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Daughters’ experiences of the impact of eating disorders on the mother-daughter relationship: An analysis of disclosure, deception, and family environment

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Daughters’ experiences of the impact of eating disorders on the mother-daughter relationship: An analysis of disclosure, deception, and family environment

Spring 2017 – Department of Communication

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Abstract

The purpose of this project was to interview college-aged women in the recovery stage of their eating disorder to explore the impact of this experience on their relationships with their mothers, specifically in terms of disclosure and deception processes. The ten women who participated in this study were asked a set of interview questions in a thematic approach centered on disclosure, deception, and their perceptions of their family environments. Participants provided various reasons for why they chose not to disclose to their mothers, which can be categorized as (1) managing disclosure to protect, (2) managing disclosure to avoid negative consequences, and (3) managing privacy/identity. The second communication process investigated was deception. This study revealed that deception involved in mother-daughter relationships impacted by an eating disorder raised two themes (1) deception as a normalized practice and (2) deception resulting in restricted interaction. Finally, participants described their perception of their family environment and its impact on their disordered eating. This thesis provides insight into the interplay between disclosure and deception in families when an eating disorder has occurred. This study suggests future research should explore relational dialectical theory as an approach for further understanding of competing tensions involved in the mother-daughter relationship as impacted by an eating disorder. Ultimately, daughters’ eating disorder experiences in terms of disclosure, deception, and their perceptions of their family environments reflect the larger cultural expectations of what constitutes as a “good” mother-daughter relationship.
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Thank you
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Daughters’ experiences of the impact of eating disorders on the mother-daughter relationship:

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Chapter One: Literature Review and Rationale

Introduction

Following my own treatment in an intensive outpatient recovery center for eating disorders, I became strongly motivated to understand the impact of the disease on the individual who struggles with it as well as on the relationships the patient has with their family. In my own experience, this form of mental illness impacted every relationship in my life, but especially the dynamics involved in my family. The closeness and security of my relationships with my two younger sisters did not undergo a huge shift; however, it was how my mother reacted and furthermore treated me that sparked such curiosity as to how this disorder can change even the most foundational relationships in one’s life. Before the development of my eating disorder(s), I was the funny and outgoing daughter who relied on her mother for comfort and affection. Once I was in the tight grip of the disorder this comforting and affectionate bond with my mother began to deteriorate. The secretive nature of the disorder along with my mother’s strong disapproval forced us away from one another. I no longer felt comfortable in my own house and felt she was withholding any type of compassion or warmth towards me. Through my research and personal experience, I am coming to better understand why it was that my mother and I reacted the way we did.

This project will examine the impact an eating disorder has on the mother-daughter relationship. Based on interviews with ten young-adult who have experienced an eating disorder, I examined the communication processes of disclosure and deception in the mother-daughter relationship. My understanding of this process comes from the themes that emerged from interviewees’ personal accounts in this investigation; the project focused on the perspective of the daughter and considered daughters’
general understanding of eating disorders, impact on the mother-daughter relationship, changes in close relationships, family environments, disclosure of sensitive and personal information, deception in close relationships, and changes in relational experience.

The topic of eating disorders is not a new area of academic research; in fact, extensive research has been conducted on it, which I intend to discuss in the upcoming section. However, what I have been unable to find in the research about eating disorders is how the deceptive nature of disordered eating behaviors may influence communication in close family relationships. Furthermore, it is interesting to look at disclosure as a communication process central to both the experience of disordered eating and relationships within the family. This project seeks to deepen our understanding of how women disclose their eating disorders and related information, what degree of disclosure reveals about the mother-daughter relationship, the reasoning behind deception, and how deception impacts close relationships.

The Role of Family Environment in Disordered Eating

A child’s immediate family provides the first experience in an interpersonal relationship, often times shaping how a child will behave in other close relationships later in life. Family members are also the individuals who a child spends the most time with, including the time spent sharing meals. “Family of origin is the primary context in which children develop effective social skills necessary for managing the myriad stressors encountered throughout development” (Arroyo & Segrin, 2013, p. 414). So it is no wonder that a person’s upbringing and relationship with their family can impact their well-being and communicative skills as they grow older. That being said, how a family functions can impact family member’s relationship with food and eating behaviors; specifically, when there is a higher degree of family dysfunction, there is a greater risk of disordered eating (Parkinson, 2015).

The connection between family relationships, family functioning, and eating behaviors is important because prior research suggests that dysfunctional family interactions can influence abnormal
eating behaviors and attitudes (McDermott, 2002). McDermott (2002) argued that the dysfunction of a household could manifest itself in a variety of ways, ranging from simply isolating oneself from the chaos to depending on drugs or alcohol as an escape from it all. Similarly, eating disorders act as a diversion, a control mechanism, internalizing the dysfunction in family environment so that the anger is directed inwards rather than outwardly expressed. McDermott (2002) argues that disordered eating emerges when family factors go untreated, such as inconsistent parenting, marital issues between parents, overly involved parenting, communication conflicts, and parents battling for control over the child (p. 510). Other family factors that McDermott (2002) found that manifest a greater risk of developing an eating disorder included “intrafamily conflict, lack of family cohesion and organization, family attitudes towards body satisfaction and social appearance, and family emphasis on achievement” (p. 510). McDermott (2002) examined women’s self-reports of family interactions, and she found that women with eating disorders considered their family interactions unhealthier than the women without an eating disorder.

In fact, other research supports the relationship between family functioning and eating disorders and has shown a relationship between types of disordered eating and specific family processes. For instance, Prescott and LePoire (2002) report that anorexia nervosa and bulimia patients experience at-home confusion differently from one another. They found that children with the eating disorder anorexia nervosa are more likely to have come from families with abnormally high degrees of parent-child enmeshment (as cited in Kog & Vandereycken, 1989). In contrast, children with the eating disorder bulimia are often in openly hostile home environments where it is common to withhold information from family members (Humphrey & Stern, 1988 as cited in Prescott & LePoire, 2002). However, what is most important in this investigation is not the different manifestations of eating disorders in dysfunctional family settings, but rather, that there is a connection between family functioning and the
development of an eating disorder in daughters.

Possibly more important than the identification of a dysfunctional family life is an understanding of why the dysfunction has come about. Prescott and Le Poire (2002) draw on family systems theories to argue that the development of an eating disorder is a “reflection or symptom of a deeper, more pervasive problem in the family’s role structure, affective expression, relationship dynamic, and style of interacting” (Humphrey, 1989, p. 206 as cited in Prescott & LePoire, 2002). So, although an eating disorder might be often viewed as an individual behavioral problem, it may actually be the manifestation of deeper, more complex family conflict. These discussed dysfunctional family interaction patterns result in deep seated, toxic effects for the children, which may manifest in disordered eating behaviors and attitudes as a means of coping and taking control (Cooley et al., 2008 as cited in Arroyo & Segrin, 2013, p. 413). Family environments can either foster communication and attention to individual family member’s needs or they can be a place with little to no effective and appropriate communication between family members where tensions are high, which can be stress inducing for a child (McDermott, 2002). Families who live in these types of negative environments can influence a child’s need for control and coping skills to deal with the emotions happening in their homes. Because to their home may not be conductive to open/honest communication and voicing personal concerns in an outward manner, children develop strategies for controlling and coping with such negativity and uncertainty by directing those emotions inward, which can manifest itself in the form of an eating disorder (McDermott, 2002).

Eating Disorders and the Mother-Daughter Relationship

One particularly important relationship within the family is the mother-daughter relationship. This project considers how disordered eating may impact the mother-daughter relationship. This is important because research indicates that before a daughter has been diagnosed with an eating disorder, or even exhibits symptoms for developing one, the mother-daughter relationship can influence factors
that contribute to disordered eating behaviors.

A mother’s personal modeling of body dissatisfaction may impact a daughter’s perception of herself. For instance, a mother commenting about her own weight, or even going as far as to mention or critique the eating habits and appearance of her daughter, especially if she does so using teasing tactics or encouragement to lose weight, may cause her daughter to suffer from greater body dissatisfaction and an increased likelihood of developing an eating disorder (Kluck, 2010; Neumark-Sztainer et al., 2010; Wertheim, Martin, Prior, Sanson, & Smart, 2002, as cited in Arroyo & Segrin, 2013, p. 400). Households that emphasize the importance of weight and eating patterns often influence their child’s development of an eating disorder (Kluck, 2010, as cited in Arroyo & Segrin, 2013). There is importance in eating meals as a family in order for mothers to model healthy eating habits in front of her children. Again, addressing the connection between family functioning and disordered eating, family environments that involve negatively expressed emotions, stressful mealtime, food-related miscommunication, inadequate affective communication, and lack healthy problem solving skills have a higher likelihood of establishing interaction patterns associated with disordered eating in their children (Arroyo & Segrin, 2013, p. 400). These abnormal eating habits are often not accepted by one or both of the parents, but the potential disapproval from a/both parents may not deter the child from performing them anyway; instead the fear of this parental disapproval, and possibly even punishment, may influence them to perform the habits behind the parents’ backs, in private.

Mothers’ direct communication with their daughters as well as their own modeling of eating behaviors and attitudes impact their daughter’s body image (e.g., Cooley, Toray, Wang, & Valdez, 2008; Kichler & Crowther, 2011 as cited in Arroyo & Segrin, 2013, p. 400). Mothers who exhibit hyper-involvement and express overly critical, emotional communication patterns are directly associated with negative social competence, and indirectly related to the
psychological distress and disordered eating attitudes of their daughters (Arroyo & Segrin, 2013, p. 414). Mothers who often openly express concern about their own body, weight, appearance, and figure perpetuate these thoughts for their daughters in regard to their own perception of body, weight, appearance, and figure, creating a greater risk for disordered eating behavior in the daughter. Not surprisingly, factors that have a significant contribution to one’s body dissatisfaction are weight-focused teasing and critiques as well as family or peer pressures to fit a certain beauty standard (Goodman, 2005, p. 196). Mothers who point out their flaws often raise daughters who reenact these practices and express their dissatisfaction with certain personal attributes. Alternatively, mothers who embrace their appearance or do not comment about it at all may raise daughters with less concern for these things and have a better relationship with their body and the person they are inside.

Arroyo and Segrin’s (2013) study on family interaction and disordered eating assessed family interactions from a variety of family members’ perspectives, including a young adult female, a mother, and a sibling via a survey instrument. Drawing from Mallinckrodt, McCreary, and Robertson’s (1995) model of disordered eating, Arroyo and Segrin (2013) explored social competence and psychological distress as mediating factors that impact disordered eating attitudes. Arroyo and Segrin (2013) found emotions expressed in family interactions were associated with low social competence, which was associated with psychological distress, and then resulted in disordered eating attitudes, which may contribute to actual, disordered eating behavior. Arroyo and Segrin (2013) break down family interactions to include (1) family conflict, which is a family’s typical amount of open aggression and anger and believed to be expressed via eating disorders; (2) family control, meaning the patterns of overprotection and rigidity, which are risk factors for developing an eating disorder; and (3) family expressed emotion, which includes criticism, overinvolvement, excessive attention, and emotional
reactivity, all of which is associated with high levels of family conflict and low levels of family organization for people with eating disorders. Arroyo and Segrin (2013) concluded that high levels of these three forms of family interaction contributed to diminished social competence and higher psychological distress, which become risk factors for daughters’ disordered attitudes toward eating and the potential development of an eating disorder.

Arroyo and Segrin (2013) found that one protective factor for eating pathology and weight concerns in daughters was the warmth she experienced in the relationship with her mother. Daughters who felt high levels of warmth, in the form of support, from their mothers were found to have a greater protection from eating problems and weight dissatisfaction; whereas, daughters who did not share a warm bond with their mothers may be more inclined to engage in ritualized eating behaviors or to focus on weight and body. In terms of risks factors, Arroyo and Segrin (2013) found that a daughter having low levels or an absence of closeness and warmth from her mother could contribute to the development of an eating disorder. The degree of bonding and level of open communication between mothers and daughters served as two predictive factors in understanding what contributes to or deters the development of an eating disorder.

**Disclosure of an Eating Disorder**

With a fundamental understanding of the importance of the mother-daughter relationship in mind, it is time to consider how that relationship is impacted when tough, sensitive, personal issues are discussed. Research suggests that even though openness is important in family relationships, there is still a need for family members to have some sense of privacy. This investigation looks at the balance between privacy and openness in terms of the amount and content of personal information explicitly shared between mothers and daughters. Petronio (2002) describes how disclosure in family relationships serves to create shared meaning, higher degrees of trust between family members, and greater
understanding for the family as a whole. In an early study on the subject of disclosure and privacy, Petronio (2002) explained that disclosure results in co-ownership of the information, meaning that once an individual confides in a family member, that family member has gained some entitlement to information. This co-ownership of sensitive information can cause the relationship to have one of two outcomes; either the relationship can be reinforced and supported because the members feel bonded or the family member can use the information against the individual who shared it. Either way, both parties are now co-owners of the information.

Petronio (2002) offered what she calls Communication Boundary Management Theory to help provide an explanation of disclosure in family relationships. Communication Boundary Management Theory provides a type of cost-benefit analysis that an individual calculates when considering the disclosure of personal, possibly sensitive or even negative, information to family members (Petronio, 2002). This theory acknowledges the risk involved in disclosing personal information and the implications that can ensue if family members respond negatively. To manage such risks, the individual who is considering the disclosure of information can both assert boundaries and conduct rule-based management with family members, all while preserving their own privacy until they are ready to share.

Applied to situations where a daughter is experiencing an eating disorder, Communication Boundary Management Theory suggests that daughters will assess the pros and cons of disclosing their personal, sensitive, eating disorder related information to a family member. After calculating the risks involved in sharing such information with a family member, the individual may consider the possible outcomes or reactions that will ensue from the interaction. As a precaution for managing negative outcomes, the individual can assert boundaries with the family member they plan to disclose to as well as implement rules for managing their conversation so that the individual disclosing eating disorder related information feels in control and protected.
Specifically, in regards to disclosure of eating disorder related content, Swan and Andrews (2003) found that shame was strongly related to participants choice to conceal information from their therapist. Swan and Andrews (2003) found that forty-two percent of the women reported that they did not disclose certain content about themselves and/or their disordered behaviors to their therapist. Two themes emerged from this study as to why patients chose not to disclose, the first being because of therapeutic issues such as insufficient trust between themselves and their therapist, patients’ wish to preserve a sense of control within the patient-therapist dynamic, and patients’ fear of judgment from their therapist (Swan & Andrews, 2003). The second theme found centered on issues with the act of eating and, of course, to the ED. Examples within this theme involved not revealing the extent of ED symptoms, not sticking to a regimented meal plan, concealing other forms of self-harm, and not explaining other related problems such as various forms of abuse (Swan & Andrews, 2003). Although this study focused on disclosure between patient and therapist rather than between family members, these two themes demonstrate that disclosure of disordered eating is difficult and may be impacted by concerns about shared ownership of information, sense of control, and anticipated response from others.

Deception in Mother-Daughter Relationships

Because of the stigma of eating disorders, patients often perform deceptive practices to prevent others from acknowledging, challenging, or condemning such behaviors (Sansone & Sansone, 2002). Understandably, patients do not want to be ridiculed by strangers and acquaintances about their eating issues, but why is it that patients feel the need to conceal information from those they have a close relationship with? Reis and Sprecher (2009) explain how deception is both widely condemned and likewise widely practiced. They go on to reveal that, "many lies in close relationships do not even involve false accounts; they use secrets and silences in order to create a false reality for their partner" (Knapp, 2009, p. 391). These secrets and silences are not always conceived with ill intentions; in fact,
they are often constructed for the benefit of both the person being deceitful and their loved one who is being deceived. Common motivations for lying and deception are to avoid punishment or to protect oneself from harm, but other reasons are to protect someone else, to win admiration from others, to maintain privacy, and to fulfill social expectations (Knapp, 2009). But close relationships are formed and sustained through the persons involved trusting that one another will protect their vulnerabilities and shortcomings, rather than judging or exploiting them as shameful or wrong.

Of course, there are also factors that prevent someone from lying to or deceiving someone they share a close relationship with. The warmth and levels of communication between mothers and daughters are two indicators among other contributing factors that influence a daughter’s need to turn to an eating disorder for relief, comfort, or control. Factors that may work to the advantage of (a close relationship) coping effectively with a potentially harmful relationship lie(s) include:

- a) A history of the liar doing many things with positive intentions and in the best interests of the relationship;
- b) a plea from the liar for forgiveness and repeatedly demonstrating their commitment to rebuilding relational closeness;
- c) a situation in which the discovery of the lie opened up issues for the relationship that needed to be discussed for the survival and welfare of the relationship;
- d) a situation in which the lie, by bringing the relationship to the edge of disaster, reminding both involved how much they wanted to save the relationship; and/or
- e) a situation in which the process mutually solving the problem(s) created by the lie served to reestablish or strengthen relationship bonds (Knapp, 2009, p. 393).

Furthermore, Knapp (2009) explains how some lies are benevolent and/or altruistic in nature because they are used to support, protect, or sustain the relationship of the person being lied to; these lies may take the form of telling someone what they want to hear to promoting their self-esteem. This project seeks to reveal how deception about disordered eating may influence the mother-daughter relationship
and shape other communication practices in the relationship.

Within the mother-daughter relationship, a daughter may lie to her mother to make the mother feel competent, protect the relationship, or sustain the false belief that the daughter does not have an eating disorder. However, deception is often difficult to maintain in close relationships, and there are obvious consequences when the partner finds out that s/he has been lied to by someone close to them. A relationship may suffer from lying as it can result in lack of trust, respect, and credibility of the liar, lowered level of satisfaction and commitment in the close relationship, and less likelihood of the liar/deceived to be believed as truthful in the future (Knapp, 2009). In addition to relational consequences, there are also negative effects that lying and deception can have on the individual who deceives. Powerful effects on the liar/deceiver include guilt, shame, fear, anger, and embarrassment and these emotions can be felt in any or all conversations one has with the person being lied to/deceived (Knapp, 2009, p. 393).

There is evidence that deceptive practices of disordered eating may actually be learned by the daughter from the mother’s modeling (Cole & Mitchel, 1998). Cole and Mitchell (1998) found that children who were able to sufficiently acknowledge that other people can hold false beliefs (meaning lies) tended to recognize that they too could hold false beliefs, and thus develop the ability to differentiate fiction from reality (as cited in Gopnik & Astington, 1988). In terms of developing disordered eating rituals, a daughter may learn from her mother how to utilize deceptive practices, knowing full well that what the daughter tells or shows others is fictitious from the reality of her unhealthy eating. The daughter recognizes that in other situations her mother has been successfully deceptive, so she too can lie in order to get away with behaviors of disordered eating. Deception may also be evaluated based on its seriousness and based on who benefits from it as researched by Dunbar, Gangi, Covelski, Adams, Bernhold, & Giles (2016). Dunbar et al (2016) examined how detrimental
lying really is and considered deceptive assessments for identifying an altruistic, white lie from a more serious and consequential lie or string of lies. Unsurprisingly, they found that altruistic white lies were considered less deceptive, whereas self-serving, serious, interpersonal lies were viewed as more deceptive and consequential (Dunbar et al., 2016). In regards to an eating disorder experience, the individual entrenched in their disorder may view their deceptive behaviors as merely white lies to protect themselves and their family as well as to preserve their disordered eating. However, to the family members of someone with an eating disorder, they may view this form of interpersonal deception as serious and possibly self-serving. The disconnect between how an individual and their family perceives the degree of detriment in their deception can result in further family conflict and miscommunication.

**The Potential for Deception Resulting From Parental Disapproval**

When a daughter is unable to recognize her worth beyond the size, shape, and appearance of her body and feels the need to turn to an eating disorder, she may be punished or ostracized by her mother for her disordered eating practices. Disordered eating behaviors should not go unacknowledged or without treatment, but the means of intervention may impact how the daughter behaves in the future in terms of concealing disordered behaviors as opposed to feeling supported to openly manage her disorder. When mothers punish or ostracize daughters for disordered eating behavior then a daughter may begin to practice more deceptive actions such as saying she has eaten when she has not, eating in front of others and then purging shortly after, or hoarding food in secrecy to binge later in private (Schreiber-Gregory et al., 2013). There is limited research on deception in disordered eating, but research on deception between adolescents and parents suggests particular relationships. Parents may assume that they are fully aware of their teen’s activities, but this parental knowledge is influenced by their teen’s openness to discuss such things with their parents, while being constrained by the teen’s deceptive capabilities (Bristol, 2005, p. 79). Bristol (2005) highlights that deception is part of the
independence seeking that teens do. For instance, a mother may believe she is abundantly attentive to her daughter’s needs and behaviors, but this may be falsely assumed based on the daughter’s choice to be open and honest or deceptive toward her mother in an attempt to gain her own identity/independence. Also, when teens experience the consequences of their action enforced by a parent, they often consider the ways in which they can perform the same way without getting caught the next time, rather than not doing the act at all. This work on teens is relevant because disordered eating often manifests in adolescence. So, if a mother punishes her daughter’s disordered eating, the daughter will work to conceal future disordered behaviors, rather than stopping these practices completely.

A family’s communication environment is at the core of understanding teen deception, so certain types of family communication patterns can unintentionally contribute to a teen’s deception (Bristol, 2005, p. 80). Family environments that inflict grave punishments for a teen’s actions may perpetuate the need to conceal information and perform acts without the parents knowing or finding out. Bristol (2005) found that “these disclosure deficits may reflect omission, obfuscation, dissimulation, or lying” (p. 80). However, it is important to recognize that deception and lying actually serve important developmental functions; they provide a way for the teen to establish independence and their own identity separate from their parents (Ekman, 1989 as cited in Bristol, 2005, p. 80). In fact, beginning in childhood a person inherently learns to utilize deception in order to adapt to and adjust to the conflicts around them (Bristol, 2005, p. 81).

To better understand deception, it is critical to look at the nature of the family’s communication environment. Certain environments are conducive to deceptive practices because teens feel restricted from speaking openly and honestly about controversial topics. Alternately, teens who feel comfortable in their communication environment discuss such issues and do not feel the need to practice deception in this context (Bristol, 2005, p. 81). In a home where a daughter feels constrained to voice her problems or
concerns about relationships, she may enact deception to perform disordered eating; whereas, a family environment that welcomes open and honest communication, a daughter may feel inclined to ask for help from her mother in treating her eating disorder.

Research has demonstrated a clear impact of mother-daughter interaction on the disclosure and management of disordered eating. Features of the family environment and unique aspects of the mother-daughter relationship are important to the emergence and experience of disordered eating. Additionally, Prescott and Le Poire (2002) have noted that communication between mothers and daughters once a disorder is present can be important to how eating disorders are managed. They proposed Inconsistent Nurturing as Control (INC) theory which states that because of competing goals of nurturing and controlling, mothers of daughters with eating disorders will unintentionally foster the very attitudes and behaviors they are trying to discourage; this occurs due to inconsistent manifestations of reinforcement and punishment (p. 59 as cited in Le Poire, 1992, 1995). Their study investigated how patterns of between mothers and daughters actually developed or preserved the daughters’ eating disorder. Prescott and Le Poire (2002) found that daughters struggling with an eating disorder typically experienced abnormal parent-child enmeshment, open hostility in the home environment, and a lack of communication clarity between family members. Fassino (2009) also found that women who struggled with an eating disorder experienced maternal jealousy and competition, emotional distance from their mothers, and maternal control and over concern.

Prescott and Le Poire (2002) “hypothesize that a mother’s communication strategies for dealing with a daughter’s eating disorder may be inconsistent in that she may reinforce the behaviors initially, punish the behavior subsequently, and revert to a mix of reinforcement and punishment subsequent to being frustrated with her unsuccessful control attempts” (p. 59). After interviewing 40 college-aged women battling eating disorders, Prescott and Le Poire (2002)
found that mothers’ reinforcement of the eating disorder occurs less often than proposed, but that mothers are indeed more likely to punish an eating disorder once it has been labeled as such. Furthermore, consistency in punishing and reinforcing behaviors impact recidivism and perceptions of persuasive effectiveness (Prescott & Le Poire, 2002). Therefore, it is important to recognize that although mothers’ influence on reinforcing daughters’ eating disorder is less likely, that mothers’ influence on daughters’ recidivism can be just as damaging. While the mothers are not encouraging their daughters to engage in such practices, mothers’ negative reactions to their daughters’ disorder may in fact contribute to the perpetuation of disordered behaviors.

*Justification*

Prior literature on eating disorders highlights the factors that influence the development of the eating disorder and the characteristics of those who acquire the disorder. Additionally, research on eating disorders suggests that disordered eating impacts relationships, but often does not go into great detail, especially regarding close family relational interactions. To fill this gap, this project has a deeper focus on close family relationships, specifically examining the mother-daughter relationship when the daughter has struggled with an eating disorder. The research that currently exists in regards to close family relationships impacted by a daughter’s eating disorder is not nearly as extensive as it could be. Unfortunately, there is a prevalence of eating disorders among young adult females in our society, and considering that eating disorders have the highest mortality rate of any mental illness, the time to take action for the best communication and treatment of these individuals is now (Fields, 2011).

By focusing on the daughter’s perspective, this research provides insight into the experience of young women who struggle with disordered eating. From this point of view, other
mothers, family members, and even specialists will be able to better understand the disclosure and deception involved in eating disorders and may use this to improve the communication within families dealing with this.

**Relationships and Disordered Eating**

When disclosing personal information, often times of sensitive or negative nature, individuals often seek out someone who they trust and rely on. Unsurprisingly, a family member is typically the person to go to when an individual needs someone to confide in and possibly seek help. Considering the importance of the mother-daughter relationship, we might expect her to share this information first with her mother. However, as recognized by Petronio (2000 & 2002), the daughter is taking a great risk when she disclosing her development of an eating disorder to her mother. This study explored how the daughter goes about disclosing such powerful information, and furthermore, how that disclosure impacted her relationship with her mother and future disclosure to her mother. Thus, this study poses the following research questions centered on the process of disclosure:

**RQ 1:** How did daughters disclose their eating disorder, and what was the reaction to this from their mother?

**RQ 2:** What do the reasons for not disclosing disordered eating suggest about participants’ views of the relationship and boundary management in mother-daughter interaction?

**RQ 3:** How does a mother’s reactions about other personal and/or sensitive topics influence communication following the eating disorder experience, once the daughter is in a recovery stage?
Understandably, the stigma surrounding mental illnesses, specifically eating disorders, often leads to deception about the disordered eating behaviors. Often times lies, secrets, and private practices work to simultaneously save face for the person doing them and to protect the close relationships from the pain, embarrassment, and stigma of their condition. Warmth, in the form of support, and closeness with one’s mother may also signal the level of deception a daughter feels the need to practice in relation to her eating disorder. A daughter who feels more supported and closer to her mother may feel safer, more comfortable, and less judged so she does not practice deception as often or on as great a scale as a daughter who has a less supportive and close relationship with her mother. A daughter who feels less warmth and closeness with her mother may be more likely to enact deceptive practices, even more so if she is punished or ostracized for performing disordered eating behaviors. To gain insight into this interaction between mothers and daughters when the nature of eating disorder results in deceptive practices, I asked:

RQ 4: How does a daughter’s engagement in deceptive practices associated with her eating disorder impact the mother-daughter relationship?

Prior research reveals the impact of family environment on how that individual behaves in other interpersonal interactions as well as the possibility that family dysfunction during childhood may manifest dysfunction in other relationships later in life (McDermott, 2002). Patterns of family dysfunction have been associated with daughters having a greater risk of developing an eating disorder (McDermott, 2002). The chaos of a malfunctioning household can lead a daughter to use other means of coping and controlling situations; this may present itself in the form of an eating disorder, whether it be restricting, purging, binging, or any other practice of disorder eating behavior. Prescott and Le Poire (2002) draw on family systems theories to argue
that the development of an eating disorder is a “reflection or symptom of a deeper, more pervasive problem in the family’s role structure, affective expression, relationship dynamic, and style of interacting” (p. 206 as cited in Humphrey, 1989, p. 62). Petronio (2002) presents the idea of disclosure as a family process in which Communication Boundary Management Theory comes into play. Using this theory, a family member, for example, a daughter, will evaluate the risks and benefits of disclosing sensitive personal information to another family member, such as a mother; knowing that once that information is shared with her it is no longer solely owned by the person who disclosed it, but rather that the person who it was shared with now has co-ownership of the content and can potentially choose to use that information against the person who disclosed it (Petronio, 2002).

In order to assess the role of family functioning on the development of eating disorders, this research question was raised:

RQ 5: How does a daughter’s disclosure reflect her role in the family in relation to the family boundaries in place and her sense of approval to speak openly about the topic within the family unit?
Chapter Two: Methods

Participants

Participants of this study included 10 women who were willing to speak about their past experiences with an eating disorder. Participants had first-hand experiences with eating disorders, while also feeling safe, comfortable, and in a stage of their recovery where they could speak about their experience and their relationship with their mother. The women in this study were between the ages of 19 and 25 and self-identified as White females of middle to upper class socioeconomic backgrounds. This group of participants is appropriate for the study because these women have had first-hand experiences with an eating disorder and provided accounts of how their disorder impacted the relationship with their mother. The personal insight these women provided pertains to the study’s research questions. It is important to note that the women in this study demonstrate what is referred to as “therapy-talk” when discussing their narratives about their mother-daughter relationship as impacted by an eating disorder. All of the participants sought some form of intensive program to treat their disorders, during which time mental health professionals provided them with therapeutic vocabulary to utilize in describing their experiences. This “therapy-talk” is evident in the interviews; this is critical to note because not having received such language may have altered how the daughters narrated their experiences. Below is a table providing the information about each of the participants in this study; however, pseudonyms have been given in order to protect the individuals’ privacy.
Table 1

*Participant Information*

<table>
<thead>
<tr>
<th>Participant’s Name and Age</th>
<th>Duration of Eating Disorder Experience</th>
<th>Type of Eating Disorder</th>
<th>Years Spent Living with her Mother during ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casey (19)</td>
<td>4 years</td>
<td>Anorexia and Bulimia</td>
<td>4 years</td>
</tr>
<tr>
<td>Elena (20)</td>
<td>2 years</td>
<td>Anorexia and Bulimia</td>
<td>2 years</td>
</tr>
<tr>
<td>Emily (21)</td>
<td>6 years</td>
<td>Anorexia</td>
<td>4 years</td>
</tr>
<tr>
<td>Molly (21)</td>
<td>3 years</td>
<td>Anorexia and Bulimia</td>
<td>3 years</td>
</tr>
<tr>
<td>Beth (20)</td>
<td>10 years</td>
<td>Anorexia</td>
<td>8 years</td>
</tr>
<tr>
<td>Kenzie (25)</td>
<td>16 years</td>
<td>Anorexia and Bulimia</td>
<td>9 years</td>
</tr>
<tr>
<td>Nicole (22)</td>
<td>3 years</td>
<td>Anorexia and Bulimia</td>
<td>2 years</td>
</tr>
<tr>
<td>Jen (23)</td>
<td>4 years</td>
<td>Anorexia, Bulimia, and Binge-Eating</td>
<td>1.5 years</td>
</tr>
<tr>
<td>Kimberly (25)</td>
<td>9 years</td>
<td>Anorexia and Extreme Over-Exercising</td>
<td>5 years</td>
</tr>
<tr>
<td>Grace (23)</td>
<td>5 years</td>
<td>Anorexia and Bulimia</td>
<td>2 years</td>
</tr>
</tbody>
</table>

In order to obtain participants for this study, the researcher initially contacted several individuals she had met during her treatment at an intensive outpatient program in Boulder, Colorado. The remaining participants were mutual contacts of the researcher’s social network. Two participants were friends of other participants and were contacted via Skype due to their out of town locations.
The women who agreed to participate in this study were provided written information about the study but were asked to give verbal rather than written consent before the interview process began to help protect their privacy.

**Procedures**

Semi-structured interviews were conducted with all 10 participants, and the interviews were audio-recorded. Five of the interviews were performed in-person, and the remaining five interviews were carried out over Skype video. Prior to both forms of interviews, in-person and via Skype video, the researcher again asked for the participants’ verbal consent and to ensure their approval of the interview’s audio-recording. The researcher guaranteed the participants’ request to stop recording at any time during the interview if the participant requested it.

Each interview lasted approximately 15 to 30 minutes and if conducted in-person, took place at an agreed upon public location where the participant and researcher met. The face-to-face interviews occurred at local coffee shops, while the Skype interviews took place at the homes of the participant and researcher in separate locations. The interviews were semi-structured due to the set list of questions asked of all 10 participants, but participants were encouraged to share as much information about their experience and their mother-daughter relationship as they felt comfortable.

The interview questions asked in this study are provided in Appendix A. Topics asked about in the interview included: (1) topical information about the daughter’s perception of her mother and their relationship growing up and during the eating disorder experience; (2) the disclosure of the eating disorder and specific examples of how that impacted the mother-daughter relationship; (3) the deception involved in the eating disorder experience and the mother-daughter relationship; and (4) the overall experience of having an eating disorder, how it
impacted the mother-daughter relationship, and any other tidbits of information that the participant wished to share with the researcher.

During each of the interviews conducted, the researcher provided the participant a printed copy of the interview questions but tried to make the interview a conversation about the topics and sought to encourage participants to elaborate on their experiences. While the interviews were being conducted, the researcher took handwritten notes and marked the time of significant quotes on her own printed copy of the interview questions. Following each interview, the researcher transferred the audio recording of the interview to her password-protected computer. Once all of the interviews were conducted and recorded, the researcher used an online application to transcribe the 10 interviews. After completing transcription of all 10 interviews, the research had a total of 40 pages of transcribed data. After the transcription process was complete, the researcher reviewed each interview’s audio recording simultaneously with the handwritten notes and transcripts in an open-coding approach. This open-coding process involved researcher marking key lines of the transcription where she found significant quotes or emerging themes to be used during the analysis process. The researcher created an interview data analysis table during the open-coding process in order to identify significant quotes and key ideas, themes, and processes found within the interviews.

Analysis

Open coding yielded a total of nine themes and topics for analysis. Guided by prior literature, the researcher considered how each of the quotes and ideas identified in open coding connected to the three communication processes of (1) disclosure, (2) deception, and (3) family environment. The research questions pertaining to this project were also considered for a better understanding of the data correspondence to this thesis. The research questions included: (1) In
the mother-daughter relationship, how does the deception involved in the eating disorder change the relationship? (2) Does openness about aspects of the ED make deception after disclosure less likely? (3) How does a mother’s reaction influence deceptive practices about the ED? (4) How did daughters disclose, and what was the reaction to this from mother? And (5) Revelations of closeness or quality of the relationship as a result of dealing with the ED.

The process of open coding was applied to each of the 10 completed transcripts in order to identify the themes, ideas, processes, and significant quotations from the data. Below is the open coding data table constructed after full transcription of the participants’ interviews, listed are the themes found from the data collected.

Table 2

Themes found from Open Coding of Data

<table>
<thead>
<tr>
<th>Disclosure</th>
<th>Deception</th>
<th>The Role of Family Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The way in which the daughter’s eating disorder was disclosed to her mother (directly vs. indirectly, one-on-one vs. involving other people)</td>
<td>- Deception as a normalized practice, either because of the longevity of time spent practicing it or the family’s modeling of deceptive acts</td>
<td>- Family function or dysfunction indicated the daughter’s development of an eating disorder and then later how the daughter’s eating disorder was managed within the family unit</td>
</tr>
<tr>
<td>- Reasons as to why the daughter chose not to disclose information to her mother</td>
<td>- The impact of daughter’s deceptive practices on the mother-daughter relationship</td>
<td>- The daughter’s perceived role in the family and their approval or disapproval of addressing sensitive, personal topics</td>
</tr>
<tr>
<td>- Daughter’s disclosure related to mother’s modeling and her own insecurities or relationship with health/fitness</td>
<td></td>
<td>- Family function or dysfunction and family rules/feelings about lying and withholding personal information</td>
</tr>
<tr>
<td>- Disclosure based on family functioning and the role of the daughter/her assessment of family’s approval to disclose sensitive information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2
Following the open coding process, the above data table was assembled and a catalog of themes found was presented. The themes that emerged in regards to the disclosure component of the study were (1) how the daughter’s eating disorder was disclosed to her mother; either directly or indirectly and was the person who disclosed information the daughter who had the eating disorder or was it a third party outside of the mother-daughter relationship who disclosed that information. Another theme that developed from the disclosure category was (2) the reasons found as to why the daughter chose not to disclose information to her mother, a total of thirteen reasons were provided by the study’s participants. An additional theme that arose from the analysis of disclosure was (3) how the daughter’s disclosure or lack thereof was related to her mother’s modeling and her own insecurities or relationship with health and fitness. The final theme identified in correspondence to disclosure was (4) disclosure based on the family functioning and the role of the daughter within the family as well as the daughter’s perception of family’s approval to disclose such personal information.

In terms of the category of deception, two overarching themes were identified from the participants’ interview responses. The first theme centered on (1) deception as a normalized practice for the daughter with an eating disorder, either because of the extended period of time spent performing deceptive acts and/or because deceptive practices were committed within the family unit so the daughter learned that deception was normal. The other theme found was in regards to (2) the impact of the daughter’s deceptive practices on her mother-daughter relationship.

The final category, the role of family function, consisted of three themes that emerged from the data analysis. The first was (1) how a family’s function or dysfunction was related to
the daughter’s development of an eating disorder as well as how the daughter’s eating disorder was managed by the family unit. The second theme was in regards to (2) the daughter’s perceived role in the family and their approval or disapproval of addressing sensitive, personal topics. And lastly, the third theme addressed (3) the family’s function or dysfunction and feelings/rules regarding lying or withholding personal information from other family members.

The analysis of this data provided insight on the mother-daughter relationship as impacted by an eating disorder, a phenomenon that may not have been understood without the unique narratives provided by the study’s participants. The analysis sought to demonstrate the communicative processes involved in the mother-daughter relationship around disordered eating. The data of this study addresses the importance of sense making for individuals, how individuals narrate their experience, and individual’s communicative choices in interpersonal interactions.
Chapter 3: Findings

The interview questions asked participants about their experience with an eating disorder and were centered on the processes of disclosure and deception. Each interview asked participants about these processes before the eating disorder, at the point of disclosure about the eating disorder, after the disclosure, and about current relational experiences. Additionally, participants provided insight into the family’s influence on disclosing personal information as well as the family’s modeling of deceptive practices unrelated to the daughter’s eating disorder. This was critical because it revealed potential reasons and risk factors as to why a daughter might choose not to disclose information to her family along with enacting deceptive practices. The analyses of disclosure and deception consider these processes across time in the relationship. This study revealed several themes in regards to disclosure, specifically management of disclosure for protection, for avoidance of negative consequences, and for identity/privacy. Furthermore, the study demonstrated that for many participants, deception became a normalized practice, which resulted in restricted interaction; all of which were related to the theme of daughter’s perception of their family environment.

The Disclosure Process

Disclosure is a key relational process, and research has revealed its importance in family interactions (Petronio, 2002). For participants in this research study, admission of the eating disorder to the mother marked an important juncture in the relationship and revealed interesting insights about the way that communication about the disorder shaped the mother-daughter relationship. The reasons daughters gave as to why they chose not to disclose to their mothers exposed significant revelations about the daughters themselves and their relationships with their mother.
How the Daughter’s Eating Disorder was Disclosed to her Mother

This study’s first research question asked how daughters disclosed their eating disorder to their mothers, and how their mothers reacted to the news. Understandably, a daughter’s struggle with an eating disorder may be a difficult subject matter to address with her mother. This type of disclosure is often so challenging and a daughter’s denial of her disorder may be so strong that an individual from outside of the mother-daughter relationship must intervene. This was the case for a majority of the women interviewed, five of whom explained that they did not disclose their eating disorder to their mother; instead, it was communicated by a third-party. Disclosure to a third-party individual is what interpersonal communication scholars refer to as the “stranger on a plane” phenomenon, which claims that a person is more willing to reveal something personal and private about themselves to a stranger because that person believes they will never see that stranger again and therefore, will not have to deal with any relational consequences (John, Acquisti, & Loewenstein, 2010). Similarly, participants demonstrated their willingness to disclose to a third-party individual knowing that they did not have to be around that person for extended periods of time, like they would with their mother; and that the third-party could uphold a more objective evaluation of the situation and disclosed information, unlike a mother who may react with more emotion and subjectivity. Often times, another immediate family member was the one to disclose the information to the mother, one participant, Elena, noted that it was her father who told her mother, even though the two parents were divorced and remarried.

My dad was like "okay I have to tell your mom" and so that's how she found out, so I never actually told her myself. She was like, "I can't believe you told your father before me" is what she said.
In this particular situation the daughter chose to initially disclose the sensitive matter to her father. Rather than taking an indirect approach to disclose to her mother, Elena, chose to avoid disclosing to her at all. Performing this type of concealment may indicate Elena’s discomfort in the relationship with her mother and in dealing with an already uncomfortable issue, like the disclosure of an eating disorder. Elena chose to minimize her uneasiness by disclosing to her father first as she felt closer to him than she did her mother.

Another participant, Nicole, stated that it was her sister who served as the third-party immediate family member to disclose Nicole’s eating disorder to their mother. “Well actually my mom found out because I was in the bathroom and my sister heard me. So then she told my mom and they both confronted me about it.”

Mental health/physical health care professionals were also identified as third-party personnel who were concerned about the daughter’s health and wellbeing so they made the professional decision to disclose the daughter’s eating disorder to her mother. One participant, Casey, explained how a faculty of her middle school was involved. “My mom walked into the living room with my sister and was like Guess who we just got a call from? and I was like Oh crap, who? and she was like your school counselor.”

Again, rather than taking a more indirect approach, this participant, similar to Elena, chose to not disclose to her mother at all. The fact that Casey felt more comfortable talking about such a sensitive issue with a school counselor—someone outside of the family unit—rather than her own mother reveals the sense of worry and possible fear Casey presumed would ensue once her mother knew about her eating disorder. Fearing the process of disclosure is not surprising; what is more interesting are the reasons because daughters’ hesitancy to disclose. In this case, Casey was not too nervous to disclose eating disorder related information to her school counselor, but
she was nervous to disclose such content to her mother specifically. The cautionary position Casey took during her disclosure process reveals the timidity and fear of the unknown involved in her relationship with her mother.

Another participant, Emily, described how a third-party disclosed information about her eating disorder to her mother and the significance of Emily’s denial that she had a problem at all.

I actually didn't tell my mom that I had an eating disorder she found out because I mean I'm sure that people suspected it for a long time, but it was my director at dance who said I couldn't perform unless I had a consultation at the Children's Hospital. So I went there with my mom and they basically told her I had an eating disorder, and I didn't even think I had an eating disorder, I just thought all of these people wanted to keep me from dancing. So it was really hard because I didn't believe I had one and when she heard the doctor say that I just tried to convince her that I didn't have one for a really long time.

In this situation, the daughter recognizes that her eating disorder illness is apparent to others around her, yet still she is unwilling to admit she has a problem and needs professional help. It is when a third-party from outside of the family unit steps in and threatens her ability to perform in a dance competition that she begins to recognize the gravity of the situation and the disclosure that needs to take place. Emily’s struggle to disclose to anyone, much less her mother, stemmed from her disillusions with her disorder. She did not believe she truly had a problem and, in fact, thought those around her were only trying to sabotage her dance career. Even after a medical professional diagnosed Emily with an eating disorder, she was still unable to come to terms with the severity of her condition, making it impossible for her to disclose to her family.
For Molly, she expressed concern about her mental health to her mother, but did not explicitly identify her problem as food/weight/body-image related and instead, it was a health care provider that disclosed her diagnosed eating disorder to Molly’s mother.

I actually didn't tell my mom that I had an eating disorder. I was having a lot of anxiety issues and so I told her that I wanted to talk with a therapist, but I didn't actually tell her why. It was actually at the therapist, after talking to me that was like "You have an eating disorder" and she told my mom because I had signed a disclosure agreement.

Similar to the other participants who felt unable to disclose their eating disorders to their mothers, either directly or indirectly, Molly felt more comfortable meeting with and disclosing to a complete stranger about her condition. Molly’s willingness to speak with a therapist reveals that she was aware of the serious nature of her disorder and had a desire to seek professional help. Speaking to a professional who understood the psychological complexities of an eating disorder as well as being an unbiased ear and voice for Molly was something she felt would not have been understood had she disclosed to her mother.

Alternately, four of the 10 participants reported disclosing the eating disorder to their mother directly in a one-on-one conversation. Kenzie described her lack of desire to share information about her eating disorder to her mother, but clarified that she did so out of necessity. At this point in Kenzie’s life, she was no longer living with her parents but her preferred treatment center was out-of-state from where they lived so she needed to inform her mother that she was moving and her reason for doing so.

I told my mom, not because I was in the mood but because I was going to treatment like I was moving to a different state to go to treatment so I felt like I had to tell her. So I actually emailed my mom and that's how I told her.
Additionally, Jen described how other problems in her family prevented her from disclosing her eating disorder to her mother sooner.

It was my freshman year of college when it [the eating disorder] started seriously. It was right after my sister had a really bad suicide attempt so it was really hard for me to come out and say that after that happened because my parents were so focused on it. It took me a really long time to tell her, I kind of slowly came about telling her over the phone and when I did tell her she almost didn't believe it. At first, she just thought like no that's not an eating disorder, it was really hard for her to admit the full gravity of the situation. She didn't accept it for a while because she was so gung-ho about none of her daughters ever having an eating disorder. But my mom had experience treating eating disorders; she worked as a psychiatric nurse and worked on the adolescent psych floor so she really was the one who helped me through my eating disorder.

For Jen, her disclosure was dependent on the state of her family life. Due to her sister’s suicide attempt, Jen felt restricted from disclosing her own personal issues to her mother because she did not want to minimize her sister’s trauma or add to the chaos the family was already experiencing from it. Once the tensions settled down and Jen’s sister was placed in a psychiatric facility, then she felt comfortable to disclose to her mother. As she mentioned, Jen’s mother did not want to believe her daughter was struggling with an eating disorder; however, when Jen was able to disclose more and more information about her thoughts and behaviors and relate those to the symptoms of some of the patients her mother had treated, then Jen’s mother was able to accept the situation and wanted to help her daughter seek treatment.

Kimberly took a more indirect approach for the disclosure of her eating disorder to her mother, but eventually had a direct in-person conversation about her struggles with her mother.
It was actually over the phone when it all kind of came out and then shortly after, I went over to her house and told her I was having X, Y, and Z problems and it's really starting to impair my life.

Likewise, Grace described how she was more indirect when first disclosing her eating disorder to her mother and that it was her mother who responded by carrying out a very direct approach to addressing her daughter’s issue.

I think that even still to this day I have a hard time saying I have an eating disorder. I was at my first school in the Midwest and I remember Rosh Hashanah was coming up and I would usually go home for it. It was first semester of my sophomore year and I remember having so much anxiety thinking about going home because the food was not conducive to my behaviors and what I would allow myself, so that was paralyzing. So it was crunch time and I had to decide either to not go home and stay in my disorder because my family doesn't know about it or do I suffer by going home and having this huge secret? So I had to tell my mom over the phone and for some reason my mom jumped into this caretaking role and was like "oh okay we'll come to you". So I didn't go home, they came to see me. I think my mom's number one reaction was like "everything will be good once I see you", "just let me come take care of you", jumping into this like superhero role. So when she saw me and I was at a different weight and what she was used to, you would think that would help her understand that there was an issue but she was just so blinded by it. Just like "my daughters having a hard time, but only for right now".

Similar to Jen and her mother not accepting Jen’s eating disorder, Grace’s mother also did not believe in the reality of her daughter’s condition. Both participants, Jen and Grace, were hesitant to disclose to their mothers not only because of the discomfort they felt in regards to the issue,
but also because they sensed that their mothers would not accept their disclosures; which may have added to their discomfort and worries.

Only one participant reported that it was her mother who actually confronted her about the eating disorder. Beth explained how her mother addressed Beth’s eating disorder and how Beth subsequently denied having any issue and tried to convince her mother of this as well.

She actually nagged me about it. Like I've had some signs of an eating disorder since I was like 9 or 10. Then when I got to high school I started running competitively and it was on and off not eating all of high school. It was my senior year when I relapsed really bad and she, for like the whole year was like, "I think you're anorexic". But I would always lie to her and tell her that I had just gone out eating with friends and whatnot. But she was not having it, like she didn't believe me.

Interestingly, though Beth’s mother initially confronted Beth about the disorder on her own, she later reached out to a third-party individual, an extended family member, to help intervene with her daughter’s eating disorder.

My uncle is a doctor and he just happens to specialize in eating disorders… they [her mother and uncle] pretty much had a whole intervention for me… I wouldn't have sought help if it wasn't for her and my uncle doing that.

Due to the denial and shame of their eating disorders, some participants did not personally address their struggles to their mothers. Instead third-party individuals stepped in to disclose the information to the mother; these individuals consisted of other family members and mental/physical health care professionals who were concerned with the daughter’s wellbeing and realized the severity of the situation, resulting in the urgency to have her mother informed.

The majority of women in this study did not disclose their eating disorders to their
mothers themselves, but rather, a third-party individual intervened to inform the mother. The daughter’s need for third-party assistance in their eating disorder disclosure was the result of discomfort speaking about the topic with their mothers directly and fear of their mother’s reaction/repercussions to their relationship. The topic of a daughter’s eating disorder as discussed with her parents, specifically her mother, is a nerve-wrecking and sensitive conversation. Daughters were fearful of their mothers’ unknown reactions to the uncomfortable and worrisome news, which postponed their disclosures.

For the four participants who did disclose their eating disorders to their mothers in a one-on-one conversation, they did so in an indirect manner and all used a technology medium, or barrier, when they did address their disorder. One woman disclosed via email while the other three chose to disclose the information over the phone. All four of these participants were out-of-state from their family's hometown during the development of their eating disorders so it is possible that they chose to use technology as a means of convenience for informing their mothers of their disorders. However, it is also likely that the use of technology acted also as a barrier/buffer medium to ease the tension of disclosing such serious information to their mothers, as opposed to the immediacy involved in a face-to-face conversation. The use of technology allowed daughters to be methodical in their delivery of their eating disorders to their mothers using a computer or phone, rather than being on the spot in a face-to-face conversation; daughters could map out what they were going to say beforehand and even edit their disclosure delivery because of the technological medium. Using technology to disclose also provided a delay in the disclosure process, specifically when using email. Daughters sent disclosure emails to their mothers and then daughters experienced a sense of relief knowing that they did not have to engage in a real-time conversation, instead they could think about their next communication
strategy while waiting for their mothers to reply to their email.

The one participant who reported that it was actually her mother who confronted her about having an eating disorder was struggling for a long time, since early childhood, performed restricted eating behaviors openly, and was the niece of a doctor who specializes in treating eating disorders. Due to the longevity, blatant nature of behaviors, and a well-informed mother on how to spot the warning signs of an eating disorder, the mother had enough evidence and information to go forth with her assumption that her daughter was dealing with an eating disorder, resulting in the mother confronting her daughter about the matter.

The second research question of this study wondered what the daughter’s reasons for not disclosing suggest about the mother-daughter relationship and the boundaries involved in their interactions. Although all participants expressed some concern about disclosing the eating disorder to the mother, they oriented differently in their explanation for why they did not want to disclose their disorder. Their expressed reasons for not disclosing consisted of wanting to protect the mother or themselves, wanting to avoid negative consequences, and desiring their own identity/privacy.

**Managing Disclosure to Protect**

Several participants described their concealment of information as an attempt to safeguard either themselves or their mothers from the dark realities of having an eating disorder or from repercussions to their relationship. Daughters expressed concern about disclosing the graphic nature of their eating disorders for fear that it would take too great of an emotional toll on their mother and furthermore, their mother-daughter relationship. Additionally, daughters managed the degree of their disclosure to their mothers in order to protect themselves from
backlash for engaging in such dangerous behaviors. Managing disclosure also protected the mother-daughter relationship from arguments pertaining to the daughter’s eating disorder.

Four participants described their experiences of consciously choosing to not disclose information to their mother about their eating disorder in an attempt to protect the mother. Elena attested to this experience as she chose to conceal information in order to ensure her mother’s happiness rather than her own. “I just remember trying to like make her happy and be like the daughter she wanted me to be cuz like when she was younger she was like super popular and she was kind of like the mean girl in high school.”

Elena goes on to explain that she did not disclose information in the hopes that doing so would protect the fragile relationship she had with her mother.

I didn't really feel like telling her it was her pressure was what made me feel like I did, like I didn't want to like blame her or anything, you know because I've always liked wanted a relationship with my mom, like it has been rough but when we are good even like a fake good, so when we are like on better terms I just wanted to make her happy and make it last.

Unsurprisingly, the details of what goes along with having an eating disorder can be equally as hard to share, which is exactly why Grace chose not to disclose such information to her mother.

I'm protecting her from the horrific details of an eating disorder, but also because she's very logical more than emotional and that's setting me up to be disappointed because I need an emotional, compassionate, empathic ear.

Grace goes on to explain that her continuous non disclosure is the result of her attempt to shield her mother from the dark reality of having an eating disorder even while she is in
recovery. “If there is a secrecy happening now it's only out of the intention to try to spare her from seeing my suffering.”

Daughters also concealed information to protect themselves in their mother-daughter relationship. Daughters explained that both personal shame and fear of repercussions were the driving forces behind their management to protect themselves from disclosing to their mothers. Once again, in doing so the daughters could preserve their eating disorder and continue engaging in behaviors. Without acknowledging their awareness of the fatal disorder and recognition that their related behaviors would be condemned or punished, the daughters were able to protect themselves and inadvertently protect their eating disorders in order to continue. These circumstances were true for one participant, Elena, as she described her mother’s reaction to her eating disorder.

I felt horrible about myself every time I lied or was sneaky with food or exercise, but I felt worse if I didn’t do a behavior so I chose the lesser of two evils. I knew my mom wanted me to be skinny, but I also knew she’d be angry if she knew I was purging and restricting. In a really twisted way we were both getting what we wanted, she got the skinny daughter she always wanted and I could do behaviors in private to be that skinny person, but not worry about her getting mad at me.

**Managing Disclosure to Avoid Negative Consequences**

A main reason daughters chose not to disclose to their mothers was due to daughter’s own personal shame. Some participants reported that they were able to muster up the courage to disclose personal information, eating disorder related or otherwise to their mothers, and it was only after their mother’s negative reaction that they found a different reason to prevent further disclosure. Other participants explained that they did not reach that level of comfort and courage
and were never able to assess if they could disclose to their mothers because they did not ever attempt it. Daughters explained that their own guilt and shame around their feelings about themselves, their bodies, their behaviors, etc. all prevented them from taking the next step in an attempt to seek help and disclose to their mothers. A situation that one participant, Grace, could attest to having experienced.

There’s this like very naive child-like part of me so when I first started struggling, I wouldn't even say to myself that I have an eating disorder. Then, that same child in me felt humiliated by what I was doing and scared of what might happen if I told someone. I knew what I was doing was wrong, but I couldn’t stop it or explain myself.

Similarly, daughter’s inability to explain the reason(s) for their eating disorder or related information also prevented them from disclosing in an attempt to protect themselves from any repercussions. Participants reasoned that although they may have felt comfortable and confident enough to disclose to their mothers initial information about their personal life, they were unable to explain their struggles and knowing that they would not be able to provide their mothers with reasoning, they opted out of disclosure completely. As Jen explains, she found it most difficult to disclose to her mother because she was shameful, but also because of the complexity of her eating disorder.

It was difficult to explain to her the reasoning as to why I had an eating disorder and what it was doing for me because it really wasn’t weight related. I hated who I was and what I was doing, I constantly felt ashamed and guilty, but I couldn’t explain why I kept doing behaviors so I just didn’t say anything to her [Jen’s mother] about it at all.

Disclosure to manage protection occurred equally in an attempt to protect the mother as it did to protect the daughter. Participants described their choice not to disclose out of a need to
Mother-daughter relationships and eating disorders

protect their relationship with their mother, especially if it was a tumultuous dynamic to begin with, and to protect their mothers from the graphic reality of their disorders. By doing so the daughter's eating disorders could also be sustained. If the daughter's work to protect her mother was successful then the daughter could argue that neither their relationship nor the side effects of the illness had any real consequences. One participant, Grace, describes her experience with this false sense of normalcy and security from real consequences.

She would notice me at a smaller size or doing strange things with my food, but never attribute it to me being psychologically unwell. She would always assume it just was what it was, that I was just losing weight and being a picky eater, simple as that. It was very surface-level, she saw things and let them be and because I was getting away with it and she wasn’t visibly upset, I just kept doing it [eating disorder behaviors].

Daughters also chose not to disclose to their mothers because they felt it was unsafe or toxic to disclose and perceived their mother as reinforcing the eating disorder. Casey explained how her mother’s forceful reaction to the initial disclosure of her eating disorder prevented her from wanting to disclose anything more about it. “She was like we’re going to get Tokyo Joe's, what do you want cause you're going to eat something whether you like it or not.”

Elena explained how she had a desire to disclose information about her eating disorder in order to begin a recovery process, but requested the help of a mental health professional instead of speaking about it with her mother. “She was like “you don't need a therapist... only skinny girls have eating disorders.”

Beth described the unhealthy habits her mother exhibited right in front of her after Beth’s eating disorder was disclosed; leaving Beth feeling like coming to her mother with eating disorder issues only reinforced her toxic relationship health, food, body-image, and fitness.
Well she's a personal trainer and it was when I was just starting treatment and she was training for a bodybuilding show and I don't know if you know what all that entails, but it's a lot of weighing your food and counting your calories and restricting a lot of things; so it was really hard for me to see that. It was a really bad patch of our relationship, I was just so pissed at her for doing that in front of me.

Molly described her experience with disclosure of eating disorder information and how it resulted in her mother’s negative reaction, which led her to feel invalidated, unsafe, and uncomfortable to share any sensitive personal information with her mother in the future.

So I had a nutritionist and my nutritionist would tell my mom what I needed to eat and you need to make sure she is and my mom would just disagree and didn't think I needed to eat that much. So that was uncomfortable because she really didn't believe in my treatment plan. Like when I was a patient at the inpatient program at Eating Recovery Center they had a hard time getting through to my mom because she didn't agree with the therapists, she thought that what they were saying was wrong. Even though they were the experts she wouldn't listen to them and so that was really uncomfortable and the hardest thing I'd say.

Most often it was the daughter who felt like she was not living up to her mother’s expectations, but two participants explained that they did not disclose information to their mothers because their mothers were not meeting their expectations. Elena explained how she once tried to address ways in which she was not fulfilling her mother’s expectations, but how doing so only resulted in her mother’s reinforcement of such expectations for her daughter. “I was like "Mom I'm not popular" like I had accepted it and I was fine with that and she was like "No, my daughter is popular; any daughter of mine will be popular.”
Molly expressed that she initially used her eating disorder as a tool to repair her mother’s unhappiness following a divorce and how Molly utilized her mother’s reverence of health and fitness to try to reach her expectations to gain her attention and restore their relationship.

I knew my mom was very into fitness and very into it and always weighing herself so as a kid saying that, that made a big impact on me and then how I chose to act. So in a way, my eating disorder began as a way to please her because she was so depressed after my parents got divorced, I knew that wait was something she cared about so I thought that if I lost weight she would care about me, be proud of me, she'll want to be around me and not stay in her room all day. And it didn't work but at that point, it was too late, I had already become addicted to my eating disorder.

Alternately, Grace reported that it was her mother’s failure to meet her expectations and unkempt promises that influenced her decision to not disclose further information to her mother about her eating disorder. “I had a lot of expectations, that like she would just understand because she said that she would, right?”

Daughters felt like if, and when, they disclosed information to their mothers then the focus was placed on their mother and her wellbeing, rather than the attention and care being given to the daughter’s struggles. Understandably, the daughters felt ignored and unattended to when their mothers shifted the attention from the daughter’s mental illness onto themselves. Once daughters fostered up the courage to disclose information to their mothers, they had already endured a lot of self-doubt and self-criticism. Then, upon their mothers’ lack of interest and concern regarding the information presented, daughters concluded that because their efforts were not resulting in their mother’s concern and attention, they would no longer disclose such emotionally-exhaustive information to her again.
Daughters described that they had no desire, motivation, or support to disclose information to her mother due to mother’s lack of interest in the subject or physical/emotional availability. When daughters disclosed sensitive and emotional news to their mothers and mothers reacted with little or no concern or effort to help or understand, daughters were put off by this reaction and decided to not disclose future information to mothers. The two most influential factors that prevented daughters from disclosing were mothers’ misunderstanding/lack of knowledge about eating disorders and the type of information being disclosed.

Participants reiterated throughout their interviews how emotionally draining it was for them to overcome their fears and shame around their eating disorder in order to actually come out and report their issues to their mothers. However, when their efforts were met with mother’s lack of knowledge and misunderstanding about eating disorders, including ritualized behaviors and negative self-talk, the daughters chose to no longer invest time and energy disclosing to someone who they felt did not understand their struggle.

Another reason daughters chose not to disclose to their mothers was out of fear of mother’s ulterior motives once information was disclosed. Daughters explained that once they disclosed something personal to their mothers, eating disorder related or not, they had previously experienced their mothers using this information against them at a later date. Because sensitive subject matter became a source of ammunition for the mother to use against her daughter, daughters chose to not disclose to her out of fear and a felt need for protection. One participant, Molly, described her experience of her mother’s ulterior motives of using previously disclosed information against Molly.

I remember one night I just hit a breaking point and I told my mom a lot about the behaviors I was doing and how out-of-control I felt when I was doing them. At that time,
my mom was pretty stone faced when I told her; it was only a few weeks later that she asked me about something non-ED related and when I responded she brought up how untrustworthy and sneaky I was, then she brought up specific behaviors I had confided in her about weeks earlier.

Several participants reported that a mother’s indirect communication style was another reason for daughters decided not to disclose sensitive information. Daughters explained that, while they found it challenging to find the courage to speak with their mothers about their eating disorder, when they finally decided to do so, they did it in a direct fashion, addressing the issue head-on. Hoping to be met with a similar communication accommodation, daughters felt frustrated and let down by their mothers when the topic was acknowledged in a roundabout manner. One participant, Kenzie, explained her experience with this type of frustration and disappointment after attempting to address her eating disorder with her mother.

One day my dad stopped by my room and said that my mom was worried that I had "what the movie stars have" [eating disorders]. So I just pretended like I didn’t know what he was talking about, so there have been things and I don’t know if they’re just in their own denial about their kid not being normal.

In this particular situation, Kenzie explained that her frustration came from the fact that not only did her mother respond to her disclosure by sending Kenzie’s father to report back about it, but also that both of her parents could not even acknowledge the medical terminology for her condition; instead they sugarcoated her Bulimia and Anorexia by referring to it as “what the movie stars have”.

For several of the daughters, their decision not to disclose was related to their mother’s beliefs that their daughters’ eating disorder was only a temporary problem, rather than a serious
form of mental illness that would require long-term treatment. Because there was a disconnect in communication between mothers who felt their daughter’s eating disorders was a short-term issue and daughters who felt misunderstood and not taken seriously, the topic of eating disorders was avoided and disclosure was postponed and/or prevented.

**Managing Identity/Privacy**

Daughters argued that their lack of disclosure to their mothers about their eating disorder and other related concerns was an attempt to have something completely their own, apart from their mother’s knowledge and input, in order to gain their sense of self and personal identity.

One participant, Grace, attributed her need for separation from her mother as a reason for her conscious decision not to disclose personal information with her once she developed her eating disorder.

When I was younger she would say "you're never going to know you like I know you". And so I felt like I was stripped of my own identity, and again it was all with good intentions and coming out of love, but then it's very confusing because I would think to myself "I don't know who I am, only mom knows who I am". So I think that keeping secrets became partly to have something that was mine only, something that she couldn't take away from me.

Grace was not alone in this rationalization, several other participants explained that concealing information from their mothers provided them with their own sense of identity apart from the one created and reinforced by their mothers as they were growing up. When asked if there was anything further that Grace wanted to discuss in regards to her mother-daughter relationship, Grace described a realization she reached after her eating disorder experience, which is the need for more boundaries in her relationship with her mother.
My relationship with my mom there's been an immense need for identity work, an immense need for attachment work; I haven't really known healthy attachment or secure attachment because of my enmeshment with her. I think that a lot of our enmeshment has resulted in me not knowing how to navigate the world, in the basics of finances, and independence, and connection. There's been a huge need for boundaries and it's difficult because if I don't do that then I can't get what I need.

Daughters described their decision not to disclose to their mothers as driven by a significant desire or even need to detach from the mother-daughter relationship in order to assert personal identity, which they felt could not be established if the daughter did not have something, like an eating disorder, to consider all her own. Despite it being a negative and ineffective form of identity work, daughters felt like the secrecy of an eating disorder allowed them to be their own person separate from their mothers and their mother’s knowledge of them doing so. In consideration of the various reasons provided as to why daughters chose not to disclose, identity and privacy management were central to the daughters’ concealment of personal information. Choosing not to disclose information, eating disorder related or otherwise, revealed daughters’ position in the relationship with their mother in that they were taking control of their autonomy and the extent to which sensitive subject matter was disclosed.

**Disclosure Following Eating Disorder Experience**

The reasons for not disclosing about an eating disorder reveal the complexity of disclosure in mother-daughter relationships and how management of information is impacted by past experience and the way that management of information can be related to boundary work that occurs in relationships (Petronio, 2002). A daughter’s eating disorder in inherently secretive,
and revelation of the illness had impacts on disclosure afterward. This section examines how disclosure processes changed following the daughter’s eating disorder experience.

One participant, Emily, described how she posted a mini-memoir of her eating disorder experience to Facebook a few years into her recovery and explains how her mother reacted to it.

My mom called me after I posted it and that was the first time in she apologized to me for how she acted, she was crying and saying how sorry she was that I had to go through that. I think she misunderstood why I had an eating disorder so after reading that I think it helped her be more compassionate towards me.

Unfortunately, it was not always the case that mothers and daughters could retrospectively recognize what each did wrong during the eating disorder experience. In other instances, daughters explained that their mother’s reactions during their eating disorder experience prompted them to withhold disclosure about the topic to their mothers in the future.

Two participants, Molly and Kenzie, described their current hesitancy to disclose to their mothers, even though they are now in a strong recovery stage.

It bothers me sometimes when she seems interested now because I'm like well where were you for me then? Why are you only interested now? I almost feel like now it's a way to get back at her, and I know that sounds bad, but her concern doesn't feel genuine. At the time that I was struggling she wasn't there for me when I needed it the most, so why now does she care? It's like what motives does she have? Why does she care? I don't know for me it's a little bit of resentment.

Kenzie noted a similar sense of hesitancy:

There was a time when I was more willing, like when I went to treatment and then when I got out of treatment and we did family therapy stuff, that was I the time I would have
been willing to share stuff because I was in treatment and it was a big deal. I would have
been willing to share stuff with them then had they been willing or asked me questions
but they never did that. It was just weird. So now it's like if you weren't going to then
when I gave her more of an opportunity, then I'm definitely not going to talk about it
now.

Other participants, such as Nicole and Grace, describe their current feelings in regards to
sharing sensitive information with their mothers now that they are in a recovery stage from their
eating disorders. Although Nicole previously described her relationship with her mother as being
very close to the point that Nicole considers her mom to be her best friend and would tell her
anything, Nicole contradicts herself to say that if a situation were to arise in the future to where
she was struggling again that she would not disclose this or any related information to her
mother.

I know she doesn't do it to be mean but she'll make comments about my weight, so that
feels really hard for me to hear and makes me not want to talk to her about it. There is a
possibility if I ever got to that place again, that I would try to hide it in the beginning and
deal with it myself. I just don't want to put her through that again, it's something I'm more
aware of with my body and I think I could deal with it on my own.

Another participant, Grace, described the transformation her mother experienced over the course
of Grace’s eating disorder and how her mother’s current state-of-mind makes it challenging to
disclose to her. “She went from blaming herself in the beginning to now her being like this
narcissist, saying she did everything she could and making it out to be all my fault and something
I needed to deal with all on my own.”
Research question number three questioned how a mother’s reactions about other personal and/or sensitive topics influence open and honest communication following the eating disorder experience, once the daughter is in a recovery stage? Daughters’ desire to disclose now that the eating disorder is behind them can be linked to their mothers’ reaction to them during and immediately following their eating disorder experience. In cases where the mother reacted positively and with understanding and empathy, the daughter felt more inclined to disclose with her now that the eating disorder is not as prevalent in their lives. Alternately, if mothers responded negatively, were indifferently, or were absent during and immediately after their daughters' eating disorder experience, then daughters restricted future disclosure to their mothers out of resentment, self-blame, or fear of mother's reaction to information disclosed to her.

To understand the disclosure process as generating a sense of shared ownership of the information discussed, Petronio (2002) described Communication Boundary Management Theory, which explains how disclosure results in co-ownership of the information shared. Meaning that when a daughter confides in her mother about her eating disorder or related content, her mother has gained some entitlement to information. This co-ownership of sensitive information can cause the relationship to have one of two outcomes; either the relationship can be reinforced and supported because the mother and daughter feel bonded or the mother can hold the information against the individual who shared it if they believe it is in the best interest to do so. These interviews conclude that daughters were cognizant that the content they disclosed could result in co-ownership between themselves and their mothers. This acknowledgement prevented some daughters from disclosing even after their eating disorder experience out of fear that the information may be used against them. Other daughters also explained that they did not want their mothers to have co-ownership over the disclosed content solely because the disorder
was something they dealt with on their own and therefore, wanted full ownership over related information.

Following their eating disorder experience, daughters gave various reasons as why they chose to disclose or to not disclose to their mothers. Participants’ hesitancy with future disclosure was related to Petronio’s (2002) Communication Boundary Management Theory, in that they did not feel comfortable or see the advantages of their mothers having co-ownership of the disclosed information. Continued non-disclosure was also related to persistent deception, which resulted in deception becoming a routine behavior. A behavior that over time participants considered normal. In the following section, participants explain how deception became a normalized practice.

Deception as a Normalized Practice

Eating disorders are inherently deceptive due to the nature of the disease and the behaviors it entails. Patients with the disorder recognize that many of the actions they make to fuel their disorder are incredibly dangerous and in some cases life-threatening. The negative consequences along with the stigma of eating disorders as a mental illness result in a need to conceal one’s deeds from those closest to them. A pattern of concealing these behaviors evolves into a normalized practice for the individual and over time, what once was considered a devious act behind closed doors becomes an everyday routine in order to continue engaging in the disorder. This section considers how deception, eating disorder related or otherwise, became a normalized practice for the women of this study. Two participants, Molly and Nicole, explain how deception became a normal aspect of their everyday life during their eating disorder experience. “Without her support, deception was so easy and it happened so often that it became normal.”
Molly attributes her normalized deception to her mother’s lack of support, and indicates that without her guidance and concern, Molly was able to achieve deception. Molly also explains that because of her mother’s constant emotional unavailability, the deception became easier to accomplish and over time Molly was engaging in deceptive behaviors so frequently that it became normal to her.

Similarly, another participant, Nicole, noted that the frequency at which she was committing deceptive acts also contributed to the acts becoming normal in her mind which made it easier to practice them.

I think once I got into it, it just became so normal. Like my family loves to eat big meals so we'd be out and I would eat and then say I have to go to the bathroom. And I didn't feel guilty about it, honestly, it was just what I became what I was used to; it was normal.

One participant, Jen, illustrated how deception was a learned practice for her and that it was demonstrated by her parents from a very early age, which contributed to her understanding of deception as a normal activity.

I come from a very religious family too so there was a lot of lying and secrets going on when I was growing up with all of us. My family also has a bit of a perfectionistic tendency where you want to always appear like you're doing your best to your mom [and dad.] I would come to realize I was hiding something. Then after I realized I was hiding it I would always justify it right after.

In this case, Jen’s perception of deception was not normalized solely based on the regularity with which she was performing it, but was also due to what she saw as a family culture of secrecy. Additionally, her family’s emphasis on perfectionism impacted her need to conceal anything that strayed from their image of an ideal daughter. But much like Molly and Nicole,
Jen’s deception too became part of her routine and over time she considered it to be her new normal.

The literature suggests that deception is a learned practice (Cole & Mitchel, 1998) and as supported by one of this study's participants, deception performed by one or both parents impacts a child's perception of deception as an acceptable and normalized act. Furthermore, daughters described a cycle of deception that they believed began with a lack of support. When a daughter did not feel supported by her family, specifically her mother, deception became easily performed because there was less surveillance. Then, because mothers were unaware of daughters' deception, it became easier to achieve and once it was easily achievable on a regular basis, daughters considered it a normalized practice. Other times, mothers became hyper-vigilant of their daughters behaviors once their eating disorder was disclosed. In these cases, daughters practiced greater deception in order to accomplish disordered eating behaviors due to their mothers’ hyper surveillance. A few participants explained that they performed deceptive practices in part to see if their mothers would recognize them being deceitful and react with concern. However, when mothers did react to their daughters’ inherently deceitful disorder, daughters felt the need to work harder to accomplish deceptive practices because of their mothers’ hyper surveillance.

**Deceptive Behavior Resulting in Restricted Interaction**

The fourth research question posed was in regards to how a daughter’s engagement in deceptive practices associated with her eating disorder impacted the mother-daughter relationship. In addition to evolving into a normalized practice, deception also resulted in restricted interactions between the individual struggling and those closest to them in an attempt to continue their eating disorder behaviors without being challenged or condemned by others for
engaging in an unhealthy lifestyle. In order to avoid criticism and possible intervention, daughters performed deceptive practices to conceal their disordered eating behaviors from family members. When daughters engaged in deception, their interactions became restricted as a way to protect themselves and their behaviors and to avoid negative communication and/or consequences with their family. One participant, Kenzie, explained how her decision to engage in deceptive practices evolved from a desire to get away with behaviors into an actual cry for help and recognition from her mother.

I felt good hiding it because I knew that no one would suspect anything. When I got older, it honestly made me resent that she didn't notice. Because I was a kid, I gave them more leeway because it may have been harder to realize I had a problem. But as I've gotten older, like right after college, I was noticeably thinner and there was no comment about it. That's when I became resentful of her not noticing, but I guess I was still deceptive. It was weird because I was deceptive but I also wanted them to notice.

Kimberly, another participant, had a similar experience in that she too had several emotions come up when she performed deceptive practices. “It was very two-sided in that it brought about guilt, but it also gave me a lot of satisfaction doing a behavior and getting away with it without her knowing.”

For another participant, Jen, her deception was directly impacted by her mother’s restricted interaction, or rather recognition, of Jen’s disorder as a real and serious issue.

It was a lot of saying things like these behaviors are attention seeking and you're just playing the victim. And neither of those were the motive behind my eating disorder because I wasn't at all vocal about it so that really hurt my feelings. I think for a while my mom wanted the mentality of "if you don't address it, if you don't pay attention to it, it'll
go away", but I think that's changed a little bit more for us. I think that because she has worked with it she can now share what she finds helpful and I want to share with her what's happening for me with it.

Jen clarifies that once her mother’s mentality changed about her daughter’s disorder, then Jen felt less of a need to be deceptive towards her and actually goes to her for help and support now that their interactions are not as restricted.

Another participant, Grace, described how her mother-daughter relationship is still subject to restricted interaction due to Grace’s deception toward her mother.

Now if she suspects me of doing an eating disorder behavior she won't yell, she'll just cry and that's enough for me to feel like an ass and then not want to continuing doing that behavior, but then it's always seemingly at the expense of me. Like, I'm just going to sit here and feel miserable about myself or I'm going to do it [a behavior] and feel miserable for hurting her. So it's a lose-lose situation.

By definition, deception requires that something be perceived as true or valid when it is in fact, false or invalid; therefore, some of women of this study performed deceptive behaviors to be perceived by their mothers as honest and healthy, when in reality they were engaging in unhealthy, dishonest behaviors. Other women performed deception to appear normal to their mothers and family, while practicing disordered eating in private. Whether it was to seem honest, healthy, or normal, daughters performed deceptive practices in order to accomplish unhealthy disordered eating behaviors without anyone else’s knowing of it, resulting in restricted interactions with their mother and other family members.

Daughters explained that their deceptive practices did result in some feelings of guilt or remorse, but the satisfaction the deception provided was too great to disengage from and it
allowed them to sustain their eating disorder. In order to continue engaging in disordered eating behaviors, daughters chose to have minimal interaction with their mothers for fear that their deception would be revealed and/or punished. Minimal interaction with their mothers also allowed daughters to convince their mothers that their eating disorder was not a problem, which made both mother and daughter feel better and ultimately allowed the daughter to continue engaging in deceptive practices.

**Daughters’ Perceptions of the Family Environment and its Impact on Disordered Eating**

While the processes involved in disclosure and deception related to a daughter’s eating disorder provide significant insight into the communicative patterns in the mother-daughter relationship, family environment illustrates the bigger picture of why it may be that a daughter engages in deception and how disclosure is managed between family members. The fifth and final research question asked how a daughter’s disclosure reflects her role in the family in relation to the family boundaries and her sense of approval to speak openly about the topic within the family unit. This portion of the analysis examines the family environment to conceptualize daughter’s perceptions of appropriate communication processes, which influenced the degree of disclosure and deception she committed. In family environments that felt hostile or judgmental, daughters shared less and deceived more often; whereas, family environments with better communication and honest interactions resulted in daughters’ perception that it was acceptable to disclose sensitive personal information and less of a need to perform deceptive practices. One participant, Nicole, described her close relationship with her mother from a very early age and how that strong relationship has continued. Having a close relationship with her mother allowed Nicole the comfort and security to reveal some of her personal issues.
My mom and I have always been really close. I would consider her my best friend, I tell her absolutely everything. She knows everything about my life; and the eating disorder honestly helped bring us together.

Another participant, Grace, attests to having a similar relationship to her mother. She was my everything. She knew that I was very quiet and that I wouldn't trust people usually so the fact that she was my number one person, she just cherished that.

Everything that we were has been exacerbated even more if that's possible. So just as much love as there is, there is just as much ill health in it.

Nicole and Grace both describe having very close relationships with their mothers including the ability to go to them for every want, need, and concern, as well as having even closer relationships to their mothers following, or as a result of, their eating disorders. Nicole clarifies that it was the eating disorder that helped bring her and her mother closer together, while Grace alludes to her even closer relationship with her mother as being potentially unhealthy.

The following participants, Molly, Jen, and Kimberly, explain how their mother’s physical and emotional unavailability made it difficult for them to communicate with their mothers during their childhoods. Molly stated, “when they [Molly’s parents] got divorced our relationship was strained because she got super depressed. She would lock herself in her room and had a really hard time dealing with it and so she wasn't able to be a parent to me.”

Jen also explained a concern about availability on her mother’s part.
“When we were younger she was very disorganized and that was a huge part of my frustration with her as a child. And she left our family for a little while a couple times when we were really little so I think I always resented her for that.”

Jen’s mother leaving her family on several occasions during her childhood resulted in Jen’s inability to reach out and disclose to a mother who was not physically present for her. Jen goes on to state that her mother’s physical unavailability has left Jen with resentment toward her.

Alternately, Kimberly notes that although her mother was physically present for her during childhood, it was difficult for Kimberly to communicate with her because she was not mentally available to her.

From about the time I was born till I would say about age 8 or 9, my mom had a serious problem with alcohol. So my relationship with her just depended on her state of mind a lot of the time. I harbor a lot of resentment toward her for not being emotionally available to me as a kid.

Though these women experienced differences in the forms of unavailability of their mothers, either physically or emotionally, Molly, Jen, and Kimberly explain that their mothers not being fully present for them during their childhood created resentment around disclosing to their mothers.

The degree of disclosure in the mother-daughter relationship is significantly impacted by a mother's availability, either physically or emotionally but sometimes both. One participant described her and her mother's past relationship as being strong because they were physically and emotionally connected to one another and because her mother's physical and emotional presence has continued throughout her struggle with an eating disorder and now that the daughter is in a recover stage, their relationship has only strengthened even more. In connection to
Petronio’s (2002) Communication Boundary Management Theory, these participants felt comfortable having co-ownership over the disclosed content with their mothers because their mothers were stable figures in their lives in terms of being there for them to disclose to.

However, several of the other participants described their mothers as being either emotionally or physically unavailable to them prior to their eating disorder. Because of either or both forms of their mother’s unavailability, daughters explain how that strained the daughter's willingness and desire to disclose information to their mothers now that they are in a recovery stage as well as negatively impacted the daughter's perception of the quality of their mother-daughter relationship. In these cases, daughters were uncomfortable having co-ownership over disclosed information because their mothers were unreliable for support and guidance once sensitive subject matter was disclosed.

One participant, Jen, offered the following observation about the impact of a daughter’s eating disorder on their mother-daughter relationship.

In terms of how eating disorders impact the mother-daughter relationship, your mom cares about you so much so when you're hurting yourself you are also kind of hurting her in a way. I know it's probably hard when you're dealing with something like that to go to your mom but you have to realize it's really hard for them too to see their little baby in pain.

Jen goes on to clarify that the shift of the mother-daughter boundary was what transformed a dysfunction in their relationship into a functional, positive, and effective communication process. Her mother went from being in denial and misunderstanding of Jen’s disorder to allowing Jen the space to express her issues in a more peer-like conversation with her mother. “I think that in that moment she saw me less as her daughter and being so caught up in it
personally and was able to talk to me more like she would with one of her patients so that detachment actually really helped.”

Another participant, Grace, described the dilemma she faces in terms of how her family views and responds to her eating disorder experience.

“I've been through a lot of battles with myself of asking is it important for people to completely understand it to be supportive of you? And I don't really know the answer so yeah it's tough.”

The literature significantly supports the claim that family functioning impacts the health and wellbeing of individual family members. Previous research suggests that better family functioning can result in better relationships and communication within the family unit, whereas, dysfunction in the family can manifest itself in a variety of different ways such as a child's development of an eating disorder (McDermott, 2002). This study suggests that while the dysfunction within a family can result in a daughter's development of an eating disorder, that in turn, the daughter's eating disorder will affect the rest of her family members and the quality of their relationships.

Furthermore, the turmoil that ensues from a daughter's eating disorder can be improved upon shifting boundaries between family members, specifically between mothers and daughters. After boundaries are set and either distance or bring closer the mother and daughter, then the two can work towards better functioning and eventually better outcomes for their relationship. Shifts in the mother-daughter relationship can result from various forms of boundary management, specifically emotional boundaries. Emotional boundaries involve distinguishing between one’s own feelings and responsibilities separate from someone they are emotionally bonded to (Parkinson, 2015). For participants, this means separating their emotions and needs from their
mothers’ emotions and needs and taking care of themselves first. Healthy boundaries also reduce blame, guilt, and high reactivity, which suggest weak emotional boundaries (Parkinson, 2015). Therefore, improved boundaries lessen daughters’ negative emotions when interacting with their mothers.

A final significant component of the mother-daughter relationship explored in this study was how a daughter’s assessment of her mother’s weight and body experience influenced her eating disorder and their relationship. The literature recognizes the importance of mother’s modeling on daughters’ perceptions of themselves as they grow up. In support of this, the participants of this study explained how they perceived their mother’s sense of self and how that impacted their view of themselves, their weight/body, and their personal worth. Though there were no interview questions pertaining to the daughter’s perception of her mother’s own body/weight experience and modeling, several participants discussed how their mother’s feelings about her own body/appearance/weight impacted their perception of their body/weight growing up. Congruent with the literature, participants who received messages from their mother about her own insecurities and idealized beauty standards, grew up being hyper critical of their bodies and had an unhealthy focus on food, weight, and appearance. One participant, Elena, described how she recognized at an early age her mother’s own struggle with an eating disorder and the messages she picked up from her mother in regards to her body/weight.

She was also struggling with an eating disorder when I was a kid. I remember her just constantly talking about body image even to me as like a little kid. Like I'd be sitting in her room, having her brush my hair and she'd look in the mirror and be like "oh my gosh I'm so fat, I'm so fat, I'm so fat" and stuff like that and so I totally picked up on it. And she'd make comments, like even when I was a really little kid. She'd comment about what
I was eating and how I looked and she would even take my dinner away from me before I was finished with it.

Likewise, another participant, Emily, addressed that her mother’s own insecurities were evident to the point that she felt her mother was envious of Emily’s ability to lose weight.

I felt like a lot of my mom's anger towards me came from jealousy. Like my mom struggled a lot with her weight and saw her own mom go through an eating disorder. And at the time when I was diagnosed, she had a lot of extra weight that I know she didn't want, so I felt like she was jealous that I could easily drop like five pounds in a week. So I think some of her anger came from that place and it made her feel better to make me eat stuff I didn't want because then I was going to gain weight. We've never talked about that but it was something I distinctly remember picking up on at the time.

Another participant, Molly, expressed her concern with mother’s modeling toward her daughters in regard to weight and body and described how her mother’s unhealthy and insecure practices later influenced the development of Molly’s eating disorder.

I think that you have to be really careful how you raise your child. I remember my mom would offer to pay my older sister to lose weight, things like that. So if you grow up in that type of environment and raise her kids that way it can be really toxic and you have to be really careful.

True to what prior research suggests, Nicole explains how significant a role mother’s modeling of her own self-worth, self-esteem, and perception of body/weight experience plays in terms of her daughter’s perception of her worth and appearance.
I think a majority of what we think about our bodies comes from our moms and how they see themselves and how they see us. If they are struggling with their own weight and image issues, we can take that on as their daughters.

As the literature has found and this study’s participants can attest, mother’s modeling of her own perception of her weight/body/image/self-esteem/food directly impacts a daughter’s perception and concern of these same issues. In correspondence to prior research, this study concludes that a mother’s healthy modeling around her own body/weight/image/self-esteem/food can positively influence her daughter to also have a healthy relationship with these topics as well. Alternatively, if a mother consciously or unconsciously and directly or indirectly models unhealthy, diet-focus, skinny-oriented behaviors and messages to her daughter, then her daughter is more likely to have a negative perception of her own body/weight/image/self-esteem/food; and therefore, may resort to an eating disorder to achieve the beauty standards that were taught to her by her mother’s modeling.

Daughters' perceptions of comfort and approval of disclosure varied in regards to their perceptions of their family environment; in more open and communicative environments, daughters were more willing to consider disclosure, while in hostile or closed-off family environments, daughters refrained from disclosing information. Furthermore, when daughters felt that they could not disclose to their family, specifically their mothers, they resorted to deceptive practices to sustain the secrecy of their eating disorder. The decision to not disclose and/or perform deceptive behaviors was related to Communication Boundary Management Theory (Petronio, 2002); daughters did not want their mothers having co-ownership over the disclosed information. However, shifts in boundary management provided improved means of communicating between mothers and daughters. And consistent with the literature, daughters'
picked up on their mothers' modeling and feelings about their own bodies/weight/etc., which influenced daughters' perceptions of themselves.
Chapter Four: Discussion

The initial motivation behind this research was my own battle with an eating disorder and how it impacted the close interpersonal relationships in my life, most notably experiences with my mother. After months of therapy and years working toward a recovery stage, I realized the importance of the mother-daughter relationship from my experience with this disorder. I decided to explore the processes of disclosure and deception using one-on-one interviews with participants who also braved an eating disorder experience, but considered themselves in a stage of recovery.

Typically when one is struggling with a matter, they will first reach out to a family member for support and guidance. But who one reaches out to is dependent on who has been physically and emotionally available in the past for that person as well as their perceived reaction to difficult or troubling news. When daughters disclose an eating disorder, they may feel judged, ignored, or punished, which can impact future disclosure of information with family members. Participants in this study revealed their reasons for not disclosing information to their mothers were related to management of their own personal protection and the protection of the mother-daughter relationship, avoiding negative consequences, and management of privacy and identity.

Choosing not to disclose may also result in deceptive practices, which daughters thought could help manage identity and their mother-daughter relationship. Over time, daughters’ deception became a normalized practice because of the frequency with which it occurred and the satisfaction that ensued. Deception also resulted in restricted interaction with the mothers as a means for protecting their disordered eating behaviors and to preserve their mother-daughter relationship.
The final area of focus in this study was the daughters’ view of the family environment and its perceived impact on their development of an eating disorder. Previous research suggests that effective and appropriate communication within the family unit is associated with a better family environment, whereas, negativity within the family can manifest itself in a variety of different ways such as a child's development of an eating disorder (McDermott, 2002). This study suggests that while the quality of the family environment can impact a daughter's development of an eating disorder, that in turn, the daughter's eating disorder will affect the rest of her family members and the quality of their relationships.

Although past literature discusses the linkage between family environment and eating disorders, there is limited research on the mother-daughter relationship specifically and limited consideration of disclosure and deception as communicative processes. Therefore, this project reveals how the processes of disclosure and deception shape the mother-daughter relationship and daughter’s perception of the family environment as it relates to her eating disorder.

**Previous Literature and Results**

As suggested by Arroyo and Segrin (2013), participants in this study described the development of their eating disorder as related to coping mechanisms and a sense of control from performing disordered eating behaviors. Arroyo and Segrin (2002) studied family interactions and eating disorders and found a connection between family functioning and disordered eating. Family environments that involve negatively expressed emotions, stressful mealtime, food-related miscommunication, inadequate affective communication, and lack healthy problem solving skills have a higher likelihood of establishing interaction patterns associated with disordered eating in their children (Segrin & Flora, 2011 as cited in Arroyo & Segrin, 2013, p. 400). Arroyo and Segrin’s (2002) study also demonstrated the importance of family environment
and management of family relationships. In this study, family environment and management of family relationships influenced the reasons daughters gave for why they chose not to disclose information about their eating disorder to their mothers; the analysis revealed three categories: (1) managing to protect, (2) managing to avoid negative consequences, and (3) managing their identity/privacy.

Daughters’ management of disclosure was related to recognition that once they disclosed to their mothers, then that information became co-owned by both mother and daughter. Co-ownership of sensitive subject matter is what Petronio (2002) referred to as Communication Boundary Management Theory, which explains management of boundaries as important to relationships, since once personal information is revealed it is co-owned by the other person. This co-ownership can change the dynamics of the relationship because co-owned information can be used against the original “owner” of the sensitive subject matter. Communication Boundary Management Theory (Petronio, 2002) recognizes the dilemma one faces when weighing the risks and benefits of disclosing or concealing sensitive information. This sense of dilemma is reflected in the other reasons, aside from co-ownership, as to why a participant chose not to disclose to her mother; such as protecting herself from shame and guilt as well as protecting her relationship with her mother, avoiding negative consequences, and management of her own identity/privacy.

Communication Boundary Management Theory (Petronio, 2002) explains that disclosure promotes understanding about the subject matter being discussed and understanding among those involved in the disclosure process. However, most of the participants in this study discussed their mothers’ misunderstanding of eating disorders, and that misunderstanding discouraged daughters from wanting to disclose eating disorder related information. Communication Boundary
Management Theory (Petronio, 2002) asserts that in family relationships, individuals have their own perception of the relationship’s level of trust and understanding, meaning that there can be a disconnect between a mother’s perception of trust and understanding in the relationship and a daughter’s perception. The varying perceptions of trust and understanding in mother-daughter relationships explains why participants gave different reasons for non-disclosure in their mother-daughter relationship. Mother-daughter relationships with an already stable degree of trust and moderate understanding of the eating disorder experience may allow a daughter to feel more comfortable to disclose, whereas mother-daughter relationships with a history of little or no trust and understanding may result in greater reasons for daughters to choose not to disclose.

An eating disorder as a means for coping and control has been linked to tensions experienced at home; both McDermott (2002) and Prescott and LePoire (2002) examined the environment of the family unit of those suffering from an eating disorder. McDermott (2002) found that dysfunctional family interactions may influence the development of an eating disorder; the theme of daughters’ perception of their family environment revealed how participants felt their disorder was impacted by their family life. Many of the women in this study referenced parents’ divorce, family’s expectations, and other family issues as reasons for not disclosing sensitive subject matter regarding their eating disorder. Similarly, Prescott and LePoire (2002) explored how Anorexia Nervosa and Bulimia patients experienced family functioning differently from one another. Although this study did not focus on the differences between various types of eating disorders, it did reveal that family environments with low context conversations and perceived feelings of high tension among family members were related to the development of disordered eating. Daughters whose families were undergoing a parental divorce or other hectic circumstances left mothers physically and/or emotionally
unavailable; making it more difficult for daughters to disclose personal issues in an outward manner to their family so they resorted to an eating disorder to gain a sense of control and cope with their emotional turmoil. One participant experienced her mother’s emotional unavailability following a divorce; another participant attributed her mother’s emotional unavailability to alcoholism. In both situations, daughters were experiencing negative thoughts and lack of self-worth, but their mothers’ unavailability left daughters feeling alone and forced to cope with and control their negative emotions/actions in an inward manner, which manifested itself into an eating disorder.

Additionally, daughters’ perception of their family environment was related to their perceptions of their mother’s own insecurities or feelings about her weight/body/image. In line with the literature by Arroyo and Segrin (2002), daughters of this study noted their mothers’ modeling had a profound impact on their own perception of self-worth/self-esteem. This study’s participants reported that their mothers’ modeling or verbal expression of their unhappiness with their weight and/or body influenced daughters to scrutinize their own body; furthermore, participants noted that living up to their mothers’ expectations and/or knowing that weight/body improvements would gain their mothers’ attention influenced their development of an eating disorder.

In terms of Petronio’s (2002) Communication Boundary Management Theory, this study demonstrated how disclosed information became co-owned between the person sharing the insight and the person receiving it. Daughters were hesitant to disclose to their mothers for this very reason; some felt like their mothers would/did use the disclosed information against them, but others worried that the information would no longer truly be their own, that once it was disclosed to their mother that she too had ownership over the information.
The second process of focus in this study was daughters’ deceptive practices around eating and how those affected the mother-daughter relationship. In correspondence with the literature by Sansone and Sansone (2002), individuals performed deception to prevent others from acknowledging, condemning, and challenging their deviant behavior. Furthermore, Knapp (2009) noted that deception is often performed to prevent punishment and to protect oneself, which were two common motivations revealed by the participants in this study. Deception became a normalized practice for most, if not all, of the women in this study; after regularly performing deceptive practices to carry out eating disorder behaviors, daughters conceptualized their actions as normal and continued their unhealthy eating and exercise habits without their mothers’ knowledge. Deception resulted in restricted interaction between mothers and daughters on other issues in daughters’ attempts to continue engaging in disordered eating behaviors without their mothers’ knowing and possible punishment. And just as Knapp (2009) described, daughters justified their deceptive practices as altruistic and benevolent in nature because it was the only way to carry out their deviance and also protect or sustain their relationship with their mothers. In correspondence with this piece of research, daughters in this study explained how they kept things from their mothers to protect her from the horrific details of what an eating disorder involves. Daughters also withheld information to preserve their mother-daughter relationship from that sort of negativity.

Limitations

While this study produced valuable insight into daughters’ experiences, limitations of this study suggest caution in interpreting these results for several reasons. First, all but two of the participants were drawn from the researcher’s social network and underwent the same intensive outpatient treatment program, which may explain similarities in their narratives for the disclosure
and deception processes as well as their use of "therapy talk." Furthermore, the other two participants from outside of the researcher’s social network also completed intensive outpatient programs, just not the same one as the majority of participants.

Additionally, in order to participate in this study, volunteers were asked to be in a stage of recovery to ensure that they were comfortable and emotionally stable enough to speak about their eating disorder experience without undergoing negative side effects or risk of relapsing. Because of this requirement, many women who identify as having an eating disorder did not qualify to participate because they had not yet reached a recovery state. So while there is a smaller data set of 10 participants, the researcher felt it was important to safeguard the participants’ wellbeing while acquiring information for this study.

This study was also confined to mother-daughter relationships so it did not consider how an eating disorder impacts other family relationships, such as the father-daughter relationship. While the gender dynamics would have been interesting to look at in a father-daughter relationship, the researcher chose mother-daughter relationships to demonstrate disclosure and deception processes. Furthermore, the researcher was more familiar with her own relationship with her mother being impacted so she was interested to see how other women’s experiences with their mothers compared. However, because the research relied on interviews with daughters, it is not possible to get a full sense of the nature of the mother-daughter relationship or to understand how daughters’ views of disclosure or deception align with mothers’ views of these processes.

**Future Research**

This study focused on two communication processes in regards to eating disorder experience, specifically daughter’s disclosure and deception to understand their impact on the
mother-daughter relationship. However, future research should examine the mother’s perspective on how disclosure and deception around the eating disorder influenced the mother-daughter relationship. Furthermore, the communicative processes involved in mother-daughter relationships may be different from those encompassed in father-daughter relationships so future research may also investigate different gender dynamics surrounding eating disorders.

Future research could also explore eating disorder experiences through a relational dialectics theory approach (Baxter, 2015), looking at the dynamic communication tensions involved in the mother-daughter relationship. Relational dialectics theory (Baxter, 2015) views tension as competing forces that drive relationship; there is a need to be open but also to protect ourselves, which is a fundamental feature of relationships. The theory seeks to show how this is negotiated in relationships and how it is influenced by cultural expectations—for instance, our expectation that openness is a feature of “good” relationships. Both mothers and daughters are dealing with this and responding to the tensions. For instance, the tension between revelation and concealment is very much a part of the eating disorder experience, and relational dialectics theory could help researchers explore how this tension is managed in family relationships where eating disorders are present. Additionally, because there are two individuals involved, a mother and her daughter, it would also be beneficial to look at both of their competing interests involved in the communication process in regards to an eating disorder. Relational Dialectics Theory (Baxter, 2015) would allow for an examination of mother-daughter communication to consider how tensions between openness and protection are foundational components of relational experience and how these tensions manifest uniquely in relationships when a daughter experiences an eating disorder.
It would also be beneficial for future research to consider how “therapy-talk” influences daughters’ narration and/or reframing of their eating disorder experience and relationship with their mothers. This study identified that the participants used “therapy-talk” when describing their experiences, but future research could dig deeper to reveal both the benefits and implications of this feature in the communication process. The communication techniques and terminology taught in therapy provide daughters the means for describing an eating disorder experience, while mothers are not provided these same techniques and terminology and therefore do not communicate with their daughters in the same manner. Exploring how therapy-talk hinders and/or helps the communication process for mother and daughters would be a worthwhile avenue for eating disorder research to take.

Conclusion

Dealing with an eating disorder’s impact on relationships is a highly individualized experience and each of the women in this study demonstrated disclosure, deception, and perception of family environment using their own unique narrative. Despite variation in the participants’ eating disorder experiences, overall, participants’ narrated similar themes of disclosure, deception, and family environment. Across their interviews, women discussed their decision to not disclosure in order to manage their own personal protection and the protection of the mother-daughter relationship, to manage avoiding negative consequences, and to manage privacy and identity.

Furthermore, participants shared similar narratives on the topic of deception. This study found that deception became a normalized act for participants due to daughters’ perception that deceit was acceptable within their family unit and because of the frequency at which daughters were performing deceptive practices. Knapp (2009) explains how some lies are benevolent
and/or altruistic in nature because they are used to support, protect, or sustain the relationship of the person being lied to. In correspondence, daughters in my study explained that deception was used to preserve their mother-daughter relationship and to protect themselves, which often resulted in restricted interactions with their families.

Previous research suggests that better family functioning can result in better relationships and communication within the family unit, whereas dysfunction in the family can manifest itself in a variety of different ways such as a child's development of an eating disorder (McDermott, 2002). This study suggests that while the dysfunction within a family can result in a daughter's development of an eating disorder, that in turn, the daughter's eating disorder will affect the rest of her family members and the quality of their relationships.

Due to the complexities of the illness, both mothers and daughters struggled to understand and explain their thoughts and feelings toward each other. Additionally, those misunderstandings were related to daughters’ entanglement in a vicious cycle of non-disclosure and deception. This study demonstrates the importance of reasoning behind disclosure and deception in relationships impacted by an eating disorder. In consideration of intra and interpersonal management as well as family environment, specifically focused on daughters’ perceptions of their mothers, this study revealed rationale behind the complexities of developing an eating disorder.

Future research may provide information about the competing tensions and cultural expectations surrounding communication involved in mother-daughter relationships impacted by eating disorders. However, part of what is most interesting is that this study reveals that disclosure and deception, which both undermine the relationship in many ways, are also done in the service of supporting the relationship. Non-disclosure practices were committed in order to
preserve the mother-daughter relationship, to avoid negative consequences within that relationship, and to manage privacy/identity. In correspondence to prior literature, deception was performed in an altruistic manner to support, protect, or sustain the relationship of the person being lied to. While eating disorders are highly individualized experiences, this study revealed commonalities among participants who performed disclosure and deception practices in an attempt to sustain their relationships with their mothers.

This study revealed reasons for non-disclosure in close relationships, even though the cultural expectation is that “good” relationships consists of sharing everything with one another, which is not always the case. Similarly, deception was performed to portray the image of a “good” mother-daughter relationship, when, in reality, the relationship was operating on lies from either the daughter or her mother and sometimes both. Family environments also played a role in daughters’ perception of “good” relationships. Daughters’ deception resulted in restricted interaction with family in order to sustain eating disorder behaviors and to give the appearance that they had a “good” family relationship; while in reality, the daughters’ need to be deceitful demonstrated the lack of trust, honesty, and communication within their family unit. Daughters’ perception of their family environment was related to their decisions not to disclose and to commit deception, all of which manifested in the form of an eating disorder and were sustained in an attempt to enact a “good” mother-daughter relationship.
References


doi:http://dx.doi.org.colorado.idm.oclc.org/10.1080/1047840X.2015.954664


doi.org/10.1080/10640260290081777


doi: 10.1002/eat.22164

Appendix A.

Interview Questions

1. Ask R [Respondent] to tell me about the relationship with their mother. What it was like growing up with this person as their mother? Was your mother warm toward you? Would you describe your past relationship with your mother as being close? What about your current relationship?

Disclosure

2. How did you go about telling your mother about your eating disorder? How did your mother react to the news of your eating disorder? Do you believe your mother knew about or had suspicions of your eating disorder before you explicitly told her?

3. Aside from sharing information about your eating disorder, did you feel comfortable talking about deeper, more sensitive, personal issues with your mother prior to developing an eating disorder? How do you feel about talking about these types of things now with your mother?

4. Were there things you felt more comfortable disclosing about your eating disorder? What were those types of things? What did you not feel comfortable talking about your eating disorder with your mother?

5. What felt most difficult about sharing things about your eating disorder with your mother? Why?

6. Tell me about a time when you disclosed something about your eating disorder to your mother and she reacted positively. Do you know or can you guess why she reacted this way?

7. Tell me about a time when she responded negatively. Do you know or can you guess why she reacted this way?
Deception

8. Before you developed an eating disorder, did you feel like you kept things or were at all secretive toward your mother?

9. Were you conscious that you were hiding things/being secretive toward your mother when you were struggling with your eating disorder?

10. Tell me about a time when you consciously hid a behavior from your mother? How did that make you feel?

11. Did you notice yourself hiding things less or being less secretive once your mother knew you had an eating disorder? If yes, why was this so?

12. How do you feel about sharing things and/or acting open and honestly now that you are in recovery? Do you still feel the need to hide or keep things private from your mother? What types of things? Why do you think this is?

13. Is there anything else you would like to share with me about your experience of having an eating disorder and/or your relationship with your mother?
Appendix B.

Recruitment Email

Hello,

My name is Rachel Murray and I am an Honors student in the Communication Dept. at the University of Colorado at Boulder. I am conducting research for my honors thesis project about the mother/daughter relationship, disclosure, and deception in regards to the participant's past experience with an eating disorder.

To be eligible to participate in this study you must:

- be over the age of 18

- be willing to be interviewed (will take 45-60 minutes)

- be in recovery from your eating disorder and in a place where you feel comfortable and secure talking about your experience and your relationship with your mother

If you are interested in participating and would like further information about the interview questions and setting up a meeting place to conduct the actual interview, please contact me at this email address: rachel.murray@colorado.edu

I look forward to meeting those interested and appreciate your participation.

Best,

Rachel Murray
APPROVAL

19-Dec-2016

Dear Rachel Murray,

On 19-Dec-2016 the IRB reviewed the following protocol:

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<th>Initial Application</th>
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<td>Title:</td>
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The IRB approved the protocol on 19-Dec-2016.

Click the link to find the approved documents for this protocol: Summary Page Use copies of these documents to conduct your research.

In conducting this protocol you must follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,
Douglas Grafel
IRB Admin Review Coordinator
Institutional Review Board