy and suffers too much. [. . .] He doesn't eat healthy food or exercise at home, so I think he didn't understand my views on how I lost weight, but thought I was doing something wrong with my body” (Participant 20).

Daughters also discuss their fathers' addictions to alcohol and drugs, but in the next section, daughters are not solely focused on their fathers' health practices.

Addiction and abuse. Several participants describe their fathers as being addicted to alcohol and/or drugs. In addition, some of the participants reveal that their fathers have abusive tendencies. The following four examples capture daughters' perceptions of their fathers' addiction and abuse.

“My father has been an alcoholic since I can remember and is almost always drinking” (Participant 21).

“My dad [. . .] struggles with alcoholism and drug addiction” (Participant 24).

“My father desperately wanted to keep me as a little girl as long as possible and was verbally/physically abusive intermittently. He has anger control issues” (Participant 26).

Participant 3 claims her father is a

“raging alcoholic. [. . .] His presence was usually an abusive one.”

In these four narratives, daughters recount their fathers' addictions to alcohol and drugs as if it were a fact. There is no hope in these descriptions that their fathers will change or will work to improve their situations. Based on their words (i.e., struggles, issues, and raging), alcoholism, addiction, and abuse are all represented as negative characteristics of the father. Interestingly, although addiction is a health concern, it is not described in the narratives as pertaining to their fathers' overall health. Rather, when daughters discuss

their fathers' alcoholism, addiction, and abuse, it is to explain a specific characteristic of how they know or have seen their fathers. Importantly, these daughters do not include in their descriptions how their fathers' actions impact their relationships or the repercussions for the relational climate.

Work and accomplishments. In addition to explaining negative aspects of their fathers' characters, daughters also describe their fathers as "hard working men" who have specific accomplishments in life. In the following four examples, such descriptions become a positive characteristic of their fathers as people.

"My father was present, but was a workaholic. [. . .] I have a distant sort of respect for his intellect and things he was able to do in life, having come from a shaky past himself" (Participant 3).

"My dad is a hardworking man. He is always doing something for someone. After coming home from work he would start on some other project going on" (Participant 9).

"My dad is the hardest worker, greatest golfer, busiest man I know. He tried hard to be at all of my events, but sometimes work came first" (Participant 15).

"My dad is a very energetic, funny guy who tends to get along with everyone" (Participant 6).

Daughters' descriptions of their fathers as "hard working men" point to work as a priority for their fathers. In addition, these statements illustrate daughters' perceptions of their fathers as people outside of the father-daughter relationship. These four descriptions are positive expressions of their fathers as people; however, they depict the father as a hardworking man who is always busy with something outside of the father-daughter relationship.

Participant 3's narrative reveals that although she felt as though work was a priority in her father's life, she is still proud of him and his accomplishments; however,

she only has a “distant sort of respect” for those accomplishments. It is possible that this perceived distance is a result of her father’s alcoholic and abusive tendencies described earlier. Participant 9 then reiterates the notion of a father preoccupied with his work, and participant 15 goes further by explaining that work was a priority for her father, which sometimes came before their relationship. However, participant 6 describes her father positively as getting along with everyone. Notably, she does not comment on his relationship with her. Interestingly, daughters do not further detail their fathers as hardworking in the family or in the father-daughter relationship; rather, there is a sense that even though these descriptions are positive, these daughters do not feel like a priority to their fathers in these instances.

Throughout, this theme captures daughter ambivalence in the father-daughter relationship. When daughters describe their fathers’ health, or the lack thereof, points of connection as well as separation are identified in the father-daughter relationship. Daughters’ descriptions of their fathers’ abuse, addiction, and alcoholism represent a negative aspect of their father and a point of disconnection between fathers and daughters. Alcoholism and drug addiction are both explained by the daughters as permanent or enduring factors in the father-daughter relationship, without hope for change or improvement.

In addition to the negative descriptions of their fathers’ characters, daughters also claim their fathers are hard working, which sometimes leads to work taking precedence over the father-daughter relationship. However, the idea of their fathers as hardworking men is still a positive characteristic of their father as a person even though daughters do not further describe their fathers as hardworking in the family or in the father-daughter

relationship; rather, there is a sense that even though these descriptions of their fathers are positive, daughters are ambivalent about their relationships with their fathers in these instances. Their fathers' tendencies to be hard working outside of the home and the father-daughter relationship may be another site of perceived disconnection in the father-daughter relationship even if daughters portray this characteristic of their fathers positively.

This theme, characteristics of the father, illustrates that daughters' constructions of the father-daughter relationship are ambivalent, with the daughters revealing both positive and negative aspects of their fathers as true and unchanging. Although daughters describe their fathers positively (i.e., energetic, busy, hard working, etc.), there are several obstacles and challenges (i.e., addiction, abuse, work priorities, etc.) present in the father-daughter relationship. In the next theme, such descriptions of their fathers appear to influence the amount of information daughters provide about themselves.

Characteristics of the Daughter

Daughters do not reveal as much information about themselves; in fact, they did not describe themselves at all. Thus, this second theme is defined by daughters' general disengagement from the father-daughter relationship and their acceptance of the current state of the relationship.

Engagement. Participant narratives illustrate that daughters are disengaged participants in the father-daughter relationship as seen in the following two examples.

“He is a business man and [*he*] wants to see me do well in life” (Participant 10, emphasis added).

“I don't *have to* see my dad much anymore” (Participant 3, emphasis added).

Even though descriptions of their fathers as “hard working” were considered a positive quality in the previous theme, it is evident that this quality is also a source of frustration for the daughters. Participant 10’s statement implies that although her father is a “business man” his wishes for her to do well in life are separate from her own. Similarly, participant 3’s statement insinuates that her relationship with her father has not been enjoyable for her, and she does not want to engage the relationship anymore, which could be a result of his alcoholic and abusive tendencies. She describes seeing her father as a requirement (i.e., have to) that she has to endure instead of as an option she chooses. In the absence of engagement, daughters’ acceptance of the state of the father-daughter relationship becomes important.

Acceptance. Even though the daughters do not actively engage the father-daughter relationship, their statements of acceptance demonstrate that they still feel as though their fathers have a role to play in the evolution/non-evolution of the father-daughter relationship. The following two examples illustrate daughters’ acceptance of the state of the relationship.

“Our relationship has improved with my own recovery work, but I don't believe he will ever work to change/improve himself, and I have to be okay with that” (Participant 3).

“We first grew apart because its hard to understand a daughter in her teen years, especially one who struggles with self image and eating” (Participant 13).

From participant 3’s statement, it is clear that she feels as though her father needs to act to “change/improve himself” (i.e., his alcoholic and abusive tendencies) as she compares this to her own recovery work for her eating disorder. Since she cannot change him, she just accepts the way things are/have been in their relationship as the way things will continue to be. Similarly, participant 13’s narrative illuminates how she has accepted the

state of their relationship for what it is: a father who just does not understand his daughter and what she is/has gone through. She does not use the first person in this sentence but refers to herself as “a daughter” and “one who struggles,” signaling that she is detached from the relationship and does not feel personally responsible for the relational status quo. In both narratives, participants 3 and 13 are lacking active engagement in the father-daughter relationship.

This theme, characteristics of the daughter, reveals very little about the daughter in terms of self-description while simultaneously demonstrating these daughters’ unwillingness to engage and their acceptance of the current state of the relationship. Although daughters describe their fathers’ behaviors as enacting barriers in the father-daughter relationship, daughters also communicate, in their accounts, a disengagement from the relationship and an acceptance of the status quo, while removing any discussion of their self and its role in relational construction and maintenance. Thus, this theme indicates a further point of disconnection in the father-daughter relationship. In the next theme, father-daughter patterns of talk, points of connection and disconnection are further discussed and explained in relation to father-daughter communicative interactions.

Father-Daughter Patterns of Talk

In their narrative accounts, daughters explain patterns of talk with their fathers in six specific ways that work to characterize the types of interactions in the father-daughter relationship as well as their experiences with their eating disorders. The six codes that comprise this theme are (1) frequency of talk, (2) personal talk, (3) general talk, (4) general talk as strategic, (5) talk about food and behavior, and (6) evolution in the patterns of talk. The data exemplars below reveal that there is very little opportunity for

fathers and daughters to talk about matters that are personal or important in their lives; however, the narratives also highlight a desire for more personal talk and possibilities for change in father-daughter patterns of talk.

Frequency of talk. When describing how often they talk with their father, daughters claim they talk with their fathers multiple times per week (as illustrated in the following two examples), which is true for daughters who live with their fathers as well as those who live elsewhere.

“I keep in touch with my father through daily phone calls at least once on most days” (Participant 20).

“We talk or email weekly now that I am in college” (Participant 15).

For both of these daughters, it seems as though it is important for them to keep in contact with their fathers. Their descriptions of frequency are also representative of the rest of the participants’ frequency of contact with their fathers as well. The following five codes detail the content of these conversations.

Personal talk. Personal talk, defined in the narratives as talk about the daughters’ feelings, emotions, or things that were important to the daughter, is an important topic frequently mentioned in participants’ narratives. Two distinct patterns emerged from their accounts about personal talk. First, for several daughters, personal talk is not part of their communication with their fathers, which the following two examples illustrate.

“I do not talk to him about things that are personally important to me, because I do not trust him” (Participant 3).

“I am not emotionally-open with him meaning that I cannot talk to him about my personal thoughts” (Participant 20).

For other daughters, personal talk happens only in specific situations. The following three examples reveal the circumstances under which daughters will discuss personal matters with their fathers.

“Sometimes it was very short unless something exciting was going on”
(Participant 15).

“If I am having problems with friends I will ask him for advice” (Participant 25).

“We have many discussions about my future” (Participant 10).

In the first two examples, there is a disconnection in their talk (i.e., trust and emotional openness), which prevents the daughters from talking about personal matters with their fathers. For participant 3, her lack of trust in her father prevents her from opening up about things that are important to her. Similarly, participant 20 claims that she and her father are not emotionally open, which prevents them from talking about anything personal. For both of these women, their lack of trust and emotional openness with their father could be related to earlier descriptions of their fathers. Participant 3’s lack of trust in her father most likely stems from his alcoholic and abusive tendencies, and participant 20’s lack of emotional openness probably stems from her frequent disagreements with her father about his (and her own) health and happiness.

In the final three examples, daughters explain specific situations or circumstances in which they will engage conversations about personal matters with their fathers, which implies that under other (normal) circumstances they do not talk about personal matters with their fathers. Participant 15 writes that she and her father have more to talk about when there is something exciting happening; participant 25 asks her father for advice in certain situations with her friends; and participant 10 talks with her father about her future but does not further detail any discussions about the present. Even though some of

the daughters are able to talk to their fathers about certain personal matters, there is still a disconnection between these fathers and daughters when personal matters are involved.

General everyday talk. In the absence of personal disclosure, narratives reveal that general talk about the everyday (e.g., school, work, weather, etc.) was much more common, as illustrated by the following three examples.

“I cannot talk to him about my personal thoughts but only general stuff like the weather, what's going on at school, my plans for the day, etc.” (Participant 20).

“We talk about his work, my schooling, and things related to the activities/people we share: video games, my mother, and my brother” (Participant 26).

Participant 25 recounts a more detailed example in her narrative of the same type of general talk:

“I tell him how my day has been we usually talk about school and work and I ask him about his job. [. . .] "hey dad" "hey [name removed]" "how are things at work?" "Just the same old thing. How is school going?" " really good i am getting as and bs.””

In participant 20’s statement above, she insinuates that she talks with her father about general topics in place of more personal discussions since she is unable to have those types of conversations with him, and participants 26 and 25 explain topics of their everyday conversations more specifically.

However, within the narratives, daughters also express a desire for more personal conversations with their fathers, which the following three statements show.

“We always have shallow conversations about everyday life. Rarely do we have in depth or serious conversations. We mostly joke around” (Participant 24).

“Our conversations usually resolve around work... He excitedly tells me about his engineering projects, until my feigned interest crumbles. He has just as little patience for my teaching tales” (Participant 3).

“We talk about school, music, people, movies, and other things. its alot like some conversations you have with friends” (Participant 14).

Participant 24's use of negative adjectives (i.e., shallow and joke around) to detail the types of talk she has with her father and her use of positive adjectives (i.e., in depth and serious) to describe the types of talk she does not have with her father suggests that she would like to have more serious and in depth conversations with him. Participant 3's statement about her and her father's interest in their talk suggests that even though neither of them is interested in what the other has to say, they are both excited to tell one another about their daily experiences; however, they both experience a lack of interest in the other's content. Interestingly, participants 24 and 3 both struggle with fathers who are abusive and have addictions; the difficulty in communication and the desire for more personal talk might stem from these experiences. In addition, participant 14's statement also highlights her desire for more substantial conversations with her father (who has not been abusive or struggled with addiction), something more than conversations "you have with friends." So, even though general talk seems to be the predominant form of talk between fathers and daughters, daughters' narratives also convey a desire for more personal talk.

Talk as strategic. Some daughters go further, describing their general talk as being strategic to maintain a positive relational climate or avoid disagreements with their fathers. The following three exemplars illustrate this sentiment.

"We hardly ever talk about our personal feelings that are emotional. [. . .] Yet, we don't have disputes nowadays because we talk about general stuff most of the time. Still, I do seem to converse with him about his health because I care about it and want him to get better and live longer" (Participant 20).

"We fought alot (a few times physically) and now that we live several states away from each other we are able to be civil to each other but don't brush on the topics we disagree upon. [. . .] If we chat at all it is about topics we agree upon or topics that don't really require an opinion. For example we will talk about how classes are going or what I think of the women's tennis team" (Participant 27).

Similarly, participant 21 writes that she and her father talk about

“Just the basics like ‘hey how are you?’ ‘I’m fine, how are you’ I’ve never had a deep conversation with him because whenever I’ve tried to bring up a problem I have, he gets angry and it gets bad.”

It is clear within both participant 27’s and 21’s narratives that these two daughters want to maintain a positive atmosphere with their fathers by avoiding topics that they know will cause a disagreement. Participant 20 also expressed that she wanted to avoid disputes with her father, but there are exceptions. When describing characteristics of their fathers, both participants 21 and 20 explain points of disconnection with their fathers that are worth mentioning again here. According to their descriptions in the earlier theme, participant 21’s father is an alcoholic who is always drinking, and participant 20’s father is in poor health, does not take care of his body, and takes too many medications. Interestingly, here, participant 21 avoids conversations that will make her alcoholic father angry, but participant 20’s statement above is unique because she specified one topic she could not avoid: her father’s health. Within her narrative, the same idea of avoiding disagreement is present, but she also suggests that some topics are too important to avoid disagreement. This is also true for fathers in the next section, talk about daughter’s food and behavior.

Daughters’ food and behavior. Just as daughters avoid certain personal topics to avoid disagreements with their fathers, the narratives also reveal that fathers avoid conversations with their daughters in relation to their daughters eating habits, which the following two examples illustrate.

“In most ways my father withdraws from personal and raw issues about self image and things like that, refusing to admit that I am anything less than perfect/beautiful/etc.” (Participant 26).

“I think he doesn't like to talk about my eating habits with me as I don't like to talk about it with him, so we ignore that conversation altogether” (Participant 20).

Inherent in participant 26's statement is a disagreement of opinion. While her father does not want to talk about his daughter being anything less than “perfect/beautiful/etc,” her use of the word “admit” implies that she believes it to be a truth he cannot accept. By avoiding conversations about food and behavior, her father is able to avoid disagreement with his daughter. Participant 20 explains that neither of them enjoys having conversations about her eating behaviors, so they simply avoid the topic.

On the other hand, just as some daughters feel as though some topics are more important than avoiding conflict, daughters' narratives also demonstrate that some fathers will similarly engage topics they know will result in confrontation with their daughters.

The following two women recount such confrontations in their narratives.

“When my father found out about the large amount of body weight I lost in 3 months following last summer, he was critical, telling me that I needed to gain fat or else I was going to get sicker. I hated when he said this because his words made me feel ashamed of my body. I told him that I was eating more nutritional food and exercising more and that's why I lost weight. [. . .] I told him that my weight loss wasn't intentional, but that I want to be a healthier person. Yet, he automatically thought that I had an eating disorder. Sometimes now when we talk, he asks me what I eat and makes a comment that I need to eat more, even when I tell him that I am, as if he doesn't believe me” (Participant 20).

“He didn't understand why I couldn't just will myself better and would constantly tell me that I have a disease and I'm the reason my mom's always crying” (Participant 27).

It is clear from these two passages that their fathers care about their well-being more than avoiding confrontation with their daughters about their eating habits. Interestingly, both of these women explain that they use general everyday conversation strategically with

their fathers to avoid disagreements, but the only disagreements that are highlighted in their narratives are those about health, food, and their eating behaviors. Participant 20 and her father do not agree about health, as she describes him as not taking care of his body and being in poor health as a justification for her own eating choices; this is a recurrent theme in her narrative. Similarly, participant 27 is possibly the source of avoidance about this topic, as it is unclear from her narrative if there are other topics that serve as sources of disagreement with her father. Although these two episodes are portrayed negatively and neither of the two aforementioned fathers chose the best strategy for talking to their daughters about food and eating habits, it is clear from the narratives that these fathers care about their daughters enough to engage in conversations they know will result in disagreement.

Evolving patterns of talk. Many of the narratives recount instances where the patterns of talk between fathers and daughters evolve over time. This evolution over time is always the result of a shift in the frequency of talk or a shift from a more general pattern of talk to a more personal pattern of talk between the fathers and the daughters. First, the following two examples show an increase in the frequency of talk.

“Before, there wasn't much communication, now there's a great deal of communication” (Participant 7).

“We are actually talking to each other and we don't just try to avoid conversations” (Participant 9).

Second, the following two examples illustrate an increase in the amount of personal talk between daughters and their fathers.

“He has started sharing more stories with me about his childhood, which I love hearing” (Participant 3).

“We talk about how I am feeling more sometimes” (Participant 6).

Third, the following example reveals a decrease in the need to use strategic general talk to avoid disagreement.

“Since the development of my eating disorder my father has softened up a lot and realized just how mean some of the things he says to me have been. [. . .] He has stopped being so accusatory of things if I report less than perfect grades” (Participant 26).

This code, evolving patterns of talk, demonstrates that if something works to change the patterns of infrequency and nature of general talk in the father-daughter relationship, the entire relational climate can change as well. Participant 7 describes an increase in frequency of talk between her and her father, and participant 9 reports a decrease in avoidance of conversations, which also resulted in an increase in the frequency of talk. For participant 3, her father began sharing personal stories from his past, and there was an increase in talk about feelings for participant 6. Finally, for participant 26, the decrease in her need to be strategic with general talk has opened up the conversation, so she and her father are now able to share more with one another.

Significantly, these women and their fathers all come from different backgrounds: a father preoccupied with work who has now increased frequency of talk with his daughter (participant 9), an alcoholic and abusive father who overcame his own shaky past and is now sharing stories from his past with his daughter (participant 3), a father who is also a cancer survivor now talks to his daughter about her feelings (participant 6), and a verbally and physically abusive father with anger issues who has softened his temperament because of his daughter’s eating disorder (participant 26). These diverse examples illustrate the capacity for change in father-daughter patterns of talk and subsequent shifts in relational climate between fathers and daughters.

The third theme, patterns of talk in the father-daughter relationship, captures the frequency of talk between fathers and daughters but also the lack of personal talk in the father-daughter relationship. This theme also highlights the evolving nature in father-daughter patterns of talk rather than its static nature. Throughout this theme, two specific types of talk emerged as prominent in describing the overall nature of how fathers and daughters communicate with one another: personal talk and general talk. Daughters' narratives reveal that they find their fathers to be valuable in their lives despite the patterns of talk between them, and it is important for them to keep frequent contact with their fathers. Their accounts also demonstrate that although the father-daughter relationship is generally defined by patterns of general talk, there is a desire for more personal patterns of talk in the relationship; however, even though some of the daughters are able to talk to their fathers about certain personal matters, there is a barrier between the father and the daughter when personal matters are involved. One specific barrier that emerged from the narratives was that of disagreement between the father and the daughter, as some daughters describe their general talk as being strategic to maintain a positive relational atmosphere with their fathers by avoiding topics that they know would cause conflict. In addition, it is clear from the narratives that some topics are more important than avoiding disagreement for both fathers and daughters.

From this theme, a tension emerges between general talk and personal talk and between important conversations and avoiding disagreement. This tension evolves over time usually as a result of a shift in the frequency of talk or a shift from a general pattern of talk to a more personal pattern of talk between the fathers and the daughters. It is evident in daughters' narratives that evolving patterns of talk over time is a positive and

desired experience for the daughters. Thus, this theme highlights the possibility for change in the nature of the relationship by shifting to more personal patterns of talk.

Characteristics of the Father-Daughter Relationship

Daughters describe their relationships with their fathers in six specific ways that work to characterize the father-daughter relationship as well as experiences of the eating disorder. The six codes that comprise this theme are (1) frequency and presence, (2) roles of the father, (3) emotions experienced, (4) father's support, (5) fathering quality, and (6) evolution of the relationship. The examples below address the father-daughter relationship at specific moments and also as across time and further reveal points of connection, disconnection, and evolution in these father-daughter relationships.

Frequency and presence. When describing the frequency of contact with their father as well as their fathers' presence, daughters focus their accounts mostly on quantity and duration of time instead of quality of time. The following examples illustrate the daughters' attention to frequency and presence instead of quality of presence.

“My dad is always part of my life. [. . .] I see my dad every weekend when I go home and we text almost everyday” (Participant 10).

“Since I reside on the college campus and am an out of state student, I don't see my dad during the school year, just on breaks and summer vacation” (Participant 20).

“I see him everyday but not for *any real length of time*” (emphasis added, Participant 9).

“He was *often* absent physically, and *always* removed emotionally” (emphasis added, Participant 3).

Participant 10 describes her dad as always being in her life because of his physical presence when she goes home on the weekends. Similarly, participant 20 focuses her narrative on her proximity to her father and the frequency of her father's presence, but

she does not further detail the quality of the contact. On the other hand, participant 9 and 3's descriptions of presence are closer to quality statements. Even though participant 9 is describing the duration of their contact, there is a hint in the statement that the quality of the interaction is not meaningful but meaningful contact is desired. Similarly, even though participant 3 is describing the nature of her father's presence, there is an implication in her statement that her interactions with her father are also lacking in quality.

Interestingly, both participants 10 and 20 were discussed in regards to their father-daughter patterns of talk because even though they prefer general talk with their fathers, they both talk to their fathers about personal matters in specific situations (i.e., about the future for participant 10 and about health practices for participant 20). In addition, participants 9 and 3 both describe their fathers as being preoccupied or distracted by other things (participant 9's father is preoccupied with work and participant 3's father struggles with alcoholism); however, both of these daughters also report a shift or evolution in the patterns of talk with their fathers (participant 9's father has increased frequency of talk, and participant 3's father began sharing stories from his own shaky past). Based on these similarities, it appears that daughters desire some personal connections with their fathers even when the relationship is portrayed negatively. Although there is little focus on quality when addressing their fathers' presence, the subtext suggests quality is important, and in the next section, roles that daughters assign their fathers further demonstrate that daughters believe their fathers are valuable to their lives.

Fathers' roles. During times of presence and absence, daughters assign roles of varying closeness to their fathers. The first important role is that of “dad.”

“My dad is a big part of my life. I am a ‘Daddy's girl’ for sure” (Participant 6).

The second role assigned is dad as a (best) friend, which the following two examples illustrate.

“My dad is a great dad and friend, [. . .] but I don't consider him a positive role model” (Participant 24).

“He is my best friend, our relationship is great” (Participant 13).

The third and final role present in the narratives is the father as provider and caretaker.

“He provided well for us always and always cares about me” (Participant 15).

Because participant 6 capitalized “Daddy’s” but not “girl,” it seems as though the role of “dad” holds much more significance to her life than her role as girl. It also implies that she has, in part, defined her identity from their respective roles in their father-daughter relationship. Also, her use of the term “Daddy’s girl” would imply that she views their relationship to be a close one since connotatively the term evokes images of a father and daughter who love each other and are very close to one another. From her narrative, it appears that she is very close to her father, which could be a product of the connection she feels with her father because he has overcome cancer and she struggles with an eating disorder.

Participant 24 similarly assigns the role of “dad” but also the role of friend to her father. Consequently, her identity is not as tied in their relationship because she does not consider him to be a positive influence, which probably stems from his struggles with alcoholism and drug addiction. Interestingly, she does not assign him the role of a bad role model/influence. There is a certain degree of closeness imbued in the idea of a great

friend, but because she does not consider her father to be a positive influence, there is also a degree of distance in their relationship. On the other hand, participant 13 reveals that her father is her *best* friend. Although she discusses that her father does not understand her because of her struggles with self-image, her statement here insinuates that she views their relationship to be a very close one despite his level of understanding.

Finally, participant 15 describes her father as provider and caretaker. Her use of the terms “provider” and “caregiver” implies a traditional and culturally valued relationship, with positive connotations. On the other hand, she mentions in her narrative that work sometimes came first for her father; although, there is no way to tell from this brief description if these traditional roles have led to a close or distanced relationship for them. Whether or not daughters are close to or distant from their fathers in terms of role construction, daughters’ accounts illustrate that the father-daughter relationship is an emotional experience.

Emotions experienced in the relationship. The most prevalent emotion described in the narratives is closeness. The following four examples describe closeness in the father-daughter relationship.

“I am not close to my dad. I do not trust him with my feelings. I am sometimes still frightened of him” (Participant 3).

“I definitely wouldn't say we're close. [. . .] His alcoholism is the main problem” (Participant 21).

“We are very close, but I don't have much respect for him because of his lifestyle choices” (Participant 24).

“Like I said, I am a daddy's girl so we are quite close” (Participant 6).

First, it is evident in participant 3’s statement that there is an absence of closeness in her relationship with her father, which can probably be attributed to her father’s emotional

detachedness and his alcoholic and abusive tendencies. Second, it appears that there is an absence of closeness in participant 21's relationship with her father as well; however, she outright names his alcoholism as the "main problem" or source of the distance in their relationship and insinuates that if her father were not an alcoholic, they could be closer. In contrast, participant 24 claims that she and her father are "very close," but her statement suggests "his lifestyle choices" (discussed previously as being alcoholism and drug addiction) prevent them from being closer. For these three women who struggle with alcoholic, addicted, and abusive fathers, closeness is still a common theme in participant narratives. Finally, participant 6 reveals that she and her father have a very close relationship, which is probably in part because of the connection they formed with one another when he overcame cancer and began talking to her about personal matters. For each of the participants, closeness is affected by the characteristics of their fathers discussed earlier in this chapter.

Anger is the second most prevalent emotion described in daughters' narratives, which the following two exemplars illustrate.

"I sometimes am angry with him and his stubbornness, and am pushed away from him emotionally. I will always love him" (Participant 20).

"I still react to his outbursts of anger with a fear response. [. . .] He gets angry when I get hurt" (Participant 3).

In both of these accounts, their fathers' use of anger is followed by emotional distance, fear, or emotional hurt. Participant 20 loves her father, but she experiences emotional distance from him after episodes of anger, and participant 3 is sometimes both frightened and hurt by her father's anger. Although it is not expressed as an emotional experience, daughters also describe several types of support in their narratives.

Fathers' support. Daughters' accounts of support reveal three types of support fathers provide to their daughters: fathers' emotional support through love and care, fathers' pride, and fathers' material support. The most prevalent type of support referenced in their narratives is that of caring/loving.

“Despite everything that we have gone through, my dad is still there for me and is incredibly supportive and caring. i know he really does care about me and wants the best for me and will do just about anything to help me” (Participant 14).

“He is always there for me and will do anything to make me happy” (Participant 10).

It is clear from both of their accounts that their fathers' emotional support of love and care is extremely important and comforting to the daughters.

The second most prevalent type of support detailed in daughters' narratives is their fathers' pride, which the following two exemplars demonstrate. Participant 25 writes that when she talks about school with her father, he usually says,

“Thats great! I am so proud of you and glad you are doing what I know you are capable of.”

“He frequently tells me that he's proud of me” (Participant 13).

These two narratives show that it is pleasing to the daughters when their fathers are proud of them.

The final type of support, material support, is less affective than the previous types of support recounted in daughters' narratives.

“He supports me by buying me things, even if he is in debt” (Participant 5).

“He is there if I need anything having to do with my car or anything he can fix” (Participant 21).

Participant 5 defines her father's support as monetary support, and participant 21 defines support as physical labor. In these two accounts, material support is not affective for the

daughter in the relationship; however, there could be relational implications in this type of support, as fathers are traditionally and culturally known for their financial and physical contributions to the family rather than their relational contributions. This idea of material support echoes participant 15's account of her father as exhibiting the role of provider/caretaker discussed above. Types of support and fathering roles also inform daughters' perceptions of fathering quality.

Fathering quality. Daughters describe fathering quality as being active, negative, or as an ideal/real binary in their narratives. In the first type of fathering quality, daughters' descriptions of active fathers are illustrated by the following three participants.

“He's always interested in whats going on in my life” (Participant 13).

“He does so much for me and my family” (Participant 14).

“We always get along” (Participant 10).

These three narratives portray fathers who are both interested and active in their daughter's lives.

The following two examples, however, reveal a negative fathering quality that contrasts with the previous examples of active and interested fathers.

“I cannot forgive him for some things he has done to me. But I am acknowledging them these days, and loosening their power over me” (Participant 3).

“He is the type of man who thinks himself as right and others wrong, especially within the family” (Participant 20).

Participant 3 writes about “things he has done,” which is probably a reference to her father's alcoholism and abusive presence as well as his emotional detachment in their relationship (detailed earlier in this chapter). Participant 20 uses “himself” and “others” to explain and position her father away from those within his family. This positioning

could be a result of their disagreements about proper health and the ways in which each of them cares for their respective bodies. In these two examples, daughters allude to the distance between them and their fathers, as they describe a fathering quality that is less positive than the previous examples, one that is compounded by their perceptions of their fathers' behaviors explained in the first theme, characteristics of the father.

Third, the ideal/real fathering quality illuminates an ideal/real tension in the father-daughter relationship, as it does not meet daughters' constructions of an ideal father-daughter relationship.

“He is a very nice person and tries to be there for me, but it's more of a friendly relationship than a father-daughter relationship” (Participant 24).

“We have never been anything near what a father daughter should be” (Participant 21).

Participant 24 claims her relationship with her father is more “friendly” than “a father-daughter relationship.” This teetering on the ideal/real binary is present in her entire narrative. She assigned her father the role of a great friend but not a positive role model in her life. Similarly, she claims they are very close but has little respect for him because of his lifestyle choices. Throughout her narrative, her father's alcoholism and drug addiction are portrayed as preventing closeness between them. Participant 21, who alludes to “what a father daughter should be,” reveals that she and her father are not close because of his alcoholism. Although these two participants do not describe what an ideal father-daughter relationship would be like, their statements are suggestive of an ideal father-daughter relationship that their relationships do not meet. Ideally, their fathers would not suffer from additions to alcohol and drugs, which has been a barrier in their

respective relationships. In the next section, daughters highlight shifts to a more positive or ideal father-daughter relationship.

Relational evolution. In their accounts, many of the participants explain that their relationship with their father has evolved over time to a closer relationship, which the following three examples illustrate.

“We used to not have much of a relationship at all, but more recently I have started to build a relationship. [. . .] When I got out of treatment he apologized for not wanting anything to do with me. Since then he has asked about how he can help keep me healthy” (Participant 9).

“My father didn't use to say he was proud of me. He's been more loving” (Participant 13).

“I have an easier time separating myself from his world view, and that has allowed us to get to know each other better. I think we have a new appreciation for each other. And I NEVER thought that was possible!” (Participant 3).

For participant 9, there was an increase in the amount of care/love support her father used in their relationship, and he has become a more interested and active father. Participant 13's father also increased care/love support through verbal expressions of pride in his daughter. Participant 3's move to engage in the father-daughter relationship resulted in the two of them knowing each other better and also fostered a new mutual appreciation in their relationship. Significantly, these women and their fathers all come from different backgrounds: a father preoccupied with work who has now increased frequency of talk and the amount of care/love support with his daughter (participant 9), a father who did not understand his daughter and her struggles with self-image but has become more involved in her life expressing pride in his daughter (participant 13), and an alcoholic and abusive father who is now sharing stories from his past with his daughter, who is now also working to engage their relationship (participant 3). These diverse examples of

relational evolution illuminate the capacity for change in relational climate between fathers and daughters. This code, relational evolution, demonstrates that if something (an eating disorder or crisis in these examples) works to change the static nature of roles, emotions, support, or quality in the father-daughter relationship, the entire relational climate can change as well.²

In summary, the final theme, characteristics of the father-daughter relationship, highlights the dynamic nature of the father-daughter relationship through its capacity for change. The narratives convey the father-daughter relationship as an evolving emotional experience whereby daughters assign roles to their fathers based on their degree of perceived emotional connection. First, daughters construct a portrait of a close relationship with their fathers in their accounts. In these constructions, there is a desire for the fathers' presence to be accompanied by quality interaction. Also, closeness is described as an important emotional experience between the father and the daughter. In addition, narratives reveal that it is important to daughters when their fathers are active in the relationship and show support (whether love, pride, or material). Daughters have also constructed a portrait of distance in the father-daughter relationship. Emotional experiences of anger, fear, and hurt as well as constructions of a negative fathering quality speak to the distanced father-daughter relationship. Importantly, daughters' experiences of a father who is abusive or struggles with addiction/alcoholism significantly adds to the negative and detached quality of the father-daughter relationship. Descriptions of the fathers and the father-daughter relationship within this narrative theme demonstrate that daughters feel as though their fathers are valuable to their lives

regardless of the degree of closeness in their relationship; however, it is also evident in the narratives that a shift to a closer relationship is a positive and desired experience.

Daughters' Constructions of the Father-Daughter Relationship

The first theme, *characteristics of the father as described by the daughter*, reveals that daughters' constructions of the father-daughter relationship are ambivalent, as daughters present both positive and negative images of their fathers as both true and unchanging. When daughters discuss their fathers' health, points of connection and separation are identified in the father-daughter relationship. Daughters' descriptions of their fathers' abuse, addiction, and alcoholism represent negative aspects of their fathers, but daughters also portray their fathers positively as "hard working men," which sometimes takes precedence over the father-daughter relationship. Thus, while daughters are able to describe their fathers positively (i.e., energetic, busy, hard working, etc.), there are several obstacles and challenges (i.e., addiction, abuse, work priorities, etc.) in the father-daughter relationship. The descriptions listed in this theme (i.e., health status, addiction, abuse, preoccupation with work, etc.) become important in all the subsequent themes in this chapter, as they largely influence daughters' perceptions of their self, their talk with their fathers, and their relationships with their fathers.

The second theme, *characteristics of daughter*, illuminates very little about the daughter in terms of self-descriptions; however, this theme highlights daughters' lack of engagement in the father-daughter relationship and acceptance of the relational status quo. Although the daughters describe their fathers' behaviors as creating distance in the father-daughter relationship, daughters' accounts of disengagement and acceptance also reveal a further point of disconnection in the father-daughter relationship. Some

daughters experience distance in the relationship because of their disagreements about health and happiness with their fathers while others are emotionally detached from their fathers because of alcoholism, drug addiction, and abuse. Daughters also reveal very little about themselves as their perceptions of their relationships and talk with their fathers stems primarily from how they perceive their fathers' characters.

The third theme, *patterns of talk in the father-daughter relationship*, illustrates the lack of personal talk in the father-daughter relationship as well as the capacity for change in the patterns of talk. Two specific types of talk emerged as prominent in describing the overall nature of how fathers and daughters communicate with one another: personal talk and general talk. The daughters' narratives show that they find their fathers to be valuable in their lives despite the patterns of talk between them, but it is important for them to keep in contact with their fathers. However, their perceptions of their fathers' characters influence daughters' perceptions of talk with their fathers as well, as most daughters feel they cannot talk about personal matters with their fathers because of trust, emotional openness, and conflict in the relationship. Although the father-daughter relationship is often defined by patterns of general talk, daughters show a desire for more personal patterns of talk in their accounts. For these daughters, their own personal lack of engagement, their fathers' preoccupation with work or addiction, and their frequency and distance of interactions interrupt their ability to talk to their fathers about personal matters. In addition, tensions emerge between general talk and personal talk as well as between important conversations and avoiding disagreement. However, evolution in patterns of talk is a positive and desired experience for the daughters, as the shift usually represents an increase in closeness between the father and the daughter. These shifts stem

from either a change in the daughters' engagement of the relationship and/or acceptance of the relational status quo or a change in the father's priorities (with health, work, addiction, etc.), frequency of interactions, or quality of interactions (from general to personal talk).

The final theme, *characteristics of the father-daughter relationship*, illustrates the dynamic rather than static nature of the father-daughter relationship through its capacity for change. Similar to the evolving patterns of talk among fathers and daughters, narratives reveal that the father-daughter relationship is an evolving emotional experience and daughters assign roles to their fathers based on their perceived degree of emotional connection. Daughters' constructions of the father-daughter relationship highlight a desire for their fathers' presence to be accompanied by quality interaction and closeness, which have been hindered in most of the narratives by fathers' priorities with work, addiction, abuse, etc. In addition, the narratives prove that it is important to daughters when their fathers are active participants in the relationship and show support (whether love, pride, or material). On the other hand, daughters' accounts also show evidence of distance in the father-daughter relationship, as they describe emotional experiences of anger, fear, and hurt as well as some descriptions of negative fathering quality.

In conclusion, participant narratives document that daughters feel as though their fathers are valuable to their lives despite the degree of distance and closeness and points of connection and separation in their relationships; however, it is also evident in the narratives that there are obstacles and challenges within the relationship because of the characteristics of *both* relational partners. Shifts in father characteristics and/or daughter

characteristics combined with evolution in the patterns of talk can mark shifts in the overall relational climate, which are described positively in daughters' accounts.

The dynamic rather than static nature of the father-daughter relationship (as shown in Figure 4.1) is most evident in participant 3's narrative account of her relationship with her father. Since participant 3's narrative excerpts were present in all four themes of analysis, her account is the best example of how the narrative themes work together to form a picture of the dynamic father-daughter relationship. Participant 3 claims that her father is present in her life, but he is a "raging alcoholic" and also a "workaholic." She also reveals that she has a "distant sort of respect" for his intelligence and accomplishments, as he has "come from a shaky past himself." Within her statement, "I don't *have to* see my dad anymore" (emphasis added), she demonstrates a lack of engagement in their relationship, as she describes interaction with her father as more of a requirement than an option. She also implies that she has accepted the relational status quo as permanent when she writes, "I don't believe he will ever work to change/improve himself, and I have to be okay with that." In these few statements where participant 3 describes her father's characteristics and her own acceptance and lack of engagement, she and her father become two separate relational partners with different opinions, priorities, and agendas.

As participant 3 and her father come together as a dyad in their communicative interactions, she explains that they do not talk about personal matters because she does not trust him, and their conversations usually concern work: "He excitedly tells me about his engineering projects, until my feigned interest crumbles. He has just as little patience for my teaching tales." Even in this description it is obvious that neither of the relational

partners is interested in these conversations, but there is a desire to share with one another nonetheless. As for their relationship, she claims that she is not close to her father, that she is sometimes still frightened by his “outbursts of anger,” and she “cannot forgive him for some of the things he has done.” Moreover, she writes, “He was *often* absent physically, and *always* removed emotionally” (emphasis added). From these descriptions, participant 3 reveals a lack of closeness in the relationship exacerbated by a negative fathering quality; however, she also explains two important shifts in their relationship.

First, she describes an increase in her father’s personal talk: “He has stated sharing more stories with me about his childhood, which I love hearing.” This is the first description in her narrative that reveals closeness with her father. Second, she explains her own shift in engagement with the relationship, which has allowed her to know her father better: “I have an easier time separating myself from his world view, and that has allowed us to get to know each other better. I think we have a new appreciation for each other. And I NEVER thought that was possible!” Her move to engage the relationship and her father’s increase in personal disclosure have fostered a newfound mutual appreciation in their relationship. The experiences of participant 3 (and the extended narrative excerpts above) demonstrate that instead of direct causal relationships between father characteristics, daughter characteristics, father-daughter talk, and the father-daughter relationship, small shifts in the father’s priorities, the daughter’s engagement, and/or patterns of general/personal talk can result in a shift for the entire father-daughter relationship. In the next chapter, which will address the second research question, the dynamic nature of the father-daughter relationship is further complicated by its placement in the larger family system and the daughters’ experiences of her eating disorder.

ENDNOTES

¹ The participants' original language has been preserved throughout. The only changes that have been made to their writing were (1) capitalization of the first letter of the sentence, (2) removing names when they were used in the narratives, and (3) ellipses inserted in brackets to indicate where I removed text. No other changes were made in order to preserve the voice and agency of the participants; thus, there are several typographical errors within the narrative exemplars not marked by [sic] so as to not burden the reader or interrupt the stories of the participants.

² Since this chapter is predominantly about the father-daughter relationship, the role of daughters' eating disorders in the evolution of the father-daughter relationship will be explained further in Chapter 5.

CHAPTER 5: THE PERFORMANCE OF THE EATING DISORDER

This chapter discusses the narrative themes that address the second research question: How do the communicative roles the father performs (silence, passivity, vocal) enable the daughter's performance of the eating disorder? Participant narratives reveal two themes that help to answer this question: dynamics of the family unit and daughters' experiences of the eating disorder. As in the chapter prior, the themes have been organized to best address how the communicative roles the father performs enable the performance of the eating disorder (see Figure 5.1). First, *the dynamics of the family unit* theme shows the importance of the family context to the father-daughter relationship (previously discussed in Chapter 4). This theme is comprised of four codes: role of the mother, other fathers, stress in the family, and external events in daughters' lives. Narrative accounts illustrate that activity in the family unit coupled with the nature of the father-daughter relationship (previously discussed in Chapter 4) mutually contribute to *daughters' experiences of their eating disorders*, the second theme discussed in this chapter. Four codes define this theme: development/blame, denial, discovery/secretcy, and recovery.

Figure 5.1 below shows that the father-daughter relationship (now represented by a dotted line), does not exist in a vacuum and is not impermeable to the surrounding family system (mothers, other father-figures, and/or stress within the wider system). The figure also demonstrates that the family system and the father-daughter relationship have a reciprocal relationship with daughters' eating disorders. Just as the family unit and the

father-daughter relationship influence the development, maintenance, and recovery of the daughters' eating disorders, those processes of the disorder also influence the family system and therefore the father-daughter relationship. Each phase of the eating disorder influences and is influenced by the father-daughter relationship as well as the wider family system. The relationships between narrative themes are further detailed below.

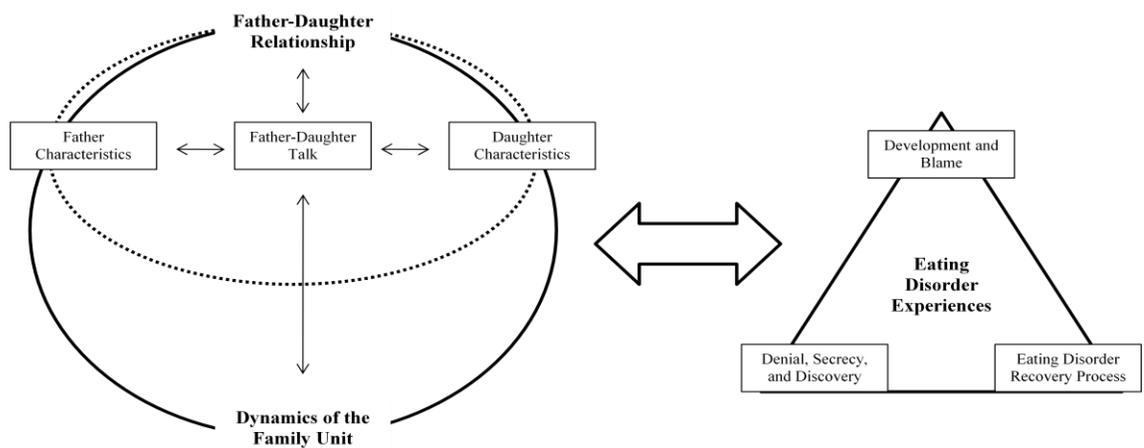


Figure 5.1. Relationships between Narrative Themes

Dynamics of the Family Unit

Daughters describe the dynamics of their family unit in four specific ways that inform both the father-daughter relationship as well as daughters' experiences with their eating disorders. The most prominent reference to the family unit is the importance of the mother-daughter relationship and mothers' roles in daughters' eating disorders. Second, daughters' discuss multiple father-figures that are present in their lives, which suggests that the father present in the household is not the only father-figure in the family unit or in daughters' lives. Third, daughters' reference stress in the family as impacting their eating disorders and their relationships with their parents, and finally, daughters' confess that there are external events happening in their own lives, which impact the family unit.

The data exemplars below highlight the father-daughter relationship as situated in the larger family system wherein multiple factors work to define and transform the father-daughter relationship.

Role of the mother. Within participant narratives, mothers' influence is a primary defining family dynamic that influences the father-daughter relationship as well as daughters' eating disorder experiences. The importance of the mother is characterized by the daughter in three specific ways. First, daughters discuss their relationships with their mother in contrast to their relationships with their fathers. Participant 20's narrative conveys this best:

“Still, when I am at home with him, we don't spend too much time together compared to the time I spend with my mom. I would say that I am closer to her than my dad. [. . .] Well, I don't feel comfortable talking to him about "girl stuff" so I do that with my mom. Because of this, I feel that he doesn't understand me and what I believe.”

Similarly, participant 6 claims this study about fathers and daughters is not as relevant to her life as a study about mothers would be:

“If you do one about mothers, that would be much more applicable.”

Participant 20's narrative reveals that she is much closer with her mother than with her father, and she talks to her mother more than her father about personal matters. Similarly, participant 6 suggested that a study about the mother-daughter relationship would be more applicable to her experiences. In both of these data exemplars, the daughters contrasted their relationship with their fathers with their relationships with their mothers.

Second, daughters suggest that their fathers only know about their eating disorders because of their mothers, as shown in the following three examples.

“I’ve had more conversations with my mom than my dad. He knows about my struggles primarily from her” (Participant 3).

“My dad has never spoken to my about it directly, even though I’m pretty sure my mom has told him about it” (Participant 24).

“We didn’t talk. He just looked at me and told my mom to fix it” (Participant 9).

Participant 3 and 24’s narratives highlight a very similar experience, as their fathers know about their disorders primarily from their mothers. Participant 9’s account, on the other hand, shows that her father dismissed himself from the situation when he discovered her eating disorder, as he asked her mother to deal with it. The narratives of these three participants suggest that their fathers were only passively or silently involved in their eating disorder experiences. Interestingly, as discussed in Chapter 4, participants 3, 24, and 9 all express a desire for more personal talk with their fathers in their narrative accounts.

Third, daughters’ narratives suggest that their mothers had a much more active role in their eating disorder experiences, as the following two data exemplars illustrate.

“For example, over Christmas we went sailing. I tore off some long folds of tortilla from my wrap and tossed them overboard after my mom had done the same. There was just too much tortilla! My dad started freaking out, shouting at my mom to look at me as I tossed food overboard. She laughed and said, “Well, there’s too much tortilla!” :)” (Participant 3).

“My mom has always struggled with self esteem issues and eating disorders all her life and seeing her go through that made me the opposite way for as long as I could” (Participant 25).

Participant 3 remembers a story where her mother modeled restrictive eating and then defended her daughter’s similar eating behavior. Similarly, participant 25 explains her mother’s own struggles with body image and eating behavior, and from her statement, she suggests that although she tried not to, she was doomed to have the same traits and

behaviors as her mother. In both of these participant narratives, mothers reinforced participant ideas of food as well as their behaviors with food. However, just as mothers have a role in the dynamics of the family system, daughters' accounts suggest there are other father-figures in their lives as well.

Other father-figures. After the importance of the mother, the daughters' relationships with other father-figures is the second most referenced family dynamic influencing the father-daughter relationship and daughters' experiences of their disorders. Many participant accounts reveal that relationships with their fathers are also, in part, defined by their relationships with other father-figures. In all three of the examples below, daughters use other father-figures in their lives to escape or replace their fathers. Participant 7 reports that she has three father-figures in her life:

“God, my dad, and my friend, Bro. Dick from church.”

In addition, she claims that she has a different amount of contact with each one of her father-figures:

“All the time - God Every now and than - my dad Most of the time - Bro. Dick.”

Finally, when asked about the conversations with her father-figures after the discovery of her eating disorder, she writes,

“From my dad. there wasn't much communication about it. From Bro. Dick from church, I don't even know if he knows... From God, I know He loves me and wants me free.”

Similarly, participant 25 writes,

“It was my grandfather for most of my life until he passed away which gave me an opportunity to get to know my adoptive dad. [. . .] Growing up with my dad I resented him because of the fact that my biological dad didnt want me and I have never met him.”

Participant 21 also explains,

“I have both my father and my godfather: I live with my father but when we are not getting along, my godfather has always been there to take his place.”

For participant 7, she had the least amount of contact with her father out of the three father-figures she describes, and her narrative implies that her father was passive or silent about her eating disorder when it was revealed to him. Rather, she has more interaction with god about the disorder. For participant 25, her adoptive dad is the main father-figure in her narrative, but her relationship with him has been defined by the lack of care from her biological father and her relationship with her grandfather. Similarly, participant 21 claims that her godfather was a replacement father-figure for her father. For all three of these women, their relationships with their fathers were influenced and defined by their relationships with other father-figures. In addition to mothers and other father-figures, stress in the family is another influence in the family unit, the father-daughter relationship, and daughters' eating disorder experiences.

Family stress. The third most referenced dynamic of the family unit in daughters' accounts is family stress, which as the following three examples demonstrate, is caused by several factors.

“My father has been an alcoholic since I can remember and is almost always drinking. This along causes tons of stress in my family” (Participant 21).

“It was a very stressful time and we were angry at each other alot. my parents were disappointed in me and i had really let them down” (Participant 14).

“My parents are still married, but don't get along very well anymore” (Participant 24).

In these examples, family stress influences the relational climate in the family unit as well as the father-daughter relationship. Participant 21 reports that her father's alcoholism

causes difficulty and stress in her family, which was something she also describes as impeding her relationship with him (previously discussed in Chapter 4). Participant 14 accepts that her relationship with her parents has caused stress in their family, but as discussed in Chapter 4, she reveals in her narrative that she desires more personal and meaningful talk with her father. Similar in experience to the previous two participants, participant 24 experiences parental discord in her family, but her narrative also explains that she desires more personal talk in her relationship with her father, which is compounded by his struggles with alcoholism and drug addiction (previously discussed in Chapter 4). In all of these examples, daughters' experiences within their family units were combined with experiences of both familial stress as well as stress from external events in their own lives. Although family stress is an influential factor for daughters' experiences of the family unit, daughters' own external events also shape their experiences in the family unit and of their eating disorders.

Influential external events. Finally, daughters explain that their involvement in other external events also defines their eating disorder experiences as well as their relationships with their fathers, as shown in the following three examples.

“My relationship with my dad (and therefor normal everyday conversations) disintegrated pretty much at the exact time that my eating disorder started, but at first it was about my choices regarding drugs and friends. My life went from being a prospective division 1 college tennis player to having severe eating problems, being expelled, and starting to use drugs all in the space of a few months, and after that our relationship/communication has never been the same” (Participant 27).

“My "eating disorder" was linked to stress from other events in my life. it was not directly associated with my body image” (Participant 14).

For participant 3, her relationship with her father and her eating disorder

“continued and worsened with sexual abuse by others.”

Participant 27 references her choices regarding drugs and friends that negatively influenced her family experiences and her relationship with her father, and participant 3 reveals that she was sexually abused by “others,” which has impacted her eating disorder and her relationship with her father. Participant 14, on the other hand, does not disclose what the “external events” were that contributed to her disorder, and interestingly, they are not discussed further in her narrative. For these three daughters, it is clear that their experiences outside of the home impact their experiences within the family unit, their experiences in the father-daughter relationship, and their disordered eating experiences.

This theme, dynamics of the family unit, highlights important contributing factors and influences to both the father-daughter relationship and the daughters’ eating disorder experiences. First, the mother surfaces in three important ways that characterize the father-daughter relationship as well as the fathers’ involvement in their daughters’ eating disorders. Daughters explain that they are closer to their mothers than they are with their fathers, therefore contrasting the father-daughter relationship with the mother-daughter relationship. In addition, daughters suggest that their fathers only know about their eating disorders from their mothers, and they claim that their mothers have/had a much more active role in their eating disorder experiences, as they influence daughters’ behaviors and attitudes regarding food. Mothers’ active roles paint a portrait of fathers as either passive or silent during/about their daughters’ eating disorder experiences. In summary, daughters recount only moments of mothers that both reinforce their daughters’ ideas about food and their behaviors with food. In contrast, daughters remember their fathers’ silent/passive reactions to their eating disorders or their fathers’ active resistance/noncompliance with their mothers’ behaviors and opinions. This scenario is

further complicated by daughters who feel their fathers are preoccupied with work, alcoholism, or addiction, daughters who have distanced or negative relationships with their fathers because of abuse, absence, or non-meaningful interactions, and daughters who are extremely close with their fathers (all previously discussed in Chapter 4) and would want to portray their mother as more of an active participant in their eating disorder experiences.

In addition, daughters' narratives reveal that their relationships with their fathers are also complicated and defined by relationships with other father-figures in their lives. In their accounts, daughters have relationships with biological fathers, grandfathers, step-fathers, godfathers, and god that complicate/challenge their relationships with their fathers. Daughters also experience family stress, such as parental discord, fathers' alcoholism, and anger and turmoil in the family unit, and they are involved in events outside of the family unit, such as drug use, poor choice in friends, sexual abuse, and other stressful events. Both family stress and daughters' experiences of external events influence the father-daughter relationship as well as daughters' eating disorder experiences. Together daughters' experiences of the father-daughter relationship (father characteristics, talk, frequency, presence, fathering quality, and fatherly roles, themes previously discussed in Chapter 4) and her experiences of the family unit (maternal influence, other father-figures, stress, and external events) influence daughters' experiences of their eating disorders, as explained in the next section.

Experiences of the Eating Disorder

Daughters describe their experiences with their eating disorder in four specific ways that highlight the connection between the father-daughter relationship and

daughters' eating disorders. First, development of the eating disorder is an important moment in daughters' experiences of eating disorders, which often includes discussions of blame in participant narratives. Second, daughters also express denial of their eating disorder's existence or of the disorder's severity, which could be linked to the secretive nature of the disorder. In addition, secrecy and discovery of the eating disorder are important moments in daughters' narratives. Finally, several daughters explain moments of recovery and reveal the significance of those moments for the father-daughter relationship. The data exemplars below illuminate how daughters' experiences of their disorders and their experiences in the father-daughter relationship are mutually influenced and shaped by one another.

Development of the disorder and blame. Daughters' accounts illustrate that the development of their disorders and placing blame for the disorder is a very prominent code in their eating disorder experiences, as participant accounts of eating disorder development are closely linked to discussions of blame. Development and blame surface in three distinct ways: direct blame, indirect blame, and non-blame. In several narratives, daughters directly blame their father for their eating disorder. The following three examples demonstrate specific reasons why daughters' directly blame their fathers for their disordered eating experiences.

“I began medicating myself with food as a very young child. My father's physical, verbal, and emotional abuse were too much for me to handle. As I grew, these occasional issues with bingeing turned into a compulsive overeating mixed with periods of severe restriction. Later, I went on to develop anorexia. The root of my struggles began with my dad's abuse, and continued and worsened with sexual abuse by others, and my perception of my dad's apparent lack of love”
(Participant 3).

“My eating disorder started and continued to get worse after I found out about my father's drug use” (Participant 24).

“My father has been an alcoholic since I can remember and [. . .] it has been what's caused me to make some of the choices I have made” (Participant 21).

For all three of these women, they have struggled with their fathers' addictions and abuse, which has become a source of blame for their eating disorder development.

Participant 3 directly blames her father both for the development of her disorder but also for its escalation, and she reflects on the amount of care/love support she has received from her father (previously discussed in Chapter 4). Similarly, participant 24 claims her father's drug use was influential to her eating behavior, and participant 21, similarly, blames her father's alcoholism for some of her own “poor choices.” For these three women, their fathers own diseases/conditions were deeply involved in the development of their eating disorders, and they directly blame their fathers for the development of their disorders for specific reasons regarding abuse, drug use, and alcoholism.

Other participants directly blamed their fathers for their disorders without specific reasons, which the following two examples demonstrate.

“I became very short with him and blamed him for everything” (Participant 15).

“They [father and mother] were heavily involved in the events that surrounded it” (Participant 14).

Participant 15 blames her father for her disorder for unspecified reasons; however, in her narrative she assigns her father the roles of provider and caretaker and explains that work was a priority for her father and sometimes came before their relationship (as discussed in Chapter 4). Participant 14 similarly blames her father and mother for the events surrounding the development of her eating disorder, which she does not specify in her narrative; however, earlier in her narrative (as discussed above), she recounts a lot of

anger between her and her parents, which could have been part of the “events that surrounded it.” Fathers, in the case of participant narratives (whether reasons are detailed or not), receive a lot of the direct blame for their daughter’s eating disorders.

Second, daughters also indirectly blame their fathers’ actions and inactions, which the following three narrative examples illustrate. Participant 5 writes,

“My father is still in my life, but he did cheat on my mother when I was 14 and that changed our relationship. I began counting calories at 13.”

Participant 26 explains how her father blamed himself for her disorder:

“He blames himself a lot for the problems in my life though they are not really his fault. He contributed to a related condition I have (generalized anxiety disorder). [. . .] I honestly believe my disorder(s) developed largely in part to my father's inaction and more because of my mother's obsession with weight. My father was very rough on me as a kid but my mother made me hate myself. Sometimes inaction is just as bad as action.”

Participant 21 reveals,

“I have never been diagnosed with an eating disorder, but I've noticed since I was little that whenever I get really stressed and upset I can't eat even the smallest bite without getting sick. I am pretty sure it is stress-induced anorexia because I am fine any other time.”

Later in her narrative, she explains that her father’s anger influences her eating disorder behaviors:

“It is what sets it off because as soon as he gets angry, I can't keep anything in my stomach and I feel like I am about to pass out. Whenever everything is okay, I can eat normally and everything is fine, but when something happens to him, it comes back.”

Participant 5’s demographic information indicates that she began struggling with her disorder between ages 14 and 17, and her statement above, which concerns her father cheating on her mother when she was 14, shows that she began counting calories at age 13. Participant 26 claims that her disorder is not really her father’s fault, but later in her

narrative she claims that “inaction is just as bad as action,” therefore indirectly blaming him for her struggles. Her statement indicates that although he might not have been directly responsible for her eating disorder, his *inaction* contributed to her eating disorder experiences. Similarly, participant 21 does not directly blame her father for her disordered eating habits, but she suggests that his anger is a primary catalyst to her disordered eating habits. Interestingly, both participants 26 and 21 claim their fathers have anger control issues (previously discussed in Chapter 4). Participant 26’s father was physically and verbally abusive to her as she was growing up and was very accusatory of her behaviors, and participant 21’s father is an alcoholic who is angry a lot; both of these participants have been unable to participate in personal talk with their fathers because of their fathers’ respective anger issues.

Finally, in some of the narratives, daughters felt the need to express that their fathers are not to blame for their disordered eating behaviors, which the following two examples show.

“I do not blame my father or parents at all for the development of my disorder” (Participant 13).

“I don't believe that I lost weight due to my father or our relationship” (Participant 20).

For both of these participants there was a need to discuss their fathers’ innocence in regards to their eating disorders; however, they did not suggest that someone else was to blame. Importantly, both of these women express an acceptance for the way their fathers are (previously discussed in Chapter 4). Participant 13 accepts that her father just cannot understand his daughter and her struggles with self-image, and participant 20 accepts that she and her father have inherent differences in opinion about health and happiness, as

they do not agree on proper methods to take care of the body and both believe the other to be unhealthy. Both of these women still mentioned blame in their narratives, and it is possible that neither of them felt the need to blame their fathers because they have accepted their fathers and the state of the relationship for what it is/has been.

In daughters' accounts then, blame is a frequent code related to the father-daughter relationship and the experiences of eating disorder development, whether or not daughters actually (directly) blame their fathers for their eating disorders. Blame is almost always included in the participants' narratives, but none of the participants blame themselves for their disorder, even when they clarify that their fathers are not to blame. Denial of the eating disorder was also a prevalent code in participant narratives.

Eating disorder denial. In addition to blame, many daughters either deny the existence or the severity of their eating disorders. In the first two examples, participants 13 and 14 deny the severity of their disorders.

“I did not suffer from an extreme case of exercise bulimia. at no point was i hospitalized” (Participant 13).

“Eating disorders dont necessarily have to be an everyday activity. i had other stressful events in my life and although i did not throw up everyday, i would if i felt like i needed to. after you throw up, your tired. when your tired you sleep. i viewed it as a way to make me tired enough to sleep so that i could escape from the other events. the disorder itself was NOT the escape. just a catalyst” (Participant 14).

Participant 13 and 14 both deny the severity of their disorders, and for both of these women, there is a layer of justification in their statements; even though they have/had an eating disorder, they did not have a *severe case* of an eating disorder, or they were *strategic* about the eating disorder in some way.

Participant 20, on the other hand, denies the existence of her eating disorder altogether. In her account, she claims,

“I did lose a lot of weight because I was exercising more than eating, but it was not of my intention to lose weight because I had a negative body image of myself; it was because I wanted to be a healthier person, but I just did one healthy choice more than the other which became an imbalance on my body.”

Later in her narrative, she continues to deny the existence of her disorder even though she tried to correct her behavior at her father’s suggestion:

“I don't feel I have an eating disorder, just the symptoms of it. Yet, when he thought I did, I felt bad about myself and made the decision to gain some weight back on so I could be at a healthy weight again. As of two months ago, I was considered underweight and haven't received my period in over 6 months. I went to the doctor and was ordered to gain at least 3 pounds by the next 2 months.”

Finally, she asserts,

“I don't have an eating disorder, just had the experience of losing a lot of weight due to changed eating habits and exercise. I was considered to be underweight and had symptoms of the disorder, but I think that I just had a poor planning of a healthy diet. Now that I'm more knowledgeable on how much I should be eating to get all the essential nutrients and am working to gain some weight back, I don't think that I will lose that much weight again but rather maintain a healthy weight. I wish my dad could see that and be more supportive of these habits because he is the one who should be eating healthier and exercising.”

It is clear from this participant’s narrative that she struggles with identifying as having an eating disorder. She goes to great length and detail in her narrative to convince the reader that she is *only* trying to be healthy and does not actually have an eating disorder even though she refers to an imbalance in her body, meets diagnosable criteria (not having a period) for her specified disorder (anorexia), and references essential nutrients instead of caloric intake. In these three examples, daughters’ accounts of their disorders are characterized by their denial of their disorders. Their experiences of denial, especially since they feel strong enough about that desire to write about it in their narratives, could

potentially impact their experiences of their disorders as well as their conversations and relationships with their fathers. For example, participant 20 recounts in her narrative disagreements with her father about health and proper care of the body (previously discussed in Chapter 4), which are most likely impacted by his perception of her eating disorder and her perception that she does not, in fact, have an eating disorder at all. Denial could also be a consequence of the secretive and hidden nature of eating disorders.

Discovery/secretcy of the disorder. Eating disorders are marked by secrecy, as discussions of the secrecy and discovery of their eating disorders are also prevalent in the daughters' narrative accounts of their experiences. When daughters describe their fathers' discoveries of their disorders, their fathers' reactions are often marked by distance and/or care. The following three examples illustrate fathers' distance and care in the discovery of their daughters' disorders. Participant 27 remembers her father's reactions when he discovered her disorder:

““You have a disease. You need to get help.” is essentially how it went. [. . .] He was always all for forcing me into treatment and buying me/providing me with any care possible.”

Similarly, participant 26 recounts,

“At first he was very accusatory and defensive as if I was being completely ridiculous by having this problem. Then it went to understanding after a bout of disbelief.”

Finally, participant 6 explains,

“He never really "discovered it" persay. When I was open about it he started talking about his own sickness.”

Participants 27 and 26 report that their fathers initially reacted to their disorders with distance, accusations, and defensiveness, but both of their fathers shifted to more care giving behaviors after a certain amount of time. For participant 27, her father's care

giving was still marked by distance, but he began to provide treatment and care for her instead of insisting that she take care of it on her own, and participant 26's father shifted toward understanding after a period of disbelief. Both of these participants describe situations that have caused distance in the father-daughter relationship (previously discussed in Chapter 4). Participant 27 created distance in the father-daughter relationship with her bad choices regarding drug use and friends, and she and her father do not talk about her eating disorder, as it sparks disagreement between the two of them. Participant 26 describes her father as being verbally and physically abusive and not understanding her issues with self-image. Both participants also claim their relationships with their fathers have been challenged because of their respective eating disorders (discussed above), as participant 27's relationship with her father "disintegrated" when her eating disorder began, and participant 26 blames her father for his inaction. Their accounts indicate that the father-daughter relationship and the daughters' eating behaviors mutually influence one another. On the other hand, when participant 6's father discovered her disorder, there was a new connection in their relationship, as he shared a point of identification with his daughter. His "own sickness" was his experiences of overcoming cancer, as experience of illness is another point of connection in their relationship (previously discussed in Chapter 4).

For all three of these women, their relationships with their fathers shifted more in the direction of understanding or care once their fathers discovered their disorders, despite the previous state of the relationship. This could be related to an increase in care/love support and/or an active fathering quality (previously discussed in Chapter 4). Participant 27's father initiated discussions about her eating disorder even though it was

the cause of conflict because it was too important to ignore, thus becoming a more active, interested, and involved father. Participant 26's father realized how his own behaviors of abuse and meanness might have contributed to her disorder and stopped being so accusatory when he talked to her, thus increasing the amount of care and understanding in their relationship. Participant 6's father increased the amount of personal talk in their relationship, fostering a new point of connection with his daughter. For all three of these women, their respective eating disorders fostered change in the father-daughter relationship.

Still other narratives reveal that some daughters remain preoccupied with the secrecy of their disorders, which the following three examples demonstrate.

“I kept it all a secret and I locked him out of my personal life. It hurt him a lot” (Participant 15).

“He still doesn't know. I don't think anyone in my family does” (Participant 21).

“They [father and mother] didnt ever discover my disorder” (Participant 14).

Other than participant 15 who claimed her relationship with her father worsened because of her secrecy (possibly due to the fact that she blamed him for her eating disorder, which he did not know about), the other two narratives did not highlight any change in the father-daughter relationship because of the secrecy of their disorders.

Interestingly, there are several participants who explain that their fathers did not know about their disorders or no one knew of their disorders, and they also chose not to answer the question about the father's role in the development, maintenance, and recovery of the eating disorder. Participant 5 writes that “no one knows” about her disorder, and participant 15 explains that she never told her father. Both participants 5 and 15 left no response to the question about the father's role in the development,

maintenance, and recovery of their disorder. Similarly, participant 25 explains that her father had not yet discovered her eating disorder, and under the question about her father's role in the development, maintenance, and recovery, she writes, "He doesn't know," as if his not knowing meant that he had not played any role in her eating disorder. Oddly, participant 24 also asserts that her father "hasn't played any role" in her eating disorder even though earlier in her narrative she cited his addictions as causing the disorder. For participants 5, 15, 24, and 25, it appears as though they felt the question about the father's role in the development, maintenance, and recovery of the eating disorder was irrelevant to their specific situations.

From this, I infer that they believed the role had to be an active role, almost as if their fathers had to be aware of their disorders or act as an active participant in their disorders to actually influence their eating behaviors. From this, it appears that fathers can be participants in the family unit and in their daughters' eating disorder experiences without being verbal about food, body, appearance, or the eating disorder as seen in these narratives. Participant 21's narrative account demonstrates this best. Her father does not know about her disorder, but she blames his alcoholism for the development of her disorder and his anger control issues as a catalyst for the maintenance and continuation of her disorder. Although he does not know about her disorder and has not made verbal remarks about food, body, or appearance to his daughter, she still believes he has been an active participant in the development and maintenance of her disorder. Through their family interactions (i.e., negative characteristics, close or distant relationships with their daughters, fathering quality, and support), fathers influence their daughters' behaviors, even if those influential moments are subtle.

Recovery experience. Recovery from their eating disorders is also perceived as an important moment for the father-daughter relationship according to daughters' narratives. For some daughters, recovery caused an increase in distance in the father-daughter relationship, which the following three examples illustrate.

“He was always all for forcing me into treatment. [. . .] However I didn't begin my real recovery until this January when I finally decided to seek help for myself” (Participant 27).

“We are all burdened with the bulk of our past experiences... He never chose to work on his, and that is sad to me... I did choose to work on mine, and that is making all the difference. :)” (Participant 3).

When discussing her recovery, participant 7 writes,

“There isn't much [support] from my dad. [. . .] From God, He's been working on healing me from it through other people such as my husband.”

Participant 27's statement indicates that although her father had tried to help her with her recovery, she did not accept his help, thus creating more distance in their relationship. Similarly, participant 3's account reveals that as she worked to improve her own life, she was increasingly aware that her father had not chosen to work on his own life (i.e., his alcoholic and abusive tendencies), which created more distance and perhaps a sense of inequality in their relationship. From participant 7's statement, it is clear that her father has not been active in her recovery efforts; instead God and her husband have been her support. In these three examples, fathers' roles in their daughters' recovery efforts are not received well or are not characterized as supportive.

On the other hand, some daughters indicate that their fathers had been important to their recovery, which contributed to an improvement in the father-daughter relationship. The following three examples show this improvement in the relational climate.

“I think it has helped me recover a bit more because I see how much he cares about me and wants me to be healthy” (Participant 6).

“We never really had a relationship until I got help for the eating disorder” (Participant 9).

“As i healed, we became closer. [. . .] My dad's role in my recovery was huge. He's been a support system” (Participant 13).

Participant 6’s relationship with her father helped with her recovery process, as their connection fostered because of his struggles and triumph over cancer. Participant 9’s recovery work improved her relationship with her father, as he became a more interested and active father once she finished treatment for her eating disorder. Notably, participant 13’s statement highlights the mutual influence of the father-daughter relationship and the eating disorder process, as participant 13’s recovery process improved her experience of the father-daughter relationship, *and* the relationship aided in her recovery. These examples of connection, support, distance, closeness, and improvement in the father-daughter relationship because of daughters’ recovery processes illuminate the mutual significance of the father-daughter relationship and daughters’ recovery from their eating disorders to one another.

Overall, this theme, daughters’ experiences of their eating disorders, reveals three important things about fathers’ roles in their daughters’ eating disorder performances. First, eating disorders are perceived as relational artifacts of the father-daughter relationship, as the eating disorder influences dyadic identity and evolution in the father-daughter relationship. Throughout the narratives, relational experiences and eating disorders mutually influence one another’s progression and trajectory through interaction and communication.¹ Second, fathers potentially enable the development of the eating disorder through actions and inactions nonrelated to daughters’ food intake, appearance,

or behavior (e.g., preoccupation with work, difference in ideas about health and happiness, alcoholism and addiction, abuse, absence, anger, etc.). Third, fathers potentially further enable the performance of the eating disorder through their silence and passivity in their reactions to their daughters with eating disorders (e.g., in deference to the mother, through competition with other father-figures, in the moments of the eating disorder's discovery, in talk about health and eating behaviors, etc.). However, it seems as though daughters feel that their fathers have to be active participants to contribute to the disorder (i.e., fathers have to know about the disorder, have to be vocal about body image, have to participate in talk about eating behaviors, etc.). In the development of the eating disorder, daughters recount moments in the father-daughter relationship that they perceived served as catalysts to their disordered eating behaviors: anger, abuse, affairs, etc. In these instances, their fathers were not actively commenting on food, behavior, or appearance; rather they were passive participants or a contributing influence in their daughters' problematic ideas of food and eating. When examining daughters' blame for their eating disorders, many of the participants either directly (for specified and unspecified reasons) or indirectly (based on actions or inactions) blame their fathers for the development and escalation of their eating disorders; daughters, however, did not blame their fathers for direct actions relating to food or appearance. Instead, they blame their fathers for their passive and silent roles in their eating disorders: anger, abuse, drug use, alcoholism, inaction, and perhaps their own unhappiness, self-neglect, and bodily abuse. Some of the daughters, finally, express that their fathers were not to blame for their eating disorders, but they do not clarify further who is or might be to blame.

Recovery from the eating disorder is also an important moment for the father-daughter relationship, as narrative accounts demonstrate the recovery process can aid in the improvement of the father-daughter relationship or create more distance in the relationship. Some daughters indicate in their narratives that their fathers had been important to their recovery, which also worked to improve the father-daughter relationship. In fact, it is only in this scenario that daughters describe their fathers as being active participants in their lives as they provide support and care. As discussed in Chapter 4, through their roles of “dad,” friend, and caretaker/provider, fathers provide emotional support through love/care, expressions of pride as support, and material support through monetary contributions and physical labor. Similarly, when daughters explain their fathers reactions in the discovery of the disorder, most fathers react in a distant or passive manner first, followed by expressions of understanding and care later. However, when daughters are able to maintain the secrecy of their disorders (as some of the participants have), their narratives indicate that the father-daughter relationship worsened or did not change. The only time fathers are not included in participant explanations of their disorders is when daughters express denial about the existence or severity of their eating disorder experiences. The fact that fathers are not mentioned in this code suggests that denial about the disorder is personal rather than relational (or that it may become relational over time), as it can also be a consequence of the secretive and personal nature of eating disorders.

Enabling the Eating Disorder: Communicative Roles of the Father

The first theme, dynamics of the family unit, reveals important contributing factors and influences to the father-daughter relationship, daughters’ eating disorder

experiences, and fathers' involvement in the trajectory of their daughters' eating disorders. Daughters explain that they are closer to their mothers, contrasting the father-daughter relationship with the mother-daughter relationship. In addition, daughters suggest that their fathers only know about their eating disorders from their mothers, and they claim that their mothers played a more active role in their eating disorder experiences, as they influence daughters' behaviors and attitudes regarding food and behavior. In the narratives, daughters characterize their mothers as active participants in their eating disorder experiences and perceive their fathers as passive, silent, or uninvolved in their eating disorder experiences. This scenario of the important mother is further complicated and possibly a result of daughters who feel their fathers are preoccupied with work, alcoholism, or addiction, daughters who have distanced or negative relationships with their fathers because of abuse, absence, or non-meaningful interactions, and daughters who are extremely close with their fathers and would want to portray their mother, rather than their father, as more of an active participant in their eating disorder experiences (several themes/codes previously discussed in Chapter 4).

Similarly, daughters' narratives reveal that the father-daughter relationship is further complicated and defined by relationships with other father-figures. Daughters explain that relationships with god, grandfathers, biological fathers, and godfathers are influential as they sometimes complicate/challenge their relationships with their fathers. Daughters also experience family stress, such as parental discord, fathers' alcoholism, and anger and turmoil in the family unit, and they are involved in events outside of the family unit, such as drug use, poor choice in friends, sexual abuse, and other stressful events. Both family stress and daughters' experiences of external events influence and

shape the father-daughter relationship as well as daughters' eating disorder experiences. Together daughters' experiences of the father-daughter relationship (father characteristics, talk, frequency, presence, fathering quality, and fatherly roles, as previously discussed in Chapter 4) and her experiences of the family unit (maternal influence, other father-figures, stress, and external events) influence daughters' experiences of their eating disorders.

The second theme, daughters' experiences of their eating disorders, illustrates three important things about the fathers' role in their daughters' performances of their eating disorders: (1) eating disorders are perceived by daughters as relational artifacts of the father-daughter relationship, as they can create more distance through increased stress and difference in opinion or foster closeness in the relationship through increased engagement from the daughter and increased love/care support from the father (previously discussed in Chapter 4); (2) fathers potentially enable the development of the eating disorder through actions and inactions nonrelated to daughters' food intake, appearance, or behavior, such as preoccupation with work, difference in ideas about health and happiness, affairs, alcoholism and addiction, abuse, absence, anger, etc. (previously discussed in Chapter 4); and (3) fathers potentially enable the performance of their daughters' eating disorders through silence, passivity, and inaction in their reactions and conversations to their daughters' eating disorders (i.e., in deference to the mother, through competition with other father-figures, in the moments of the eating disorder's discovery, in talk about health and eating behaviors, etc.).

Because of daughters' responses to narrative questions, though, it seems as though daughters feel that their fathers have to be active participants to contribute to their

overall experiences of their eating disorders. In their accounts of the development of their respective disorders, daughters recount moments in the father-daughter relationship that served as catalysts to their disordered eating behaviors: anger, abuse, affairs, stress, etc., and in these instances, their fathers are not actively commenting on food, behavior, or appearance. Interestingly, even though daughters' do not represent their fathers as active participants in their eating disorder experiences, many of the daughters either directly or indirectly blame their fathers for the development, escalation, and maintenance of their eating disorders. Importantly, daughters do not blame their fathers for direct actions relating to food, appearance, or eating behaviors; rather, blame is placed on their fathers for their non-food related actions, inactions, opinions, and behaviors, for their passive and silent roles in their eating disorders: anger, abuse, drug use, alcoholism, and perhaps their own unhappiness, self-neglect, and bodily abuse (previously discussed in Chapter 4). On the other hand, although blame was important to mention in the narrative accounts, some participants explain that their fathers were not to blame, but they do not blame themselves nor do they specify who else might be to blame.

Similarly, when daughters explain their fathers reactions in the discovery of their daughters' eating disorders, most fathers react in a distant or passive manner first, followed by disbelief and then expressions of understanding/care. However, when daughters maintained the secrecy of their disorders, narrative accounts indicate no change in the father-daughter relationship (although one participant claimed the secrecy further damaged her relationship with her father). The only scenario in which fathers are not discussed as being involved in daughters' experiences of her eating disorder is in expressions of denial about the existence or severity of her eating disorder. This suggests

that denial about the disorder is personal rather than relational (or that it may become relational over time), as it can also be a consequence of the secretive and personal nature of eating disorders. Recovery, on the other hand, is closely tied to the discovery of the disorder and is also an important moment for the father-daughter relationship. Narrative accounts demonstrate that the recovery process can aid in the improvement of the father-daughter relationship or create more distance in the relationship. Some daughters indicate that their fathers had been important to their recovery, which improved the father-daughter relationship while others claim that recovery had increased the distance they experience in the father-daughter relationship. In fact, it is only in this scenario that daughters describe their fathers as being active participants in their lives as they provide support and care. As discussed in Chapter 4, through their roles of “dad,” friend, and caretaker/provider, fathers provide emotional support through love/care, expressions of pride as support, and material support through monetary contributions and physical labor.

Overall, narrative accounts of the dynamics of the family unit and daughters’ experiences of their eating disorders influence, shape, and define the father-daughter relationship. Together the daughters’ experiences of the father-daughter relationship (father characteristics, talk, frequency, presence, fathering quality, fatherly roles, and fathering support, as discussed in Chapter 4), experiences of the family unit (maternal influence, other father-figures, stress, and external events, as discussed above), and eating disorder experiences (development and blame, secrecy/discovery, denial, and recovery, as discussed above) all mutually influence each other (as shown in Figure 5.1). In Chapter 4, daughters’ ambivalent constructions of their fathers present both positive and negative images of their fathers as both true and unchanging. Although daughters are able

to describe their fathers positively (i.e., energetic, busy, hard working, etc.), there are several obstacles and challenges (i.e., addiction, abuse, work priorities, etc.) in the father-daughter relationship. Those challenges are compounded in this chapter by mothers (active participants in their daughters lives who are closer and more vocal than fathers), other father-figures (who are sometimes available to daughters as replacement fathers), family stress (parental discord, fathers' alcoholism and addiction, abuse, anger, and turmoil in the family unit), external events (drug use, poor choice in friends, sexual abuse, and other stressful events), and eating disorders (daughters' blame, secrecy, denial, and sometimes recovery).

The second theme in Chapter 4, characteristics of the daughter, illuminates very little about the daughter in terms of self-description; however, this theme demonstrates daughters' lack of engagement in the father-daughter relationship and acceptance of the relational status quo. Although the daughters describe their fathers' behaviors as creating distance in the father-daughter relationship, daughters' disengagement and acceptance also reveal a further point of distance in the father-daughter relationship. In this chapter, the secretive nature of the eating disorder is highlighted in daughters' accounts of the private nature of their eating disorders. When these two themes are compared, it appears that daughters may be disengaged from the father-daughter relationship because of their denial and preoccupation with secrecy. In fact, some daughters indicate that their fathers had been important to their recovery process once the eating disorder was discovered, which improved the father-daughter relationship while others claim that the discovery of their eating disorder and subsequent recovery processes had increased the distance they experience in the father-daughter relationship.

The third theme in Chapter 4, patterns of talk in the father-daughter relationship, illustrates the lack of personal talk in the father-daughter relationship as well as the capacity for change in patterns of talk between fathers and daughters. Throughout this theme, personal talk and general talk emerge as prominent in describing how fathers and daughters communicate with one another. Daughters' narratives show that it is important for them to keep in contact with their fathers, despite the common patterns of talk, and although the relationship is often defined by general talk, daughters desire more personal talk with their fathers. This desire is complicated in the current chapter, as some daughters also wish to maintain the secrecy of their disorders and blame their fathers for their disorders. In addition, some accounts of their fathers discovering their disorders are marked by distance and disbelief in the father-daughter relationship; however, for some fathers, this disbelief is followed by an increase in care, understanding, even connection, and then sometimes a change relationally.

In addition, Chapter 4 reveals tensions that emerge between general talk and personal talk as well as between important conversations and avoiding disagreement, which usually regarded fathers' health or daughters' health through eating behaviors. Within the narratives, though, evolution in the patterns of talk is a positive and desired experience for the daughters, as the shift usually represents an increase in closeness between the father and the daughter. This shift is most evident in the narratives when daughters describe the increase in support and care from their fathers in the recovery process. In fact, it is only in this recovery scenario that daughters portray their fathers as being active participants in their lives as they provide support and care. As discussed in Chapter 4, through their roles of "dad," friend, and caretaker/provider, fathers provide

emotional support through love/care, expressions of pride as support, and material support through monetary contributions and physical labor.

The final theme in Chapter 4, characteristics of the father-daughter relationship, reveals the dynamic rather than static nature of the father-daughter relationship as well as the capacity for change within the relationship. The narratives show that the father-daughter relationship is an evolving emotional experience and daughters assign roles to their fathers based on the degree of perceived emotional connection. In this chapter, the emotional connection between fathers and daughters is complicated by the daughters' eating disorder experiences and the dynamics of the family unit (mothers, other father-figures, stress, and external events). In Chapter 4, daughters' constructions of the father-daughter relationship highlight a desire for the fathers' presence to be accompanied by quality interaction and closeness and that it is important to daughters when their fathers are active and supportive in the relationship (whether that support is love, pride, or material). On the other hand, daughters' accounts also reveal evidence of distance in the father-daughter relationship, as they describe emotional experiences of anger, fear, and hurt as well as some descriptions of a negative fathering quality. In the current chapter, the crisis of the eating disorders presents an opportunity for a more dynamic shift in the father-daughter relationship, as discovery of the disorder, recovery efforts of the daughter, and conversations about the disorder all have the potential to improve the quality and closeness of the father-daughter relationship through connection and relationship building; however, those same moments can also increase the distance and negative feelings in the father-daughter relationship as some daughters directly and

indirectly blame their fathers for their disorders, have differences in opinion about health and happiness, and disagree about treatment options.

In conclusion, the six narrative themes discussed in Chapters 4 and 5 illuminate both ambivalence in the daughters' characterizations of her disordered eating and the father-daughter relationship. In addition, several dialectical tensions surfaced in the father-daughter relationships as a result of daughters' eating disorder experiences.² Importantly, the boundaries of the father-daughter relationship are seen to be permeable to several outside influences (e.g., fathers' attitudes and behaviors, daughters' attitudes and behaviors, mothers, other father-figures, family stress, external events, and eating disorders). In all of these instances, there is a constant tension between distance and closeness in the father-daughter relationship wherein fathers usually react with passivity, silence, or inaction to their daughters and their daughters' experiences with an eating disorder. However, the narrative themes also demonstrate that the father-daughter relationship is a dynamic experience, as there is always possibility for change in the father-daughter relationship. In the next chapter, these tensions and turning points will be further explored, and the study's contributions to the wider body of knowledge in the ecological model will be discussed.

ENDNOTES

¹ The idea of the eating disorder as a relational artifact of the father-daughter relationship is further explored in Chapter 6.

² Dialectical tensions in the father-daughter relationship are further explored in Chapter 6.

CHAPTER 6: DISCUSSION

Tensions and Turning Points in the Father-Daughter Relationship

Environments that influence behavior and development cannot be explained in a linear manner; rather they have to be explained from a systems perspective, as Bronfenbrenner's (1979) ecological model suggests. In the eating disorder literature, this model is rarely used. Moreover, as discussed earlier, even if the model is used, the father's role in families with daughters suffering from eating disorders is missing. The ecological model is useful when examining eating disorders because it allows the researcher to move beyond exclusively blaming the family environment, in this case, and helps the researcher examine the multifaceted messages surrounding the eating disorder. Furthermore, given that the family is the closest concentric circle in the ecological model to the adolescent woman suffering from disordered eating behaviors, it is important to describe a more thorough picture of the family system in which an eating disorder is present.

Bronfenbrenner's (1979) model of social context has at its center the individual (the adolescent woman) surrounded at the closest concentric circle by the family system. In such a model, the individual experiences her social environment in layers: first as a self, second through interaction with the family, third through social interaction with institutions and peers, fourth with the media, and finally with sociocultural norms and the ideology of her culture (Austin, 2000). Since the family is the closest layer to the center (the individual), it is prudent to understand how the family system responds to eating

pathology and how eating disorders affect the family system. It is evident from participant narratives that the family has great potential to influence eating attitudes and behaviors. While an ecological framework for eating disorders recognizes that there are multiple familial, sociocultural, and mediated etiological agents working in unison to encourage disordered eating behaviors, and that the mother, the father, and the family cannot be solely responsible for disordered eating in female adolescents, there are potential prevention points to be identified.

In this chapter, I will first explain the lack of information concerning the third and final research question of this project. I will then summarize the key findings of this study and connect them to the literature reviewed in Chapter 2. I then further explain tensions and ambivalence in the father-daughter relationship guided by Baxter and Montgomery's (1996) relational dialectics perspective, including some of the relational turning points discovered in the data. Finally, I will conclude this chapter with some final remarks about the complexity of relationships in the eating disorder context.

Anorexia and Bulimia: Differences in Relationship Patterns

There was not enough data to answer the final research question: How do the communicative roles of fathers of daughters with Anorexia Nervosa differ in performance from the communicative roles of fathers of daughters with Bulimia Nervosa? Previous research has found significant differences between familial interactions of bulimic families and anorexic families. Minuchin et al. (1978) claimed that families with daughters suffering from eating disorders demonstrated certain psychosomatic tendencies in family interactions. Over the years, researchers have further developed these characteristics for both anorexia nervosa and bulimia nervosa families.

Both anorexia nervosa and bulimia nervosa have been associated with “self-reported pathological family functioning on five dimensions: the family style for problem resolution (problem-solving), transmission of information (communication), differentiation of tasks (roles), experience of emotions (affective responsiveness), and general functioning” (Fornari et al., 1999, p. 439); however, the manifestation of the dysfunction in anorexic and bulimic families differs, according to previous research.

Families with an anorexic daughter have been described in the research as very rigid and overly organized (Hoste et al., 2007; Humphrey, 1986; Steiner & Lock, 1998; Vidovic et al., 2005), overprotective (Hoste et al., 2007; Humphrey, 1986; Vidovic et al., 2005), exclusive (Kog & Vandereycken, 1985), cohesive, and enmeshed (Fornari et al., 1999; Hoste et al., 2007; Humphrey, 1986; Kog & Vandereycken, 1989; Vidovic et al., 2005). Anorexic families are also conflict avoidant (Fornari et al., 1999; Humphrey, 1986; Kog & Vandereycken, 1989; Vidovic et al., 2005) to the point where they are poor or lacking in conflict resolution skills (Hoste et al., 2007; Humphrey, 1986; Vidovic et al., 2005) as well as lacking in constructive communication in conflict situations (Lattimore et al., 2000).

On the other hand, bulimic families are highly disorganized (Crowther et al., 2002; Fornari et al., 1999; Humphrey, 1986; Kog & Vandereycken, 1989; Pike & Rodin, 1991; Vidovic et al., 2005) and report more general family dysfunction (Crowther et al., 2002; McNamara & Loveman, 1990) and negative family interactions (McNamara & Loveman, 1990). They are also characterized by high levels of conflict and open hostility (Crowther et al., 2002; Fornari et al., 1999; Humphrey, 1986; Kog & Vandereycken, 1989; McNamara & Loveman, 1990; Pike & Rodin, 1991; Vidovic et al., 2005). Because

bulimic families are chaotic, conflicted, and critical (Pike & Rodin, 1991; Steiner & Lock, 1998), they enact low levels of family support (Fonseca et al., 2002), affection (Humphrey, 1989) nurturing, caring (Vidovic et al., 2005), and responsiveness to emotions (Pike & Rodin, 1991).

Humphrey's (1989) study also concluded that there were further differences in anorexic and bulimic *father-daughter* interactions. Fathers of anorexic daughters demonstrated more pseudo affection (nurturing), control (managing), pseudo help, and negation (ignoring), which their anorexic daughters responded to with pseudo self-disclosure and submission. Fathers of bulimic daughters demonstrated more pseudo understanding and control (managing), which their bulimic daughters responded to with ambivalent self-assertion and sulky resentment. These trends are not present in the data for this project, as no differences were found between the subgroups. There could be several explanations for this.

First, there are only 12 participants in this study who self-identify as anorexic (n=7) or bulimic (n=5), and there is not a balance between the two groups.¹ Gaps in experiences between the two groups probably do not represent an actual difference between the groups; rather, the participants are too few and the data is too limited to make assertions about differences. In addition, most research on family interaction with eating disorders has been done with mothers and fathers or just with mothers (without fathers), and it could be that prior research found distinctions in behaviors and specific subgroup characteristics that are only present when the mother is present or when the whole family is present, but not in the father-daughter dyadic relationship. It is also possible that these specific characteristics do not show unless the whole family system is

considered, and this project's sole purpose was to inquire about the interactions between fathers and daughters. There were no questions concerning other family members, which might be integral to finding the differences in interactions between bulimic and anorexic families. Moreover, the majority of participants in this study were recruited from an online support group or a university support group, and it is possible that these distinctions did not surface because those participants are already working out their family issues. Finally, the questions designed for this project were not intended to measure these traits in overall family functioning. In the next two sections I will summarize the key findings as they answer the other two research questions of the project.

The Nature of the Father-Daughter Relationship

Participant narratives reveal four narrative themes that help to answer the first research question: How is the nature of the father-daughter relationship communicatively constructed by the daughter? The first theme, *characteristics of the father as described by the daughter*, demonstrates that although daughters experience points of connection and disconnection with their fathers due to their fathers' health choices, abuse, addictions, and their working patterns, daughters are still concerned about their fathers' well-being. Previous research on eating disorders has also found correlations with eating pathology and abuse, alcoholism, and addiction. Polivy and Herman (2002) claim that daughters who have experienced sexual or physical abuse from a family member are at an increased risk of developing an eating disorder. Kog and Vandereycken (1985) reported that 5.7-17% of patients' immediate relatives suffered from alcoholism, and 2-6% of their immediate relatives struggled with drug addiction. However, as these previous studies

were quantitative in nature, they did not provide participants with the opportunity to reflect on their family members' behaviors. The narrative method used in this study captures daughters' ambivalent constructions of the father-daughter relationship, as daughters reveal both positive and negative aspects of their fathers, inside and outside of the relationship, as true and unchanging, which previous research does not detail. Although daughters describe their fathers positively (i.e., energetic, busy, hard working, etc.), there are several obstacles and challenges (i.e., addiction, abuse, work priorities, etc.) present in the father-daughter relationship.

The second theme, *characteristics of the daughter*, is defined by daughters' general disengagement from the father-daughter relationship. Participant narratives illustrate that daughters are disengaged participants in the father-daughter relationship, as daughters simultaneously remove any discussion of their self and their role in relational construction and maintenance; however, daughters' acceptance for the state of the relationship demonstrate that they feel as though their fathers behaviors have enacted barriers in the father-daughter relationship, and their fathers still have a role to play in the evolution/non-evolution of the father-daughter relationship. Daughters do not reveal information about themselves; in fact, they did not describe their role in the father-daughter relationship at all. Thus, this theme indicates a further point of disconnection in the father-daughter relationship. This is partially consistent with Humphrey's (1989) above mentioned study where he found that anorexic daughters responded to their fathers with pseudo self-disclosure and submission and bulimic daughters responded to their fathers with ambivalent self-assertion and sulky resentment. In this study, daughters were ambivalent in the father-daughter relationship and showed signs of pseudo self-disclosure

(general talk and strategic talk) and resentment of their fathers (in the form of disengagement and acceptance). However, as mentioned above, there were no differences found between subgroups in this study.

The third theme, *father-daughter patterns of talk*, explains several types of talk engaged in the father-daughter relationship: frequency of talk, personal talk, general talk, strategic talk, talk about daughters' food and behavior, and evolving patterns of talk. The data exemplars reveal that there is very little opportunity for fathers and daughters to talk about matters that are personal or important in their lives; however, participant narratives also highlight a desire for more personal talk and possibilities for change in father-daughter patterns of talk. Daughters' accounts reveal that they find their fathers to be valuable in their lives despite the patterns of talk between them, and it is important for them to keep frequent contact with their fathers. Importantly, both fathers and daughters in participant exemplars care enough about one another to both avoid certain topics for the sake of harmony and to insist on certain conversations for the importance of the other's well-being. Talk between family members has proved to be important in prior research as well. Al Sabbah et al. (2009) report that parent-child communication is linked with social competence, autonomy, positive attitudes toward academics and work, achievement, and self-esteem, which are all negatively correlated with disordered eating. More importantly, negative relationship and lack of communication with parents are linked to dissatisfaction with weight as well as depression, misconduct, and poor mental health. These findings are consistent with the current study, as patterns of talk were linked with disordered eating; however, this project merely highlights patterns of talk in a certain context and does not provide a direct correlation between the two variables.

Throughout the narratives, there is no support for Smolak et al.'s (1999) finding that *paternal* communication was correlated with daughters' attempts to lose weight, concerns about being fat, and body-esteem. This study examined participant accounts of their own eating disorder experiences and did not reveal fathers' communication about body image or food intake, unless it was to assert that their daughters were beautiful or when they were encouraging their daughters to eat because of their health. In previous mother-daughter studies, mothers were verbal and active about their daughters' body image, weight, and food intake (Crowther et al., 2002; Lattimore et al., 2000; Moreno & Thelen, 1993; Pike & Rodin, 1991). In fact, many mothers in previous studies actively encouraged their daughters to lose weight even when they were not overweight (Benedikt et al., 1998; Pike & Rodin, 1991). According to participant narratives in this project, fathers are not verbal about such matters. It could be that fathers and mothers differ in their communication about food, behavior and appearance, or this could be a result of the small number of participants in this study.

This theme, *father-daughter patterns of talk*, also demonstrates that the father-daughter relationship is not experienced statically by daughters; rather, the relationship is an ever-changing entity built by evolving patterns of talk in and about the relationship. The ambivalence between general and personal talk as well as the ambivalence between conflict and avoidance of certain topics eventually evolves into new patterns of talk for some of the participants. The evolving patterns of talk evident in participant narratives demonstrate that if something (an eating disorder) works to change the patterns of infrequency and nature of general talk in the father-daughter relationship, the entire relational climate can change as well. It is evident in daughters' narratives that evolving

patterns of talk over time is a positive and desired experience for the daughters. This finding is consistent with Henry's (1994) finding that adolescents who are more satisfied with their family disclose more emotional information with their parents, are more compliant with family expectations, and most importantly, have a greater quality of life. The patterns of talk theme also further exemplifies the tension between closeness and distance in the father-daughter relationship as daughters struggle to negotiate levels of general, personal, and strategic talk with their fathers. Together the first three themes provide a picture of the father and daughter as separate people coming together as a dyad in talk, struggling to maintain their relationship through conflict and avoidance, and negotiating their relational identity through evolving patterns of talk over time.

The previous three themes combine and work to inform the final theme, *characteristics of the father-daughter relationship*, which details frequency and presence in the relationship, roles of the father, emotions experienced by the daughter, types of fatherly support, fathering quality, and evolution in the relationship climate. The fourth theme, combined with the previous three themes, works to address how the father-daughter relationship is communicatively constructed by the daughter. Although there is little focus on quality when addressing their fathers' presence, the subtext of daughters' narratives suggests that quality interaction with their fathers is important. This is consistent with Phares (1996), who reports evidence that "it is *quality* rather than *quantity* [of time] that seems to have a greater impact on children's wellbeing" (emphasis in original, p. 18). All of the participants in this study referenced the quantity of time they spend with their fathers, but many of them were unsatisfied with the quality of those interactions.

Throughout this theme, daughters' reveal varying degrees of closeness with their fathers in their descriptions, and for some daughters, father-daughter closeness is described as an emotional experience in the relationship. The narratives convey the father-daughter relationship as an evolving emotional experience whereby daughters assign roles to their fathers based on their degree of perceived emotional connection. Closeness is also important in participant narratives to descriptions of frequency and presence of father-daughter interactions, assigned fathering roles, descriptions of fatherly support and fathering quality, and is an integral component to descriptions of evolution in the father-daughter relationship.

For adolescents, there is a correlation between feelings of closeness with their father and self-esteem. Phares (1996) reports that girls who felt support and warmth from their fathers showed higher levels of self-esteem than their peers. Yet, throughout participant narratives there are tensions present that prevent or impinge upon father-daughter closeness and connection in the relationship. Descriptions of fathers and the father-daughter relationship within this narrative theme demonstrate that daughters feel as though their fathers are valuable to their lives regardless of the degree of closeness in their relationship; however, it is also evident in the narratives that a shift to a closer relationship is a positive and desired experience. Within their narratives, daughters portray their relationships with their fathers both negatively and positively, but it is evident from their descriptions that daughters desire some personal connections with their fathers despite how they have communicatively constructed their relationships in their narratives.

Lamb and Tamis-Lemonda (2004) argue that fathers play an integral role in the development of their children, are often salient in the lives of their children, and affect the course of child development for either the better or worse. The authors also claim that children who have “secure, supportive, reciprocal, and sensitive relationships” with their fathers are more likely to have better psychological development than children with less satisfying paternal relationships (p. 10). From this section it is evident that daughters desire more closeness with their fathers, but their fathers’ actions, their own disengagement, and their lack of openness in talk has created a barrier in the father-daughter relationship. Despite the finding above which shows that both daughters and fathers are emotionally involved and concerned about one another’s well-being, previous research asserts that fathers of daughters with eating disorders appear to be more emotionally uninvolved in their daughters’ lives than control fathers (Phares, 1996). Even though there was not a control group for this study, daughters’ accounts did not reveal that they felt their fathers to be emotionally uninvolved. McVey et al. (2002) also claim that low paternal support, in particular, is highly correlated with disordered eating, but the majority of the participants in this study explained in their own words, that their fathers were generally supportive in a number of ways, rather than how they were not. These contradictions further exemplify the tension between closeness and distance in the father-daughter relationship, as participant accounts reveal that fathers and daughters struggle with emotional involvement over time. In addition, many of the participants explain that paternal support increased because of their eating disorder experiences. Previous research shows a static picture of the father-daughter relationship whereas this study demonstrates

that although fathers and daughters may be emotionally detached at one point in time, emotional closeness and support continuously change for relationship partners over time.

In answering the first research question, daughters communicatively construct their relationships with their fathers through the tension of closeness and separation in the father-daughter relationship. First, although daughters describe relational barriers caused by their fathers (i.e., anger, abuse, addiction, etc.), the subtext of their narratives reveals that some of those barriers are in fact created by the daughters themselves (through disengagement and acceptance). Second, daughters do not communicatively construct their relationships with their fathers based on interactions about food intake, weight, and appearance but rather around issues of quality interactions, support, and closeness. Third, in their accounts, daughters construct the father-daughter relationship as an evolving emotional experience, whereby their eating disorders influence the evolution of the relationship over time. Participant narratives document that daughters feel as though their fathers are valuable to their lives despite their struggles with closeness; however, it is also evident in the narratives that although there are obstacles and challenges within the relationship on both sides, change in the relational climate is not only possible, it is a positive and desired experience for daughters. Finally, the narrative exemplars demonstrate that instead of direct causal relationships between father characteristics, daughter characteristics, father-daughter talk, and the father-daughter relationship, small shifts in the father's priorities, the daughter's engagement, and/or their patterns of talk can result in a shift for the entire father-daughter relationship.

Enabling the Eating Disorder: Communicative Roles of the Father

The dynamic nature of the father-daughter relationship is further complicated by its placement in the larger family system and the daughters' experiences of her eating disorder, as the father-daughter relationship does not exist in a vacuum. The communicative roles performed by the father are perceived in relation to mothers, other father-figures, and the family system as a whole; they are also simultaneously received by a daughter struggling (sometimes secretly) with an eating disorder. Participant narratives reveal two themes that help to answer the second research question: How do the communicative roles the father performs (silence, passivity, vocal) enable the performance of the eating disorder? First, *the dynamics of the family unit* theme shows the importance of the family context to the father-daughter relationship. Narrative accounts illustrate that activity in the family unit coupled with the nature of the father-daughter relationship mutually contribute to *daughters' experiences of their eating disorders*, the second theme.

Daughters describe the *dynamics of their family unit* in four specific ways that inform both the father-daughter relationship as well as the daughters' experiences with their eating disorders. The most prominent reference to the family unit is the importance of the mother-daughter relationship, as daughters contrast the mother-daughter relationship with the father-daughter relationship, revealing that they are more open to sharing personal information with their mothers and describing their mothers as having a more active role in their eating disorder experiences. These findings are consistent with some previous findings about mothers. Wertheim et al. (1999) found that mothers were more likely to help their daughters diet, participate in a diet with their daughters, and

criticize their daughters' weight, but the authors did not discuss the role of the father in these exchanges. In this study, one participant claimed that her mother had an eating disorder, and she resisted developing an eating disorder for as long as she could. Another participant claimed that her mother supported her eating behaviors when her father openly disagreed with her disposal of food. Although this study cannot fully confirm all of Wertheim et al.'s (1999) findings, mothers are more likely to help their daughters diet in this study. However, the same findings are not true for the fathers of this study who openly speak against deviant eating behaviors, react silently or passively in their discovery of the disorder, or provide support and treatment after the discovery of the disorder.

Daughters' relationships with other father-figures is the second most referenced family dynamic, and many of the narrative accounts describe escaping or replacing their father with other father-figures. As fathers have not traditionally been included in the eating disorder literature, other male figures have also not been included in the literature to compare findings. This is important because any omission in the research leaves further gaps in the ecological model of eating disorders. If fathers are important in daughters lives and affect psychological development (Phares, 1996), then father-figures (i.e., grandfathers, step-fathers, etc.) might also affect psychological development and self-esteem. More specific to this context, other father-figures might have just as much influence on development, maintenance, and recovery of eating disorders as biological fathers, and in some cases, more influence.

Third, daughters reference family stress as impacting their eating disorder experiences as well as their relationships with their parents. This is consistent with

Cummings et al.'s (2004) report that marital conflict and quality are correlated with child development, adjustment, and overall functioning. In fact, the authors claim that high marital conflict tends to result in poorer overall *paternal* parenting, specifically for daughters in those households. Within the current study, marital conflict and family stress impact the father-daughter relationship negatively, but daughters also reference other types of familial stress, which they have caused.

Finally, daughters' confess that there are external events happening in their lives, which also impact the family unit. Previous literature has not recorded adolescent causes of stress in the eating disorder literature. Stress caused by adolescents is explainable though through Ackerman's (1984) definition of the family as "a household in which the behavior of any one person is at all times a function of behavior of all other members" (p. 16). Galvin et al. (2006) add that the family is essentially a group, and groups are bound together as a social system by their communication. Given this literature, it makes sense that adolescent stress (and adolescent eating disorders) can cause familial stress as well (and vice versa). These factors situate the father-daughter relationship within the larger family system wherein multiple factors influence father-daughter closeness and work to define and transform the father-daughter dyadic identity.

This dyadic identity is further complicated by daughters' experiences with their eating disorders. Daughters describe these experiences in four specific ways that highlight the mutual influence of the father-daughter relationship and daughters' eating disorders on one another. First, development of the eating disorder is an important moment recorded in participant accounts of their eating disorders, which often includes discussions of blame. Blame, in most participant narratives, is discussed in relation to

their fathers' actions (i.e., addiction, abuse, creating family stress, etc.) or inactions (i.e., preoccupation with work, in deference to mothers' actions, etc.). In some participant narratives, daughters express that their fathers were not to blame without further discussion of who was at fault. Notably, all participant narratives discuss blame in regards to the development of their disorder, but none of the participants blame themselves or their own actions for their eating disorder experiences. Thus, the eating disorder becomes a relational artifact marking certain significant relational moments of interaction in participant narratives. Although blame and development are not thoroughly studied in the eating disorder literature, illness narratives are often used by patients to make sense of their illness, which includes discussions of development and blame. Sharf and Vanderford (2003) claim that narratives serve to create meaning out of seemingly random events, people, and actions as they allow us to make our own connections and understandable patterns. In addition, the illness narratives used in this study support the ecological model of eating disorders as they prove that no two participants have the same developmental experiences. Their environments are different before and after the onset of their respective disorders. The authors add that sense-making "frequently involves assigning responsibility and sometimes blame" (p. 19). Being able to generate a story unique to her own experiences allows the narrator to reestablish agency in her own life. By labeling causes for symptoms and behaviors concerned with one's illness, individuals regain some semblance of control over their own lives.

Second, some of the participants express denial of their eating disorder's existence or of the disorder's severity, which could be linked to the secret and personal nature of eating disorders. Interestingly, the only scenario in which fathers are not

discussed as being involved in daughters' experiences of her eating disorder is in expressions of denial about the existence or severity of the eating disorder. This suggests that denial about the disorder is personal rather than relational or that it may become relational over time, as several narratives reveal that secrecy will often lead to the discovery of the disorder. The findings about secrecy and denial are consistent with previous research detailing the secretive nature of eating disorders (Austin, 2000; Botta, 1999; Polivy & Herman, 2002). However, no previous studies examining eating disorders have discussed eating disorders as relational artifacts, as being non-relational during the time of secrecy but influencing relational identity after the discovery. Sharf and Vanderford (2003), on the other hand, explain that narratives record how illness affects relationships: "Another kind of challenge revealed through narrative analysis is the way in which illness alters relationships, an inherent dimension of identity. While renegotiation of relationship roles tend to be gradual, the impact can still be quite dramatic" (p. 22). Thus, it appears that there is another gap in the eating disorder literature, as the current study and literature about the narrative method both highlight the need to further examine how illness (i.e., eating disorders) and relationships mutually influence one another. This study begins to describe these patterns of mutual influence in the father-daughter relationship.

Third, discussions of the secrecy and discovery of their eating disorders are also prevalent in daughters' narrative accounts. While some participants remain preoccupied with the secrecy or denial of their eating disorders, other participants explain that their disorders have been discovered by (or revealed to) their fathers. When daughters describe their fathers' discoveries of their disorders, their fathers' reactions are often marked by

inaction or distance first, but some fathers eventually reacted to their daughters' disorders with care and support after some time. Importantly, a father's discovery of his daughter's eating disorder is an important moment both in the father-daughter relationship and in the progression of the daughter's eating disorder experiences. As some narrative accounts demonstrate, fathers' reactions to their daughters' disorders impact the father-daughter relationship over time, creating an increase in closeness for some dyads and an increase in distance for others. In addition, when daughters chose to maintain the secrecy of their disorder, there was only evidence of an increase in distance in the relationship (for one participant) but not an increase in closeness. These findings are consistent with Henry et al.'s (2006) claim that parental connectedness and support, which includes praise, encouragement, and physical affection, are indicators of adolescent adaptation and positive development in youth. Parental support is also linked to general competence, identity achievement, and self-esteem. For daughters in this study who experienced an increase in care, love, support, and closeness with their fathers, their eating disorder recovery process was aided by their relationship with their father.

Finally, several daughters explain moments of recovery and detail how these moments have been significant to their relationship with their fathers, as experiences of recovery similarly influence closeness and distance in their relationships. Some daughters indicate that recovery caused an increase in distance in the father-daughter relationship while others explain that the recovery process helped them to become closer with their fathers. In turn, for some of the participants, their improved relationship with their fathers and the increase in father-daughter closeness helped them through their recovery as well. These findings are inconsistent with Wertheim et al.'s (1999) claim that "father

influences did not add significantly” (p. 183) to daughters’ eating attitudes and behaviors in their study. According to Bronfenbrenner’s (1979) ecological model, the father is still present in the family system, and his actions (whether they are in deference to the mother, verbal, passive, or silent) are still important to the other members of the family, especially the one suffering from an eating disorder. In fact, McVey et al. (2002) found “high levels of involvement and unconditional support from fathers is the most optimal” to reduce the risk factors associated with disordered eating (p. 90). Marta (1997) reported that “fathers, traditionally and culturally less involved in child-rearing, emerge as important parents in situations of risk for the adolescent” (p. 484), which was certainly true for this study. Consequently, intervention studies that have increased *paternal* involvement have evidenced positive changes in child behavior (Pleck & Masciadrelli, 2004), which this study further highlights.

Thus, the crisis of the eating disorders presents an opportunity for a more dynamic shift in the father-daughter relationship, as discovery of the disorder, recovery efforts of the daughter, and conversations about the disorder all have the potential to improve the quality and closeness of the father-daughter relationship through connection and relationship building. However, those same moments can also increase the distance and negative feelings in the father-daughter relationship, as some daughters directly and indirectly blame their fathers for their disorders, have differences in opinion about health and happiness, and disagree about treatment options. Connection, support, distance, closeness, and improvement in the father-daughter relationship because of the daughter’s recovery process illuminate the mutual significance of the father-daughter relationship and the daughter’s recovery from her eating disorder.

Overall, in answering the second research question, daughters' experiences of their eating disorders reveal four important things about fathers' communicative roles in their daughters' performances of an eating disorder. First, eating disorders are perceived as relational artifacts of the father-daughter relationship (i.e., marking important moments in the relationship, fostering tensions between closeness and distance, etc.). Second, fathers potentially enable the development of the eating disorder through actions and inactions *nonrelated* to daughters' food intake, appearance, or behavior (i.e., preoccupation with work, difference in ideas about health and happiness, alcoholism and addiction, abuse, absence, anger, etc.). Third, fathers potentially further enable the performance of the eating disorder through their silence and passive reactions to their daughters' disorders (i.e., in deference to the mother, through competition with other father-figures, in the moments of the eating disorder's discovery, in talk about health and eating behaviors, etc.), but have the potential to aid in the recovery process with care, support, and expressed closeness. Fourth, it appears that daughters feel that their fathers have to be active participants in their disorders to contribute to the disorder (i.e., fathers have to know about the disorder, have to be vocal about body image, have to participate in talk about eating behaviors, etc.), and when fathers are active participants in their daughters' recovery process, the relationship and the recovery process both benefit from the active participation.

Relational Dialectics and Tensions in the Father-Daughter Relationship

In answering the first two research questions, Baxter and Montgomery's (1996) relational dialectics perspective can help explain some of the oppositional contradictions and tensions present in the father-daughter relationship. The authors assert that "personal

relationships are constituted in communication,” as “communication is the vehicle of social definition; participants develop a sense of self, partners develop a sense of their relationship, and societies develop a sense of identity through the process of communication” (p. 42). Inherent in social life and communication is contradiction. Baxter and Montgomery (1996) “subscribe to a dialectical perspective on social life, that is, a belief that social life is a dynamic knot of contradictions, a *ceaseless interplay* between contrary or opposing tendencies” (emphasis in original, p. 3). The relational dialectics perspective proposes that opposing contradictions (e.g., closeness/distance, certainty/uncertainty, and openness/closedness, etc.) are the backbone of all relationships, and “the ongoing interplay between oppositional features is what enables a relationship to exist as a dynamic social entity” (p. 6).

Although there has not been much research conducted on dialectical tensions in parent-child dyadic relationships, it is evident that dialectical tensions exist in those relationships (Baxter & Montgomery, 1996). Therefore, it is expected that those same tensions are present in the father-daughter relationship, especially in those negotiating an eating disorder. Dialectical contradictions “illustrate the multifaceted process of social life” (p. 3) and help the researcher to realize the fluid rather than static nature of the father-daughter relationship in this context. Moreover, there has been little, if any, research examining dialectical tensions (also referred to as contradictions and oppositions) regarding parent-child interactions when the child is struggling with an eating disorder, but there were very clear dialectical tensions present in the data exemplars (previously discussed in Chapters 4 and 5).

Tenets of relational dialectics perspective. Baxter and Montgomery (1996) explain four tenets to the relational dialectics perspective: contradiction, change, praxis, and totality. In their conception of dialectical tensions, contradiction is not a negative concept but an integral and inherent facet of relationships. They write, “It is the interplay of opposing tendencies that serves as the driving force for ongoing change in any social system, including personal relationships” (p. 10). The authors support a model of indeterminacy wherein “two opposing tendencies simply continue their ongoing interplay, although the meaning of interplay is fluid” (p. 12). Father-daughter closeness and disconnection is a dialectical tension experienced by all of the participants in the study. Although many of the participants experienced this tension uniquely based on their relationship histories, the tension is ongoing over time.

Second, as oppositional tensions are always in flux, change is also an inherent part of relationships. Baxter and Montgomery (1996) use the term “spiraling” to explain dialectical change, as the boundary between linear change and cyclical change is not always clear in relationships. They write, “Dialectical interplay between stability and change is inherent in relating; thus sameness (i.e., repetition) co-occurs with difference (i.e., nonrepetition)” in a spiraling pattern (p. 69). The evolution of the father-daughter relationship discussed above is made possible because of the ongoing dialectical contradictions inherent to all relationships.

Third, praxis refers to the actions taken by the two relational partners as they react and respond to the contradictions in their interactions. Baxter and Montgomery (1996) explain, “Praxis focuses attention on the concrete practices by which social actors produce the future out of the past in their everyday lives” (p. 14). As the participants in

this study explain their frustrations with dialectical tensions, many of the participants also describe how they managed the tensions in their relationships. Those praxical patterns are further detailed below.

Finally, totality embraces the holism of contradictions, recognizing that relational tensions do not exist in a vacuum but coexist with other tensions both within and outside of the relationship. A relational pair experiences many contradictions at once, which is evident in this study through participant accounts of their eating disorders, which is also discussed below.

Praxis patterns. Dialectically oriented research has identified eight praxis patterns that relational partners employ to work through contradictions in the relationship (Baxter & Montgomery, 1996). Baxter and Montgomery (1996) add that antagonistic contradiction, when relationship partners align with different oppositional poles, may lead to multiple praxical solutions for the same tension, and many praxis patterns co-exist for relational partners. Six of these praxis patterns can be seen in the data exemplars below.²

First, *denial* “represents an effort to subvert, obscure, and deny the presence of a contradiction by legitimating only one dialectical pole to the virtual exclusion of the other poles” (p. 61). This is effective only if the relationship partners can truly ignore the other dialectical poles. The following example demonstrates denial of the openness/closedness dialectic.

“We hardly ever talk about our personal feelings that are emotional. [. . .] Because of this, I feel that he doesn't understand me and what I believe. He is the type of man who thinks himself as right and others wrong, especially within the family. [. . .] He doesn't eat healthy food or exercise at home, so I think he didn't understand my views on how I lost weight, but thought I was doing something wrong with my body. I did lose a lot of weight because I was exercising more than eating, but

it was not of my intention to lose weight because I had a negative body image of myself; it was because I wanted to be a healthier person, but I just did one healthy choice more than the other which became an imbalance on my body. [. . .] I wish my dad could see that and be more supportive of these habits” (Participant 20).

She is completely open with her father about her intentions of losing weight, but this openness denies the existence of her secrets, of her closedness. Within this statement, and her denial of actually having an eating disorder, she is denying that she is keeping information from her father.

Second, *disorientation* “involves a fatalistic attitude in which contradictions are regarded as inevitable, negative, and unresponsive to praxical change,” which often results in partners who “reproduce their plight through a passive acceptance that often becomes manifest in the ambiguity of mixed messages” (p. 62). In the following example, participant 3 demonstrates disorientation in her relationship with her father.

“My father was present, but was a workaholic and raging alcoholic. He was often absent physically, and always removed emotionally. His presence was usually an abusive one. [. . .] As a 35 year old woman, I don't have to see my dad much anymore. Our relationship has improved with my own recovery work, but I don't believe he will ever work to change/improve himself, and I have to be okay with that. [. . .] Our conversations usually resolve around work... He excitedly tells me about his engineering projects, until my feigned interest crumbles. He has just as little patience for my teaching tales.”

In this example, participant 3 displays a fatalistic attitude toward both openness and closeness with her father, wherein they reproduce the distance in their relationship and their dissatisfaction with conversations about work that neither of them enjoy.

Third, *spiraling inversion* refers to “which pole of a given contradiction is dominant at a given point in time” and is “characterized by an irregular spiraling shift in the ebb and flow between which oppositional exigence is privileged” (p. 62). Shifts in relational closeness and the emotional experience of the father-daughter relationship best

exemplify this praxis pattern. The following example illustrates how the dominant tensions of distance and closedness shift over time to closeness and openness.

“Since the development of my eating disorder my father has softened up a lot and realized just how mean some of the things he says to me have been [. . .] At first he was very accusatory and defensive as if I was being completely ridiculous by having this problem. Then it went to understanding after a bout of disbelief” (Participant 26).

Because of her eating disorder, both participant 26 and her father have become more open about how their communication affects the other, and as a result, they have grown closer over time although they still struggle with the openness/closedness and closeness/distance contradictions.

Fourth, *segmentation* “involves an ebb-and-flow pattern, but the basis of inversion is not time but rather topic or activity domain. Relationship parties perceive that certain topics or activity domains are more appropriately suited to one opposition over the other oppositions” (p. 63) such as which topics are open for disclosure and conversation and which topics are off limits. Segmentation was the most common praxis pattern in the data and was used mostly in patterns of father-daughter talk, wherein certain topics were deemed appropriate and other topics were avoided, which the following two examples illustrate.

“I do not talk to him about things that are personally important to me, because I do not trust him. He has started sharing more stories with me about his childhood, which I love hearing” (Participant 3).

“I will always love him, but I am not emotionally-open with him meaning that I cannot talk to him about my personal thoughts but only general stuff like the weather, what's going on at school, my plans for the day, etc. [. . .] Still, I do seem to converse with him about his health because I care about it and want him to get better and live longer” (Participant 20).

For both of these participants, they avoid topics that are personal for them, and they focus on more general topics of conversation; however, participant 3 enjoys hearing her father's personal stories from his childhood, and participant 20 cares enough about her father to talk to him about his health practices. Both participants regulate openness with their fathers based on their preferred topics of conversation.

Fifth, *balance* is a compromise between relationship partners about a certain dialectical tension, which is shown in the following example.

“If we chat at all it is about topics we agree upon or topics that don't really require an opinion. For example we will talk about how classes are going or what I think of the women's tennis team” (Participant 27).

Participant 27 and her father have compromised that they will only be open with one another about topics in which they agree or topics that do not require an opinion, and all other topics of communication between them are forbidden.

Sixth, *recalibration* “captures a synthesis or transformation in the expressed form of a contradiction such that the opposing forces are no longer regarded as oppositional to one another” (p. 65). For the purposes of this study, recalibration is most obvious in the daughter's recovery processes as father-daughter connection/closeness and the daughter's experiences of her eating disorder cease to be oppositional and become mutually influential to one another. The following exemplar illustrates this recalibration.

“We first grew apart because its hard to understand a daughter in her teen years, especially one who struggles with self image and eating. but as i healed, we became closer” (Participant 13).

In this example, participant 13 explains that connection/closeness suffered with her father because of her struggles with an eating disorder, but as she recovered, the eating disorder no longer caused an oppositional tension in her relationship with her father.

Primary contradictions. Baxter and Montgomery (1996) then discuss three primary dialectical tensions experienced between relationship partners: closeness, certainty, and openness. For the purposes of this study, I examine closeness and openness in the father-daughter relationship, as those were the most predominant contradictions in the data. It is also important to note that dialogic contradictions are not binary polarities but multi-vocal unities, wherein tensions are not as simple as the binary of closeness/distance but are instead clusters of oppositions (e.g., closeness, connection, distance, disconnection, separation, autonomy, etc.).

The most prevalent dialectical tension emerging from participant narratives is that of closeness. Closeness and distance are “fundamental in our culture’s understanding of personal relationships” (Baxter & Montgomery, 1996, p. 79), and they are also one of the most referenced set of oppositional tensions in parent-child dyads. Baxter and Montgomery (1996) report, “Certain relational events [such as eating disorders] are likely to involve qualitatively different constructions of connectedness and separateness for relationship parties” (p. 96). Also, relational conceptions of connection and distance are always in flux, as the tensions are “created in the chronotoped dialogue of the moment between self and other” (p. 89), so conceptions and experiences of closeness and distance should vary over time.

The second most prevalent tension expressed in narrative accounts was that of openness (i.e., openness, closedness, candor, discretion, revelation, concealment, etc.). Baxter and Montgomery (1996) write, “The self boundary is closed and open depending on the person’s perception of the various costs and benefits associated with candor and discretion” (pp. 139-140). In other words, the dialectical tension of openness and

closedness is a common ongoing interplay in relationships, especially in the father-daughter relationships discussed in this project. In addition, once information is shared between individuals, it becomes jointly owned as part of the relationships communal property; thus, eating disorders, because of the ongoing interplay of openness/closedness regarding the eating disorder, have the ability to become a relational artifact in the father-daughter relationship.

Although they were discussed separately for clarity, the tenet of totality explains that contradictions do not exist in a vacuum but among and within other tensions. The three examples of the openness/closedness and closeness/distance tensions provided below demonstrate how they are experienced simultaneously by participants.

“My father is still in my life, but he did cheat on my mother when I was 14 and that changed our relationship” (Participant 5).

“When I was open about it he started talking about his own sickness. [. . .] I think it has helped me recover a bit more because I see how much he cares about me and wants me to be healthy” (Participant 6).

“We typically just talk about stuff going on in our lives like school and work. [. . .] We are actually talking to each other and we don't just try to avoid conversations. [. . .] When I got out of treatment he apologized for not wanting anything to do with me. Since then he has asked about how he can help keep me healthy. [. . .] In some ways the eating disorder was the best thing that happened to our relationship” (Participant 9).

For participant 5, the revelation (openness) of her father's behavior changed their relational climate (closeness). Participant 6 also experienced a shift in closeness and openness, but in the opposite direction because as she increased openness with her father, he reciprocated; thus, they became closer through their openness with one another. Similarly, participant 9 and her father are now attempting to communicate with one another (openness), which has helped them to also become closer. For all three of these

participants there is a shift in both openness and closeness as their relationships progress/evolve over time. According to Baxter and Montgomery (1996), contradictions determine both change and stability in a relationship, as “the communicative choices of relationship parties can be viewed as links in a discursive chain; each link adds something new to the chain but is inherently tied to prior and subsequent links” (p. 59). In the next section, I discuss turning points in the discursive chain of oppositions.

Turning Points in the Father-Daughter Relationship

Important to this study, dialectical tensions and praxical patterns employed by relationship partners help the researcher to see integral turning points in those relationships. This is yet another area that has not been explored in the eating disorder literature. Bolton (1961) defined relational turning points as personal or interpersonal events wherein relational partners experience a significant shift in their relationship (both positive and negative shifts). Baxter and Montgomery (1996) extend this definition when they write, “From a relational dialectics perspective, turning points are conceived as moments in a relationship’s history when the pressures of dialogic interplay are of sufficient intensity that a major quantitative or qualitative change occurs for the pair” (p. 72).

Early research on turning points examined the development and progression of romantic relationships (Baxter & Bullis, 1986; Bolton, 1961; Bullis, Clark, & Sline, 1993). More recently, turning point research has begun to examine blended families (Baxter, Braithwaite, & Nicholson, 1999) and parent-child dyadic relationships (Dun, 2010; Golish, 2000; Willer, 2007). Much like relational dialectics, “turning point analysis allows for an examination of change while also linking change to a sense of continuity”

(Bullis et al., 1993, p. 214). Golish (2000) claims, “Turning point analysis allows one to capture the dynamic nature of relationships by analyzing events that contribute to relationship change and to movements from one direction to another” (p. 81). Turning point analysis also allows the researcher to examine how relational identities evolve based on the history of the relationship because it provides a view of the relationship as a process instead of a static entity (Bullis et al., 1993).

Turning point analysis, then, examines those integral moments of change in relationships from within the complexity of the relational context (Baxter et al., 1999). Research in this area has proven over time that relational context is important to what turning points will be identified in the analysis. I agree with Bullis et al. (1993) when they write, “Turning points, then, provide an alternative lens through which to understand developing, maturing, and disintegrating relationships” (p. 234). It is evident from the current study that turning point analysis might help the researcher to better understand how eating disorders might operate as a relational artifact and influence the dyadic identity over time. Participant accounts of their eating disorders highlight their development of the eating disorder, moments of discovery, and the recovery process as potential turning points in the father-daughter relationship.

Particularly relevant to the current study, Golish’s (2000) turning point analysis of parent-child closeness is particularly insightful, as her data confirms that parent-child closeness evolves over time and is marked by certain turning points in the relationship. The author names several relational factors that speak to the change in parent-child closeness: gender of the parent, communicative openness, and times of crisis. Gender of the parent and communicative openness were related in her study. Golish (2000) reports,

“Men tend to use more indirect displays of affection . . . and the children may want more overt expressions of affection” (p. 83). Many of the participants in her study “noted that their fathers did not openly communicate closeness with them” (p. 94). Consequently, “a lack of communication was associated with a substantial decrease in the level of closeness” (p. 92) between parents and children. This is consistent with participants in the current study who indicate in their narratives that they engage their fathers in more general talk instead of personal talk, but they desire an increase in personal talk and closeness. Interestingly, the participants in her study also defined closeness as an emotional experience.

Golish (2000) also found that “closeness can increase or decrease dramatically in such times of crisis. . . . From the participants’ perspectives, their closeness depended on how their parents reacted to them as a result of the crisis” (p. 92). In her study, times of crisis “created a sense of urgency or a need for an increased degree of closeness in the participants. If that immediate need for closeness was not fulfilled, the level of closeness decreased with their parents” (p. 92). Although she does not include eating disorders in her category of crisis, I believe eating disorders similarly create an urgency for an increase in father-daughter closeness. Daughters’ narratives detail their fathers’ reactions to their eating disorders in moments of discovery, and those fathers who eventually responded to their daughters with an increase in expressed care, love, and support facilitated a turning point marked by an increase in closeness in the relationship. Thus, in the context of eating disorders, turning point analysis in the father-daughter relationship might align with the progression of the eating disorder, but further research in this area is needed to confirm these patterns.

Conclusion

I agree with Baxter and Montgomery (1996) when they write, “We believe that the social scientific enterprise needs to focus more concerted on the complexity and disorder of social life, not with a goal of ‘smoothing out’ its rough edges but with a goal of understanding its fundamental ongoing messiness” (p. 3). In addition, the contradictions reviewed above which have been present in the narrative accounts show that the family system with a daughter negotiating experiences of an eating disorder is not a static system with certain recognizable characteristics to be measured and counted, as every single eating disorder experience is unique to the woman who experiences it firsthand. Sharf and Vanderford (2003) claim that authorship of self-narrative allows those suffering with illness to reassert a degree of control that may have been stripped away in the process of becoming sick, seeking medical help, negotiating medical space with families, etc. Creating a narrative also allows the one with an illness to emphasize certain aspects and contributing factors of the illness, as they see fit. Put simply, the act of ordering events in one’s own life is an act of control.

While there are multiple risk factors for eating disorders reported in the literature, there is little information about the father-daughter relationship in this context. As families are socializing agents at the center of all of the eating disorder influences, this is an oversight in the eating disorder research. The family exists as a bubble in a world that demands people (especially women) are thin, and when the family contributes to the number of sociocultural agents promoting thinness, it is more likely an eating disorder will occur (Wertheim et al., 1999). Sharf & Vanderford (2003) claim that patient narratives are adept at challenging previous research and biomedical knowledge that has

ignored the voices and experiences of the patients themselves. Within this study, participants have painted a portrait of their relationships with their fathers, providing more information for the ecological model.

Polivy and Herman (2002) explain, “The interaction of etiological factors in a complex behavioral syndrome such as [eating disorders] is difficult if not impossible to capture. There are so many possible influences that their particular combination in any given individual becomes almost unique” (p. 205). Hopefully this uniqueness was captured in this study, and if the research body is no closer to pinpointing etiological causes for eating disorders, it is closer to understanding how important family prevention can be as well as how paternal influence has great potential to impact the recovery process. Al Sabbah et al. (2009) found that family connectedness was one of the most important protective factors against disordered eating, and parental involvement and communication between parent-child dyads increases connectedness as well as increases the quality of parent-child relationships. This was certainly echoed in participant accounts of their eating disorders. However, it is important to remember that this study still only measured daughters’ views and perceptions, so the voice of the father is still absent in the literature, but we at least now have a *beginning* picture of the role of the father in the development, maintenance, and recovery of eating disorders.

The data (i.e., narrative accounts of the participants) used for this project is their accounts, their truths, which might not be the reality for all women with eating disorders and might not necessarily represent all father-daughter relationships in this context. Rather, this study contributes to the ecological model of eating disorders, as it *begins* to highlight and explain patterns of behavior for the father-daughter relationship in this

context. With this in mind, it is important to note whose truths exactly are being represented in this document. Out of the 15 participants, 14 self-identified as being Caucasian, and one participant self-identified as being both Hispanic and Native American. Predominantly, the results of this study are similar to previous studies in their lack of ethnic representation. Future studies should try to become more ethnically diverse in their samples by recruiting in more ethnically diverse areas and/or institutions. Also, it will be pertinent for future studies to include those of different socio-economic backgrounds. Although there were no demographic questions to inquire about socio-economic status, most of the participants in this study were recruited from a university setting, which marks some level of privilege. The other four participants, who were recruited from SupportGroups.com, had regular access to the internet, which also marks a certain level of privilege. Thus, the truths being represented in this study are those of a predominantly Caucasian population with at least some privilege, and the ecological model that is broadened by this study is only the ecological model for this demographic. These factors may have impacted the findings of this study, and future research should broaden the demographic representation in this research to take other truths into account as well, as different populations could yield different results. In the next and final chapter, I will highlight key findings of the project, discuss theoretical, methodological, and pragmatic contributions to the field, and suggest directions for future research.

ENDNOTES

¹ Those who self-identify as anorexic or bulimic only account for 12 of the 15 participants in this study. Two women self-identified as struggling with EDNOS, and were not included in the comparative analysis. One woman self-identified as struggling with bulimirexia, a combination disorder not recognized by the American Psychiatric Association's (2000) *Diagnostic and Statistical Manual of Mental Disorders*, so her narrative was also not included in the comparative analysis.

² No examples of the other two praxis patterns (integration and reaffirmation) were found in the data for this study. *Integration* "refers to a response in which the parties are able to respond fully to all opposing forces at once without any compromise or dilution" (Baxter & Montgomery, 1996, p. 65). Baxter and Montgomery (1996) admit that although this is the most stable praxis pattern, it is a relatively infrequent response due to the very nature of contradiction. *Reaffirmation*, similar to disorientation, "involves an acceptance by the parties that contradictory polarities cannot be reconciled in any way. However, unlike the disorientation pattern, reaffirmation celebrates the richness afforded by each polarity and tolerates the tension posed by their unity" (p. 66).

CHAPTER 7: CONCLUSION

This study examined daughter's experiences of eating disorders and the father-daughter relationship in that context. The overarching goal of this project was to discover the paternal role in the development, maintenance, and recovery of eating disorders because of the importance of the father to the daughter's overall psychological development and to her abilities to navigate between systems in the ecological model. With this goal in mind, I asked the following research questions: (1) How is the nature of the father-daughter relationship communicatively constructed by the daughter? (2) How do the communicative roles the father performs (silence, passivity, vocal) enable the performance of the eating disorder? and (3) How do the communicative roles of fathers of daughters with anorexia nervosa differ in performance from the communicative roles of fathers of daughters with bulimia nervosa?

Participants for this study were recruited from SupportGroups.com's four separate eating disorders support groups, Dr. Helen Bowden's body image and nutrition clients at Colorado State University, and Colorado State University's Public Speaking students. The two support groups were chosen for their relevance to the study, their proximity to support, and their willingness to share their eating disorder experiences. Because of the broad nature of the public speaking course and the diversity among the students enrolled in the course, this sample was chosen because it was more representative of the general public than the previous two groups. Overall, fifteen women chose to participate in this study, answering the narrative questions provided on Survey Monkey's website. In so

doing, the women who participated provide a picture of their eating disorder experiences, their relationships with their fathers, and how those two experiences mutually and significantly influence one another.

Each narrative account was coded for relational and experiential themes with categories arranged in order of importance and appearance with respect to participant experiences. Six narrative themes were found in relation to the first two research questions: characteristics of the father as described by the daughter, characteristics of the daughter, father-daughter patterns of talk, characteristics of the father-daughter relationship, dynamics of the family unit, and daughters' experiences of their eating disorders.

Key Findings

Baxter and Montgomery's (1996) relational dialectics perspective proposes that opposing contradictions such as closeness/distance and openness/closedness experienced by the participants in this study are the backbone of all relationships, and "the ongoing interplay between oppositional features is what enables a relationship to exist as a dynamic social entity" (p. 6). The authors would also assert that it is in this interplay of contradictions that relational partners make sense of their dyadic identity. In answering the first research question, daughters communicatively construct their relationships with their fathers through the tension of closeness and separation in the father-daughter relationship in four specific ways.

First, although daughters describe relational barriers caused by their fathers (i.e., anger, abuse, addiction, etc.), the subtext of their narratives reveals that some of those barriers are in fact a product of the daughters behaviors (through disengagement and

acceptance). Second, daughters do not communicatively construct their relationships with their fathers based on interactions about food intake, weight, and appearance but rather around issues of quality interactions, support, and closeness. Golish's (2000) relational turning point analysis of parent-child closeness reveals that fathers use more indirect affection rather than verbal or direct affection which might not align with their child's needs. Many of the participants in her study "noted that their fathers did not openly communicate closeness with them" (p. 94). Consequently, the lack of verbal closeness was associated with lower levels of closeness for her participants. In addition, daughters' management of the closeness/separation and openness/closedness tensions through praxis patterns further illustrate how both fathers and daughters create barriers to closeness and openness in their relationships.

Third, in their accounts, daughters construct the father-daughter relationship as an evolving emotional experience, whereby their eating disorders influence the evolution of the relationship over time. Participant narratives document that daughters feel as though their fathers are valuable to their lives despite their struggles with closeness; however, it is also evident in the narratives that although there are obstacles and challenges within the relationship on both sides, change in the relational climate is not only possible, it is a positive and desired experience for daughters. Finally, the narrative exemplars demonstrate that instead of direct causal relationships between father characteristics, daughter characteristics, father-daughter talk, and the father-daughter relationship, small shifts in father's priorities, daughter's engagement, and/or patterns of talk can result in a shift for the entire father-daughter relationship. Relational change and turning points in the father-daughter relationship are made possible because of the ongoing dialectical

contradictions inherent to all relationships. Baxter and Montgomery (1996) explain, “Praxis focuses attention on the concrete practices by which social actors produce the future out of the past in their everyday lives” (p. 14). Many of the participants in this study describe the praxis patterns by which they manage the tensions in their relationships (i.e., denial, spiraling inversion, disorientation, balance, etc.). The use of praxis patterns over time can, and for some participants did, lead to relational turning points and a change in relational closeness. Baxter and Montgomery (1996) write, “It is the interplay of opposing tendencies that serves as the driving force for ongoing change in any social system” (p. 10).

In answering the second research question, narrative accounts reveal four important things about fathers’ communicative roles in their daughters’ performances of their eating disorders, which are inherently related to the management of dialectical tensions and the importance of closeness in crisis situations. First, eating disorders are perceived as relational artifacts of the father-daughter relationship (i.e., marking important moments in the relationship, fostering tensions between closeness and distance, etc.). Eating disorders contribute to the dialectical tensions experienced in the father-daughter relationship as fathers and daughters struggle with closeness and openness, and eating disorder experiences influence the praxis patterns employed by the relationship partners as they try to manage those contradictions through time (Baxter & Montgomery, 1996). In addition, eating disorders directly impact the father-daughter dyadic identity as they create an urgency for an increase in father-daughter closeness (Golish, 2000). Daughters’ narratives detail their fathers’ reactions to their eating disorders in moments of discovery, and those fathers who eventually responded to their daughters with an

increase in expressed care, love, and support facilitated a turning point marked by an increase in closeness in the relationship.

Second, fathers potentially enable the development of the eating disorder through actions and inactions *nonrelated* to daughters' food intake, appearance, or behavior (i.e., preoccupation with work, difference in ideas about health and happiness, alcoholism and addiction, abuse, absence, anger, etc.). Third, fathers potentially further enable the performance of the eating disorder through their silence and passive reactions to their daughters' disorders (i.e., in deference to the mother, through competition with other father-figures, in moments of the eating disorder's discovery, in talk about health, etc.), but have the potential to aid in the recovery process with care, support, and expressed closeness. Fourth, it appears that daughters feel that their fathers have to be active participants in their disorders to contribute to the disorder (i.e., fathers have to know about the disorder, have to be vocal about body image, have to participate in talk about eating behaviors, etc.), and when fathers do take on an active role in their daughters' recovery, the relationship and the recovery process both benefit from the active participation.

Golish (2000) reports that "closeness can increase or decrease dramatically in such times of crisis. . . . From the participants' perspectives, their closeness depended on how their parents reacted to them as a result of the crisis" (p. 92). In her study, times of crisis "created a sense of urgency or a need for an increased degree of closeness in the participants. If that immediate need for closeness was not fulfilled, the level of closeness decreased with their parents" (p. 92). In the current study, fathers who eventually responded to their daughters with an increase in expressed care, love, and support

facilitated a turning point in their relationship. Thus, the crisis of the eating disorder presents an opportunity for a more dynamic shift in the father-daughter relationship, as discovery of the disorder, recovery efforts of the daughter, and conversations about the disorder all have the potential to improve the quality and closeness of the father-daughter relationship.

Theoretical, Methodological, and Pragmatic Contributions

Overall, theoretically, this study contributed to the ecological family portrait of eating disorder development, maintenance, and recovery. This study suggests fathers play an important role in their daughters' lives, in their daughters' health, and have the potential to significantly alter the progression of the father-daughter relationship as well as their daughters' eating disorder experiences through expressed closeness. In addition, the eating disorder literature as a whole has been enriched as this study has begun to fill gaps in the literature in three significant ways. First, this study suggests that fathers are important players in their daughters' eating disorder experiences. Second, this study highlights important dialectical tensions present in the father-daughter relationship negotiating an eating disorder and suggests that further dialectical tensions might be identified in relation to experiences of eating disorders. Third, this study illustrates important relational turning points in the father-daughter relationship that come about in the negotiation of the eating disorder and the father-daughter dyadic identity and suggests that eating disorders, as relational artifacts and times of crisis, need to be further explored in a turning point analysis.

In future studies, or to understand a more holistic view of the father-daughter relationship in this context, I would use an ecological framework to examine both the

fathers' narratives as well as their daughters' narratives. This would really bring the voice of the father into the eating disorder literature, as this project provides just a picture of the father as a relational partner. Moreover, family members are also affected by illness experiences, and according to Sharf and Vanderford (2003), family members create their own illness narratives as explanations for illness experiences. Future research in this area should explore and compare narrative accounts of both fathers and daughters in this context to understand motives, dialectical tensions, and relational turning points more holistically. In addition, it will also be important to compare father-daughter interactions with mother-daughter interactions, as the literature suggests that the mother-daughter dyad and the father-daughter dyad negotiate eating disorders differently.

Methodologically, I used narrative interviews as a way of collecting data in order to understand how eating disorder experiences and the father-daughter relationship affect one another. This method has only been used once before in the eating disorder literature and should be used and expanded to study more facets of the eating disorder phenomenon. In order to have a more complete ecological portrait, we must listen to the voices of those who have experienced eating disorders firsthand. Only through their experiences will we know the full story behind the etiology of eating disorders. Methodologically speaking, narratives are useful in confirming and challenging prior research on illness populations (Sharf & Vanderford, 2003).

Also, if I would have been able to gather more complete narratives, my data could have been stronger in light of other research projects. For those using narrative methods in the future, it is important to note that some participants will be more willing than others (and certain groups of an illness population may be more willing than other

groups) to share their stories. For me, it was important to establish trust with the participants. Recruitment on SupportGroups.com proved to be difficult because some of the members did not approve of my study; however, when Dr. Helen Bowden passed out the recruit script to her support groups and when the SPCM 200 instructors made the recruit script available to their students, potential participants were able to connect the study to a trusted member of their social network.

Pragmatically, this study contributes to the field of eating disorders as well as family and health communication. This research is useful to healthcare professionals and health centers treating eating disorder patients in two important ways. First, illness narratives, as a method, are useful to health care professionals. They allow patients to be experts in their own lives, make sense of the events surrounding their illness, and reassert control over their own lives, which all aid in the healing process (Sharf & Vanderford, 2003). In addition, narratives have the potential to aid health care professionals in diagnosis, prognosis, and treatment (Bosticco & Thompson, 2008). In the future, health care professionals and treatment centers should utilize the benefits of illness narratives on patient wellbeing. Second, it is important for health care professionals to understand how the family environment can impact treatment of illnesses such as eating disorders. This study begins to highlight the impact of fathers in the development, maintenance, and recovery of their daughters' eating disorders. Prior research has confirmed the importance of including the family in therapy for eating disorders (Munichin et al., 1978), but this study further highlights the mutual significance of relationships and eating disorders. In the future, health care professionals and treatment centers can and should include fathers in the treatment and recovery process for eating disorders.

At the beginning of this study, communication studies, as a field, was lacking research in connection to eating disorders. Many prior research projects had examined the family or dyads within the family capturing glimpses of family and health communication, but this study examined the family and communication about health as its main focus. This study adds to the field of communication studies because it highlights the importance of communication, dialectical tensions, and relational turning points to health related messages and situations in the father-daughter relationship. This study also adds to the overall research on eating disorders in the United States, as it begins to examine the importance of fathers to eating disorders. Using a very specific lens and method, this study examined eating disorders from a family and health communication perspective. Hopefully this study will encourage more research in the areas of family and health communication. In the following section, I will explore implications for future research on eating disorders and communication.

Future Directions

Today we know what percentage of the population is affected by eating disorders (Polivy & Herman, 2002), we know that eating disorders are becoming more and more prevalent around the world (Harrison & Cantor, 1997; Steiner & Lock, 1998), and we know that the prevalence of eating disorders increases as the fear of obesity becomes more widespread and dieting becomes more popular (Austin, 2000; Pike & Rodin, 1991). However, we still do not know why women all over the world suffer from eating disorders. Instead of quantitatively measuring media consumption, family behaviors, and dieting practices from scales that might be outdated now, we need to be imploring those who have firsthand experiences to share their stories. Once we have examined those

stories for their experiences, then we can create new and updated quantitative measures to examine the phenomenon. However, Baxter and Montgomery (1996) remind us that “relational knowledge is an elusive, evolving knowledge that is always unfinalized and immune to objectification and generalizability” (pp. 40-41). Knowledge about health is ever-changing and the ways in which we conduct our relationships are changing just as quickly. As researchers, we must search for answers while we realize that there may not be one generalizable truth about eating disorders. However, I have a few suggestions for where to begin future research in this area.

First, we must continue to include the father in research about eating disorders. Future studies should examine and compare narratives of both fathers and daughters in this context to gain a more complete picture of the father-daughter relationship experience. In so doing, we might uncover motives for shifts in patterns of talk and relational evolution. We might also uncover moments where perception of the interaction does not truly capture the interaction. I suggest that these narrative accounts be coupled with participant observation in clinical settings during family therapy sessions, if possible. There is also a need to differentiate between the communicative natures of fathers that have daughters with eating disorders as opposed to the fathers that have daughters with healthy body ideals. In addition, future research should explore the role(s) of father-figures as well. It would be important to the eating disorder literature to have narrative accounts from entire families, but we must remember that the whole family includes the father (as well as other father-figures), as prior research has often forgotten.

Second, we must not forget that eating disorders are communicative relational artifacts, as relational experiences and eating disorders mutually influence one another's progression and trajectory through interaction and communication. Future research should inquire about the family's influence on eating disorders but also the eating disorder's influence on family interactions. It would also be wise for researchers to go back to those psychosomatic descriptions of family interactions Minuchin et al. (1978) wrote about over 30 years ago, as it is possible those descriptions are no longer representative of family interactions in the 21st century.

Third, future research should study relational dialectics in families with eating disorders as their main focus. The dialectical contradictions of both openness/closedness and closeness/distance were important to the participant narratives in this study. It would be interesting to uncover other dialectical tensions in this context, as those tensions might shed light on the relational implications of eating disorders and how families might be able to prevent them from occurring. Similarly, future research should further examine how the eating disorder experience can create significant relational turning points in not only the father-daughter relationship but for the mother-daughter dyad as well, as turning points in the mother-daughter relationship might differ from those in the father-daughter relationship.

Final Thoughts

As a woman and researcher, I am concerned for the future of this research for several reasons. First, I want to help other women struggling with the thin ideal to be liberated from the chains of the capitalistic dieting monster. Second, I want my family, friends, and future children to be comfortable in their own bodies and unafraid of the

ridicule of others. Third, I want the women who have chosen to share their stories in this project to be heard and supported in their endeavors. Finally, I want to provide an opportunity for others to share their illness narratives, their own stories, as it is part of the healing process.

As researchers, we need to continue to ask why this phenomenon is so prevalent and be steadfast in seeking answers as to how this damages self-esteem, skews images of women, and challenges the progression of women around the world. The thin ideal and images of sexy “emaciated” women only play into the sexist commoditization of the female body. The implications for women around the world are too great, and we must be diligent in our efforts to find a solution(s) to this problem. As long as the female body is trapped by the capitalistic and patriarchal structures of society, eating disorders will continue to be a safe-haven for women around the world to control their own bodies.

However, we have to remember that the expectations placed on women to be thin are not the fault of the men in their lives. This is why it will become more important in the future to educate women *and* men about the problem of eating disorders. With more research on fathers and father-figures, we will need to educate women *and* men about the harms of the commoditization of the female body and the relational implications of eating disorders. However, we will also need to educate men *and* women about the commoditization of the male body as well. Women and men should be supportive of one another instead of judgmental about the appearance of the other. If we educate men *and* women that certain appearances are impossible to attain or unhealthy, we might begin to influence the future of eating disorders both within and outside of the family. We also have to realize that while only 10% of eating disorder cases are experienced by boys and

men, eating disorders affect both men *and* women. At the end of this project, it remains important to include men in our research, even if the problem we hope to fix is a problem faced predominantly by women.

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APPENDIX A

Narrative Interview Questions

Demographic Questions:

1. What is your current age? (Multiple choice – age ranges)
2. What is your ethnicity? (Multiple Choice – choose all that apply)

Eating Disorder Background Questions:

3. Which eating disorder were you diagnosed with or do you most identify with?

(Multiple Choice)

Anorexia Nervosa_____ Bulimia Nervosa_____

Eating Disorder Not Otherwise Specified (EDNOS)_____

Other (please

specify)_____

4. How old were you when you began struggling with your eating disorder?

(Multiple Choice)

Narrative Interview Questions:

5. Describe the person(s) you consider to play a fatherly role in your life.
 - a. How much contact do you have with this person(s)?

6. How would you describe the nature of your relationship with your father-figure(s)?
 - a. How has the nature your relationship with your father-figure(s) changed since the development of your eating disorder (if at all)? Please explain.
7. Describe the types of conversations you and your father-figure(s) have. Please provide an example.
 - a. How have the types of conversations you and your father-figure(s) have changed since the development of your eating disorder (if at all)? Please explain.
8. Describe the conversations you had with your father-figure(s) when he (they) discovered your eating disorder. Please provide an example.
9. What role, if any, has (have) your father-figure(s) played in the development, maintenance, and recovery of your eating disorder? Please provide examples as necessary.
10. Is there anything else you would like to share?

APPENDIX B

Email to SupportGroups.com

To whom it may concern,

My name is Ashton Mouton, and I am a researcher in the Communication Studies Department at Colorado State University. I am conducting a study about eating disorders and father-daughter communication through an online survey site called Survey Monkey. With permission from Support Groups, I would like to recruit participants for my study through the following four support groups on your site: Anorexia Nervosa, Bulimia Nervosa, Eating Disorders, and EDNOS. The recruit script that I will post in the four support groups is detailed below:

Recruit Script:

My name is Ashton Mouton, and I am a researcher in the Communication Studies Department at Colorado State University. I am conducting a study about eating disorders and father-daughter communication, under the guidance of Kirsten Broadfoot, Ph.D. in Communication Studies, through an online survey site called Survey Monkey (the link is provided below). I am interested in this topic because of my own former experiences with an eating disorder, and I would appreciate any help in understanding the complex nature of eating disorders.

The study is completely voluntary, and your data and identity will be kept confidential as your name and other identifiers are not being collected if you choose to participate. Your participation in this research would be greatly appreciated.

To participate, you must be a female of 18 years or older. If you choose to participate, this study requires you to complete a set of questions, which will take no more than one hour to complete. You may stop participating at any time without penalty.

There are no known risks or benefits associated with participation in this study. By participating, you will be contributing to the knowledge of eating disorders and the field of communication studies. Thank you for your participation.

This is the link to the questionnaire:
<http://www.surveymonkey.com/eatingdisordernarratives>

Thank you for your consideration. Please email me at the following email address with your decision: (ashton.mouton@colostate.edu).

Sincerely,

Kirsten Broadfoot, Ph.D.
Communication Studies

Ashton Mouton, Master's Candidate
Communication Studies

APPENDIX C

Participation Recruit Script

My name is Ashton Mouton, and I am a researcher in the Communication Studies Department at Colorado State University. I am conducting a study about eating disorders and father-daughter communication, under the guidance of Kirsten Broadfoot, Ph.D. in Communication Studies, through an online survey site called Survey Monkey (the link is provided below). I am interested in this topic because of my own former experiences with an eating disorder, and I would appreciate any help in understanding the complex nature of eating disorders.

The study is completely voluntary, and your data and identity will be kept confidential as your name and other identifiers are not being collected if you choose to participate. Your participation in this research would be greatly appreciated.

To participate, you must be a female of 18 years or older. If you choose to participate, this study requires you to complete a set of questions, which will take no more than one hour to complete. You may stop participating at any time without penalty.

There are no known risks or benefits associated with participation in this study. By participating, you will be contributing to the knowledge of eating disorders and the field of communication studies. Thank you for your participation.

This is the link to the questionnaire:
<http://www.surveymonkey.com/eatingdisordernarratives>

APPENDIX D

Dr. Jennifer Bone's Email to SPCM 200 Instructors

Colleagues,

Our graduate student, Ashton Mouton, is requesting your assistance for her thesis project. She needs volunteers to fill out a survey on father-daughter communication and eating disorders. I ask that you make an announcement to your students informing them of her project. We cannot offer extra credit for completing the survey (because not all students qualify to participate); however, I want you to strongly encourage your students to help with this graduate thesis project.

I attached the form for you to read. Please list the website on the board for interested students and/or post the document to your RamCT shell.

Thank you,
Jen

Jennifer Emerling Bone, Ph.D.
Director of the Public Speaking Course (SPCM 200)
Department of Communication
Colorado State University
213C Eddy Hall

APPENDIX E

Cover Letter

Dear Respondent,

This study examines father-daughter communication and disordered eating. I am interested in this topic because of my own former experiences with an eating disorder, and I would appreciate any help in understanding the complex nature of eating disorders in regards to this topic. There are no limitations on who can be a father-figure.

Your participation in this study is completely voluntary. This study requires that you are a female of 18 years or older who has struggled, or is currently struggling, with an eating disorder. If you choose to participate, this study requires you to complete the attached survey, which will take **no longer than one hour**. You may stop participating at any time without penalty. You will **not be required** to complete anything after this survey is complete.

There are no known risks associated with your participation in this study. However, it is not possible to identify all potential risks in any research. The researcher(s) have taken reasonable safeguards to minimize any known and potential, but unknown, risks. However, in the event that you feel discomfort or distressed from the questions in this study, you may call Colorado State University Health Network's Counseling Services at (970) 491-6053. In addition, you may call the National Eating Disorder Association's Information and Referral Helpline at 1-800-931-2237 (Monday-Friday 8:30a-4:30p Pacific time) or the National Suicide Prevention Lifeline at 1-800-273-8255.

There are no known immediate benefits to you for participating in this study, though you will be contributing to the knowledge of the field of interpersonal and health communication, specifically related to communication and eating behavior.

Your participation in this survey will not be connected with your name or location in any way. There will be no identifying markers linking your participation in this study. Your data and identity will be kept confidential as your name and other identifiers are not being collected. The answers that you provide in this questionnaire will be destroyed in three years.

Your participation is greatly appreciated. If you have any questions or concerns at some point once the survey is completed, please feel free to contact the Principal Investigator, Kirsten Broadfoot, at kirsten.broadfoot@colostate.edu or the Co-Investigator, Ashton Mouton, at ashton.mouton@colostate.edu. If you have any questions about your rights as a participant in this research, please contact Janell Barker, Human Research Administrator, Colorado State University, at (970) 491-1655. Please print this consent for future reference.

Thank you for your participation.

Sincerely,

Kirsten Broadfoot, Ph.D.
Communication Studies

Ashton Mouton, Master's Candidate
Communication Studies