Master's Project:

Factors Leading to Conflict in Lay Health Behavior Interventions With Family Members and Friends

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Abstract

To identify factors that contributed to conflict in health interventions between family members and friends, ten individuals who had intervened in their loved ones' health behaviours and four individuals who had received health behaviour interventions from their loved ones were interviewed about conflict experienced in these experiences. The data were analyzed qualitatively. Associated with more conflict occurring from interventions were: relationships that contained conflict before the interventions; interventions with more than one intervener; interventions occurring between family members from different generations; and interventions occurring within one or two interactions. Unrelated to the occurrence of conflict from health interventions were: the intervener's demeanour during the intervention; specific changes that the intervener would advise making in hindsight; and whether the recipient changed the targeted behaviour. Recommendations for further research include interviewing both parties to the same intervention and studying the influence of a variety of targeted health behaviours on conflict in health interventions.

Factors Leading to Conflict in Lay Health Behavior Interventions With Family Members and Friends

Bill, 65, has smoked a pack of cigarettes per day for over 40 years. His wife, Joan, 62, is deeply concerned that Bill's smoking is going to lead to cancer, emphysema, or a variety of other ailments, in addition to the impact that second-hand smoke is having upon her and has had upon their children. Joan recently read a newspaper article reminding her of the dangers of smoking and wants to find a way to talk to her husband about quitting smoking, but is at a loss as to how to approach that discussion. She knows that Bill is addicted to smoking and she recalls that comments she has made to him over the years about his smoking have resulted in arguments and tension between them – Bill disagrees that his smoking is a problem and has told Joan that he does not appreciate her criticism about it. Joan is thus hesitant to begin a conversation with Bill about his smoking; she fears that an intense argument about it will damage their relationship irreparably and is not confident that a discussion about it would result in Bill quitting smoking.

Poor health causes conflict between loved ones. Friends and family members experience distress when their loved ones are in poor health (Gilbert, Shaw, & Notar, 2000; Edwards & Clarke, 2004; Tempier, Boyer, Lambert, Mosier, & Duncan, 2006; Marshall, Bell, & Moules, 2010). At the same time, they have considerable influence on one another's health behaviors, including substance use and weight control habits (Biddle, Bank, & Marlin, 1980; Andrews, Tildesley, Hops, & Li, 2002; Eisenberg, Neumark-Sztainer, Story, & Perry, 2005; Leatherdale & McDonald, 2005; Wouters, Larsen, Kremers, Dagnelle, & Geenen, 2010).

A large literature base (Balls and Eisenberg, 1986; Butler, Pill & Stott, 1988; Searcy & Eisenberg, 1992; Westmaas, Wild, & Ferrence, 2002; Park & Gaffey, 2007; Edvardsson, Edvardsson & Hörnsten, 2009) has assessed the impact of people's interventions in their loved ones' health behaviours. For instance, relevant to the above case of Bill and Joan, scholars have found that higher self-efficacy (Grembowski, Patrick, Diehr, Durham, Beresford, Kay, & Hecht, 1993) and use of a collaborative intervention approach rather than an advice-giving intervention approach (Miller, Benefield, & Tonigan, 1993; Tyler & Horner, 2008) may motivate Bill to change his behaviour. However, despite the research documenting the conflicts that can accompany poor health, little literature exists to advise Joan on how to preserve her relationship with Bill when she tries to intervene in his smoking. The current study aims to shed light on the impact of health behaviour interventions on conflict in the relationship between the two parties, i.e., the intervener and the recipient. The project examines interventions in friends' and family members' health behaviors from a conflict resolution perspective with the aim of identifying elements within these interventions that lead to conflict between the involved parties.

Health Problems Elicit Conflicts among Loved Ones

The poor health of a loved one can significantly impact people's lives. For instance, in cases of mental illness, patients' families struggle in several capacities, sometimes experiencing more anguish than the afflicted individuals (Marshall, Bell, & Moules, 2010). Caring for a loved one who is afflicted with a mental illness can become a burden for the family and can lead to social stigmatization toward both the patient and his or her family members (Marshall, Bell, & Moules, 2010). Feelings of shame and guilt can also affect the family members of individuals who have mental illnesses (Corrigan & Miller, 2004).

Various other health problems can also negatively impact patients' family members. For instance, after cancer diagnoses, patients and their families are at risk for both clinical depression and anxiety (Edwards & Clarke, 2004). Parents of children afflicted with eating disorders have reported experiencing emotional upheaval, familial disintegration, social isolation, and conflicts with other family members as a result of the illness (Gilbert, Shaw & Notar, 2000; Hillege, Beale & McMaster, 2006). In one study, the spouses of men at risk for problem drinking reported more psychological distress than did spouses of men not at risk for problem drinking (Tempier, Boyer, Lambert, Mosier & Duncan, 2006).

The negative consequences of a family member's health problems can go beyond influencing the individual family members to eliciting family conflict (Carr & Friedman, 2006; Gustafsson, Bjorksten & Kjellman, 1994; Wamboldt & Wamboldt, 2000; Spanos, Klump, Burt, McGue, & Ianoco, 2010). When individuals are injured or ill, family members and close friends sometimes take on caregiving roles. Patients, however, may have different priorities and perspectives than their caregivers when it comes to managing their illnesses (Holden, 1991). For instance, when one partner falls ill or is injured, each partner's boundaries and roles in the relationship are renegotiated. These role changes, in addition to adjusting to and coping with the illness or injury itself, can lead to conflict in the relationship (Rolland, 1994).

Conflict can also emerge when the patient's need for a caregiver declines. For instance, a study concerning teens with spina bifida found that conflict can occur as adolescents with chronic illnesses take over responsibility of their own medical regimens from their parents (Stepansky, Roache, Holmbeck & Schultz, 2010). Caregivers' perceptions of the patient's responsibility for his or her illness can also cause conflict.

Lobchuk, McClement, McPherson and Cheang (2008) found that informal caregivers who perceived that their lung cancer relatives were more responsible for controlling their illnesses were more likely to be angry at those patients, and were consequently at risk for providing suboptimal care.

These findings that poor health can cause conflict between loved ones suggest two things. For one, the occurrence of conflict as a result of an individual's health means that loved ones have a vested interest in improving one another's health. Secondly, these findings suggest that relationships between loved ones may be strained before a health intervention begins. An intervention may be occurring in a context of conflict because of the health problem.

Loved Ones Influence Health Practices

Both friends and family members can be influential with regard to individuals' health behaviors. Especially during adolescence and young adulthood, friends can affect such health behaviors as smoking cessation (Leatherdale & McDonald, 2005), dating and sexual practices (Harper, Gannon, Watson, Catania, & Docini, 2004), snacking (Wouters, Larsen, Kremers, Dagnelle & Geenen, 2010), alcohol consumption (Biddle, Bank & Marlin, 1980), weight control behaviours (Eisenberg, Neumark-Sztainer, Story & Perry, 2005) and drug use (Andrews, Tildesley, Hops, & Li, 2002). Friends can even be influential in a passive way: Labouvie (1996) found evidence of young adults improving their own substance use practices simply by choosing to spend time with new peer groups that engage in healthier behaviours than their previous, less-healthy, peer groups.

Parallel results have been observed in family members' influence in health behaviours. For instance, in a school-based drug prevention effort that involved both

children and parents, children welcomed their parents' involvement and found their parents' advice influential in making their own drug-related decisions (Velleman, Mistral, & Sanderling, 2000). A study by Westmaas, Wild and Ferrence (2002) found evidence that family members and spouses also affect, directly or indirectly, a smoker's decision to quit smoking. Because of the influence that family members and friends have on health behaviors some treatment techniques, such as the Maudsley Method for treating eating disorders, use patients' families as important resources for supporting patients' recovery (Le Grange & Lock, n.d.). These findings suggest that individuals have the potential to influence their loved ones' health behaviours.**Help is Not Always Appreciated**

Recipients interpret health intervention by relatives or friends in myriad ways. Worchel (1984) cautions that helping may strain relationships and lead to hostility between parties. Recipients of help might perceive the intervening individual as having an ulterior motive for offering help, as helping draws boundaries between the donor and the recipient, labeling them, creating psychological distance between them, and establishing a power hierarchy in the relationship (Worchel, 1984). Worchel (1984) asserts that recipients should feel less threatened by receiving help rendered by a donor of higher status than by receiving help from a donor of equal or lower status. A donor of higher status is unlikely to gain power by helping a recipient of lower status, meaning that power acquisition is not a probable motive for helping. A donor of equal or lower status than the recipient, however, may be motivated to enhance his or her own power by offering help. Recipients may thus interpret an offer of help as an attempt by the helper to gain power in the relationship or as a criticism of them.

Recipients of help may have other negative reactions to receiving help as well. Under some circumstances, receiving help can negatively influence recipients' self-esteem (Fisher, Nadler & Whitcher-Alagna, 1982),. Nadler, Fisher and Streufert (1976) found that participants who received aid from others who were dissimilar to them reported more positive self-perceptions and higher self-perceived intelligence than participants who did not receive aid from dissimilar others. Additionally, participants who received aid from others who were similar to them reported more negative self-perceptions and lower self-perceived intelligence than did participants who did not receive help from a similar other. In contrast, Schneider, Major and Luhtanen (1996) found that black participants who received help from white peers reported lower competence-based self-esteem than white participants and than participants of either race who received no help. Worchel, Wong and Scheltema (1989) concluded that helping will elicit a negative response from a recipient when self-image is a concern to them. These findings illustrate that efforts at helping can damage an individual's self-esteem. Combined with the findings that interventions may be interpreted as means of manipulating power in a relationship, it is clear that interventions have the potential to damage individuals' relationships.

Health Professionals Anticipate Conflict with Patients

Health behavior interventions are daunting even to professionals in the medical field. Physicians, nurses and nutritionists have all expressed discomfort with broaching the subject of their patients' health behaviours. Although the present project concerns interventions between individuals who are not health professionals, the challenges faced by health professionals can be useful in considering individuals' responses to health

interventions and the interactions that family members and friends might face in their health interventions.

Coleman, Murphy and Cheater (2000) interviewed physicians, who reported to be afraid of harming the doctor-patient relationship by raising the topic of a patient's smoking. The physicians were especially unlikely to mention the subject with new patients or when they had poor relationships with patients. They preferred to know the patient before mentioning their smoking to them, since in their experience, discussions about smoking have triggered confrontations with some patients.

Along a similar line, Chamberlin, Sherman, Jain, Powers, & Whitaker (2002) found that nutrition counselors did not feel comfortable telling parents that their children were overweight or obese—some even avoided using the words "overweight" and "obese" in an effort not to offend parents. They preferred to use weight charts or statistical information to avoid being perceived as judgmental. Other studies also show that, due to the sensitivity of the issue, some general practitioners and nurses altogether avoid bringing up a child being overweight or obese (Edvardsson, Edvardsson, & Hörnsten, 2009; King et al, 2007). In Edvardsson et al.'s (2009) study, nurses felt that presenting such sensitive information might lead to denial, defensiveness, excuses, and even aggressive responses by parents. Nurses and general practitioners feared that damaging their relationships with parents would discourage them from bringing their children back to health centers in the future, putting the children at higher risk for further health problems (Michie, 2007). Other studies on a similar issue show that these health professionals might be right; for instance, some smokers have indicated that they have avoided seeking medical help because they anticipated that their doctors would talk to them about smoking (Butler, Pill & Stott, 1988).

It is evident that medical professionals, despite their extensive training, experience considerable conflict in intervening in patients' health issues. People without medical training, such as family and friends, may be at a further disadvantage in offering health-related help. Such interventions could lead to increased conflict between family members and friends.

Family Members' and Friends' Experiences with Conflicts in Health Interventions

Despite the potential negative consequences of health interventions, family members and friends still attempt to help their loved ones improve their health behaviours. People actively search for health related information relevant to their own or loved ones' health issues (Abrahamson, Fisher, Turner, Durrance, & Combs Turner, 2008). When individuals have serious illnesses, different family members sometimes take on specific roles in seeking such information. For instance, in a study of families at risk for hereditary cancer, participants identified specific roles for each family member as "gatherers", "disseminators", or "blockers" of health information (Koehly, Peters, Kenen, Hoskins, Ersig, Kuhne et al, 2009).

In turn, patients value friends and family members for their support. Robbins and Tanck (1995) found that university students preferred turning to friends and family members, rather than to psychologists or members of clergy, to manage health-related stress. These participants considered talking to friends to be the most helpful coping behaviour, and talking to family as the second most helpful coping behaviour. Patients within the family-centered Maudsley Method for treating eating disorders have voiced appreciation when their parents demonstrate their support by educate themselves about their children's conditions (Treasure, Macdonald & Goddard, 2010).

Still, despite the best intentions and potential positive influences, helping loved ones also has the potential to cause conflict. Friends and family members' interventions and advice could be perceived as being excessively critical of their loved ones, engendering defensive responses from them. Searcy and Eisenberg (1992) found that among siblings, defensiveness is more likely to occur when recipients of help are of higher status and higher perceived competence than donors of help. Defensive reactions are also more likely to occur when the siblings' relationships are more conflicted and when recipients do not expect the help offered by their siblings (Searcy & Eisenberg, 1992).

Another potential contributor to conflict in interventions between family members and friends is a discrepancy between patients' expectations of their loved ones and their loved ones' actual helping behaviours. For instance, in a study among cancer patients (Dakof & Taylor, 1990), the participants distinguished among emotional support, informational support and tangible support that they had received over the course of their illnesses. The respondents expected different types of support from their family members than they expected from their significant others and from their friends. There was, however, little consensus among patients as to what types of behaviours from which members of their networks were seen as supportive and unsupportive. The types of support that patients expect can also vary depending on the targeted health behaviour. For example, the needs and expectations of patients with a chronic non-lethal illness are different from the needs and expectations of cancer patients (Martin, Davis, Baron, Suls & Blanchard, 1994).

Treasure, Macdonald, and Goddard (2010) echo patients' lack of consensus about what kinds of family support were helpful. They describe a case in which the patient who

had an eating disorder resisted her parents' efforts at helping her, only beginning to recover once her parents backed off and she came to view her recovery as her own responsibility. In other cases, patients with eating disorders have reported that conversations about their health came more easily after their parents learned about eating disorders, while still others considered their parents' use of this new knowledge to be patronizing and condescending (Treasure, Macdonald, and Goddard, 2010). These findings illustrate the difficulties that interveners might encounter in predicting how a recipient would prefer to be helped.

As demonstrated by the review of the literature, researchers have found that: (a) compromised health causes conflicts in families; (b) family members and friends can be influential in individuals' health behaviours; (c) individuals are willing to help their loved ones; (d) relationships can be damaged by attempts at helping; (e) individuals value support from their loved ones; (f) medical professionals anticipate conflict resulting from attempts to intervene in patients' health behaviours; and (g) patients want different kinds of help from different people in their lives. To date, however, the role of conflict in friends' and family members' health behaviour interventions seems not to have been a focus of research. There were some insights as to factors that might have had certain impacts on the interventions and their parties, although the current study did not have any specific hypotheses.

Factors that Influence the Impact of Health Interventions on Conflict

Relationship-Related Factors

Characteristics of the intervener's and the recipient's relationship can influence the intervention's dynamics. Within sibling relationships, older, female siblings have been

found to elicit the least defensive responses when they attempt an intervention (Searcy & Eisenberg, 1992). Also, people with previous experience and training are more likely to engage in other interventions - King, Vidourek, and Strader (2008) found that students who had previous training or experiences with helping suicidal peers were the most likely to report that they would be able to ask a friend if he or she was suicidal, and to encourage their friends to see mental health professionals. In group alcohol interventions in college-aged participants, same-gender group interventions promoted deeper disclosure and greater transparency among participants than mixed-gender groups (LaBrie et al, 2007). Same-gender health behavior interventions may put both parties more at ease, allow for greater information exchanges, and perhaps engender less conflict. Overall, more conflict can be expected in interventions in which a younger and/or male sibling is an intervener; in interventions in which the intervener has no training or prior experience with such interventions; and in mixed-gender interventions.

Individual-Related Factors

Men and women differ in how they respond to health interventions by family and friends. Women have been found to be more receptive to help than men (Balls and Eisenberg, 1986) and to report lower levels of defensiveness when help is offered (Searcy & Eisenberg, 1992). However, a different study found smoking cessation advice from loved ones to reduce men's but not women's smoking, with the researchers offering the explanation that women may interpret their loved ones' advice and concern as criticism of their lifestyles (Westmaas, Wild, & Ferrence, 2002). According to these results, some women may be expected to react more negatively to health behavior interventions than men.

Scholars have also studied the effects of age and need on recipients of help. Since younger participants in one study reported using more support sources than older participants (Mills & Davidson, 2002), younger individuals may be more receptive to interventions than older individuals. While research on gender has found mixed results, interventions with younger individuals may produce less conflict.

Intervention-Related Factors

The manner in which an intervener offers help can be of paramount importance. Studies assessing the relationships between doctors and patients elucidate this issue. One qualitative study of smokers and former smokers who had recently quit found that smokers did not appreciate physicians elaborating on the consequences of smoking, as they already knew what those consequences were (Butler, Pill & Stott, 1988). These participants preferred interventions that were conveyed in respectful tones, avoided preaching, demonstrated support and concern, and recognized each patient's individuality. Similarly, Miller, Benefield, and Tonigan (1993) found drastic differences in doctor-patient interactions comparing alcoholics in directive therapy programs and alcoholics in client-centered therapy programs: "Clients in the directive style were more likely to argue with, interrupt, and ignore … the therapist. They were also more likely to deny … and less likely to acknowledge … problems" (p. 458). Tyler & Horner (2008) similarly found that interventions that rely solely on advice-giving are frequently met with resistance from patients, calling for a more collaborative approach to encourage healthy lifestyle behaviours.

Voluntary interventions may also lead to less conflict than involuntary interventions. College students who were mandated to participate in an alcohol training

program were more defensive about their participation than were their peers who participated in the program voluntarily (Palmer, Kilmer, Ball & Larimer, 2010). Rollnick, Kinnersley and Stott (1993) noted that even when it comes from medical practitioners, unsolicited advice is often met with resistance from patients. These findings illustrate that interventions that operate on the basis of advice-giving and that are involuntary may lead to more conflict than collaborative, voluntary interventions.

Behaviour-Related Factors

Interventions' outcomes can also vary across the health behaviours that are targeted. In one meta-analysis, social support was found to be associated with increased vigorous exercise in breast cancer survivors and with smoking abstinence in head or neck cancer survivors (Park & Gaffey, 2007), implying differences inherent to the behaviours involved. While these outcomes concern behaviour change, the differences between them are sufficiently broad that it is conceivable that the occurrence of conflict could vary according to the targeted behaviours as well.

The recipient's defensiveness could also be influenced by the degree of his or her attachment to the behaviour. After all participants were presented with scientific information about alcohol use, those who consumed alcohol were more likely than those who did not consume alcohol to respond defensively to questions about whether they considered alcohol use to be an important problem or a risk to them personally (Leffingwell, Neumann, Leedy & Babitzke, 2007). Sherman, Nelson and Steele (2000) similarly found that participants who engaged in a behaviour were more defensive in their responses to information linking that behaviour to a major health risk than were participants who did not engage in the same behaviour.

Finally, the recipient's perceived need for help could also influence how he or she interprets the intervention: Worchel (1984) posits that in situations in which help is necessary for the recipient's well-being, the help tends to be met with more gratitude than when the recipient's need is more ambiguous. Interventions that aim to change lower-risk behaviours may then lead to more conflict than interventions that target higher-risk behaviours.

These findings suggest that interventions targeted at behaviours to which their recipients were more attached and interventions aiming to change lower-risk behaviours could be expected to engender more conflict between the intervener and the recipient within the intervention.

Overview of the Current Study

This qualitative interview study examines health behaviour interventions between family members and friends with the goal of identifying elements of these interventions that led to conflict between the parties. Although some literature has examined aspects of this question, most has focused primarily on the impact of interventions on behavioural change rather than on the parties' relationships. As evidenced in this literature review, conflict is a common outcome of health interventions among family members and friends. This project adopts an interview methodology to assess the impact of health interventions on relationship conflict and to identify conditions that are more likely to lead to interpersonal conflicts in the context of health interventions. By interviewing both interveners and recipients of health interventions, this study aims to contribute to a deeper understanding of the impacts that these interventions can have on interpersonal relationships.

Method

Participants. Semi-structured interviews were conducted with 14 students at the University of Massachusetts Boston. Participants were recruited using a combination of email and poster advertisements. The advertisement is shown in Appendix A. I interviewed 10 interveners and four recipients of health behavior interventions. The imbalance in numbers of interveners and recipients reflects difficulties in recruiting recipients. Potential participants were told that they could describe interventions targeted at any behavior that caused the intervener concern for the health of his or her loved one.

Four participants were men and 10 were women. Participants' ages ranged from 13 to 52 years old at the time of their interventions. All four of the interviewed intervention recipients were women. Two participants were African-American; two were Hispanic/Latino; one self-identified as "other"; and the remaining nine were White.

The interview. The semi-structured interview was constructed based on the aforementioned literature. Some questions were asked only of interveners, some questions were asked only of recipients, and some questions were asked of both interveners and recipients. The interview questions are included in Appendix B. Interviews were conducted at the University of Massachusetts at Boston and were recorded using a Sony IC Recorder and transcribed using Express Scribe software. The interviews' durations ranged from 15 to 45 minutes. Each interview began with the following introduction:

> When people become concerned about the health of a family members or friend – whether their concern is about substance use, lifestyle choices, adherence to medical advice, mental health, or any number of other health-related issues - they often want to try to help this person to improve their

> health. Sometimes these attempts at intervening are helpful, sometimes they are not, and sometimes what happens is that the intervention ends up damaging the relationship that existed between the people involved in it. You've indicated to me that you have been involved in an intervention with a family member or a friend of yours. Can you share your intervention experience with me?

Participants were first asked to "share their intervention experiences" so that they were free to discuss the aspects of the interventions that were most salient and important to them. Participants who intervened in others' health behaviors were then asked about their intentions and motivations for doing so; whether they had personal experience with the health behaviours that were the subjects of their interventions; and about their preparations for the intervention. Participants who were the recipients of health behavior interventions were asked how they had felt about the interventions; how they had reacted to the interventions; why they felt the intervener(s) had intervened; about their relationships with the intervener(s); and whether they changed the targeted health behaviours as a result of the interventions.

At the end of the interviews, participants were asked for demographic information and whether they wished to add anything to their intervention stories. Once the interview was over, each participant read a debriefing form (included as Appendix C).

Data analysis. The data were analyzed using ATLAS.ti 6 qualitative data analysis software. During the analysis, one letter and one number was used to identify the participants. The letter "A" signifies that the participant was an intervener whereas the

letter "B" signified that the participant was a recipient. The numbers were based on the order in which the participants were interviewed.

The coding scheme, initially based on the reviewed literature and then shaped by the content of the interviews, can be found in Appendix D. In the results section, I will first discuss the factors that were associated with conflict due to the interventions, followed by factors that were not associated with conflict..

Results

First, I will outline the interventions' characteristics, the health behaviours targeted, the parties' relationships to one another, and the time frames in which the interventions took place. Next, I will describe the impact of health interventions on relationship conflicts (e.g., long-term, short-term and no conflict) across the 14 interventions. Finally, I shall present those factors that were related to conflict and those factors that were not related to conflict in the interventions. The factors that I assessed in this study are grouped in four categories – Individual, Relationship, Intervention and Behavior.

Characteristics of the Interventions

Eight of the interventions were cross-gendered, four interventions occurred between females, and two interventions occurred between males. Two recipients of interventions had since passed away; one's death was a direct result of the health behavior that the intervention had intended to change. Two interventions occurred between individuals of different ethnicities, whereas the rest occurred between individuals of the homogeneous ethnicities. The health behaviors that were targets of the interventions included smoking, seeking or adhering to medical treatment, lifestyle choices (including

diet and exercise and diet pill consumption), mental health issues (in these cases, dementia, suicidal threats and anorexia nervosa), and drug use and alcohol consumption.

One unexpected finding was that a significant number of the interventions described took place over more than one or two interactions. Six interventions occurred as single events and two occurred over two interactions. One intervention occurred as a single event and after the recipient changed the behaviour her health unexpectedly required that her boyfriend intervene further; however, she discussed the initial intervention in her interview. Five interventions occurred or continue to occur on a longer-term basis. One described his interventions as a "checking up" on his sister (A2), and one recipient described her father's intervention in her health as having taken place "throughout my adult life" (A3). Another describes her approach as unfolding over stages, saying that since the recipient has yet to change her behaviour, "it is getting to the point where I'm gonna be firmer" (A8). These longer-term interventions shall be referred to as "continuous" interventions.

Three participants also reported their interventions occurring partly on a long-distance basis. In two of these cases, the parties resided in different states; in one, the parties resided in different countries. All of these interventions were continuous ones and involved face-to-face interactions as well as long-distance conversations. Two of the three participants who discussed long-distance interventions were unsure as to whether their intervention efforts had resulted in the recipient changing his or her behaviour; uncertainty about the recipient's behaviour change was present in only one other intervention.

Conflict across Interventions

Conflict occurred in 12 of the 14 interventions that were described. Four interventions resulted in long-term conflict, eight resulted in short-term conflict, and two resulted in no conflict.

Long-term conflict. Four respondents, including two interveners and two recipients, reported long-term conflicts occurring as a result of the interventions. Three of these interventions occurred between family members and one was between friends. Participants who experienced long-term conflict reported that the negative impact of the conflict in the relationship lasted for several years after the intervention. For instance, following an intervention about drug use, the recipient kicked the intervener out of their shared apartment and did not speak to him for eight years (A6). Another intervener reported that after intervening in his elderly mother's behaviour, she lost trust in him and distanced herself from their relationship. This relationship never recovered and the recipient has since passed away. One recipient, whose father intervened continuously when she gained weight at college, reports that in addition to trying to avoid coming home:

> I would respond to not wanting to gain weight so as to not sort of get that negative intervention by my father by the use of diet pills, which was one way to sort of maintain a healthy body weight, and that sort of continued on and off after college as well. And so what happened with that is that my metabolism totally got screwed up, and so when I would gain weight realizing that these were unhealthy I would be at a body size that maybe I had never been or had - was unfamiliar to my father or to me, and … it was a vicious cycle. (B1)

This participant's intervention unfolded over eight to nine years. The vicious cycle she describes impacted her relationship with her father significantly.

These cases illustrate the negative long-term effects that can occur as a result of interventions between friends and family members, causing long-term damage to the their relationships .

Short-term conflict. Eight participants, including six interveners and two recipients, reported that the interventions they experienced caused short-term conflict. Both of the interventions between significant others resulted in short-term conflict. Participants who had experienced short-term conflict as a result of their interventions described recipients briefly cutting off communication with interveners (A1); having arguments (B2, B4); feelings of "distance" (A4, A7, B1) and "resentment" (A3, A4), and experiencing a sense that trust had been violated (A1, A4). Two patterns of short-term conflict were reported in these interviews. One pattern consisted of conflict occurring and the parties' relationship recovering; in the other pattern, conflict occurred but did not significantly impact the parties' relationship.

Recipients and interveners both described relationships that had experienced the first type of short-term conflict, the type in which the relationship recovered from conflict. One intervener, speaking about short-term conflict in an intervention with her sister, said that as "she got a bit older, she realized that, you know, it's her best interest that we were worried about, so I think now we're - we're a lot better, the whole family" (A7). A recipient of an intervention describes that "in the moment, like, I was really annoyed and I wasn't afraid to tell [the intervener] that I was annoyed, in probably not the nicest language, but, you know, hindsight is 20/20, and after … I was so grateful" (B4). These interventions

caused conflict, but respondents describe that their relationships have recovered from that conflict and in some cases, that the interventions have led to positive changes in their relationships.

The other type of short-term conflict included relationships that were not significantly impacted by the interventions. One intervener described such an intervention as: "this [intervention], it may not have helped but it's not the reason why we have long-term conflict with each other" (A9). Another explained that his continuous intervention initially engendered conflict between him and the recipient, but that "after awhile, he took to me" (A5). These interventions evoked conflict, but this conflict did not damage the relationship.

Short-term conflict resulted from the majority of the interventions described; in some cases it damaged the parties' relationship temporarily, and in others, it did not damage the relationships.

No conflict. Two participants, both interveners, reported that their interventions did not result in conflict. These interventions had many commonalities. Both of the interventions occurred between friends and took place over several interactions. To the question of whether their interventions have caused conflict, both of these interveners answered "not yet" (A8, A10). Both of these interveners felt that their interventions had been ineffective, and both of them expressed that they intended to increase the intensity of their intervention efforts. One intervener who tried to persuade a friend to seek medical treatment said, "it is getting to the point where I'm gonna be firmer about making sure that she actually starts the process of … getting the appointments and … getting it taken care of, because she just can't keep putting it off" (A8). The other, who tried to intervene in a

friend's alcohol consumption, reported that she may reach a point at which she will tire of not being taken seriously when she broaches the subject of the recipient's drinking and that this will cause conflict between them (A10).

Both interventions that did not lead to conflict were continuous interventions between friends. Neither intervention had led its recipient to change the targeted health behaviour, and thus, both interveners intended to increase the intensity of their interventions. They both expected that conflict would result from their interventions becoming more forceful.

Positive Relationship Changes

Four respondents, including both parties who had experienced interventions between significant others, also reported distinctly positive changes in their relationships that occurred as a result of the interventions. One recipient shared that despite some short-term conflict at the time of the intervention, her relationship with her boyfriend has "gotten stronger", later adding that she felt that since the intervention, her significant other "became a lot more caring" (B4). The other respondent who had participated in an intervention with her significant other said that since the intervention, the couple has begun to talk about the future more (A3), and a participant who intervened in her friend's behaviour feels that her intervention has increased her friend's trust in her (A8). These examples illustrate that independent of conflict occurring, positive relationship changes can result from health interventions between loved ones.

Factors that Relate to Conflict in Health Interventions.

In this section, I will discuss the relationship between different facets of the interventions and the conflict due to these interventions. Next, I will explore the factors that were not related to conflict.

The factors related to conflict in health interventions are arranged in four categories: Relationship, Individual, Intervention, and Behavior.

Relationship factors. "Relationship" factors included two dimensions: (1) the type of relation between the intervener and recipient; that is, whether the parties were family members, significant others, or friends; (2) pre-intervention conflict in parties' relationships.

More conflict arose in interventions between family members than it did in interventions between friends and in interventions between significant others. Eight interventions were targeted toward family members (parents, children or siblings), four occurred between friends, and two between significant others (one married couple and one dating couple). Long-term conflict occurred in three interventions between family members (A4, B1, B3), while short-term conflict occurred in the remaining five family interventions (A1, A2, A7, A9, B2). Both interventions between significant others caused short-term but not long-term conflict (A3, B4). One intervention between friends caused long-term conflict (A6); one engendered short-term conflict (A5) and the remaining two reported that their interventions had not "yet" resulted in conflict (A8, A10).

Within families, intergenerational interventions caused more long-term conflict than did interventions between siblings. Of the five intergenerational interventions, two caused long-term conflict and the other three led to short-term conflict, regardless of which party, the member of the older or the younger generation, was the intervener and which

was the recipient. Three interventions occurred between siblings; of these, one caused long-term conflict and two caused short-term conflict. Perhaps anticipating that intergenerational interventions could cause more conflict, an intervener who was trying to persuade his younger sister to adhere to medical advice stated that he made a specific effort to avoid presenting himself as "a boring older brother that thinks he's her dad" (A2).

The interventions were also more likely to cause conflict when the parties' relationships had contained conflict before the interventions. Five respondents mentioned that conflicted elements of their relationships with the other parties had existed before the interventions. In these respondents' interventions, long-term conflict occurred in three interventions and short-term conflict occurred in the remaining two. One intervener said that before the intervention, "our relationship had kind of gone sour over [the recipient's drug use], anyway" (A6). Another stated that "the historical relationship between me and him …. it's based on conflict, all of it, like, always" (A9), adding that the intervention was "not the reason why we have long-term conflict with each other". One recipient said of her relationship with her father, the intervener, "there were external circumstances that had already put strain on our relationship for a majority of my adult life" (B1), and another described her sisters' intervention as a catalyst for a heated discussion about different sources of conflict that were impacting their relationship (B3). Three of the four cases in which the intervention caused long-term conflict included separate conflicts within the relationship.

Overall, more conflict occurred in interventions between family members, especially from different generations, and in relationships that included conflict before the intervention.

Factors concerning the individuals involved in interventions

"Individual" factors included the following: (1) the intervener's prior training or professional experience in intervening; (2) the extent of the intervener's preparation for the intervention; (3) and the specificity of intervener's goals.

Less conflict occurred when the intervener had training or professional experience in intervening, which was the case for four interveners. Two interveners described professional intervention experiences, including working as a nurse with combative patients (A8) and military service managing large numbers of new recruits who would by times require intervention (A7). Two interveners had also received mediation training (A2, A3). Within these four parties' interventions, short-term conflict occurred in three and no conflict has thus far occurred in the fourth. No long-term conflict occurred in these interventions. In contrast, interveners who had no training in or experience with intervening conducted all of the four interventions that resulted in long-term conflict and the four remaining interventions that led to short-term conflict. Interveners with training in or professional experience with interventions were thus less likely to cause long-term damage to their relationships with their interventions' recipients than were interveners who had no such training or experiences.

Factors concerning interventions

"Intervention" factors included the followings: (1) the number of interveners; (2) the number of interactions in which the intervention took place; (3) intervener demeanour; (4) the intervener's use of external information; (4) types of changes that the intervener would make in hindsight; (5) the inclusion of a professional in the intervention; and (6) the interventions' precipitating factors.

Interventions with more than one intervener were consistently more conflict – prone than interventions with one intervener. In the current study, five interventions had more than one intervener. Of these, two resulted in long-term conflict and the other three resulted in short-term conflict. Results were more mixed among the nine one-on-one interventions. One recipient of a one-on-one intervention expressed her preference for having only one intervener, saying that she "would've felt ganged up upon" (B2) if more than one intervener had participated in her intervention. Another recipient related that she would have preferred a one-on-one intervention rather than the two-on-one intervention that she had received (B3). This result is especially significant considering that some interveners (A6, A8, A9) who had intervened by themselves wondered whether adding parties might have improved their interventions. These findings suggest that one-on-one interventions are less likely to lead to conflict than are interventions with more than one intervener.

Interventions that occurred over one or two interactions were associated with more conflict than were continuous interventions. Three of the six interventions that took place in the span of one interaction resulted in long-term conflict, and the remaining three led to short-term conflict. Both of the interventions that occurred over two interactions resulted in short-term conflict after one interaction and no conflict after the other. Of the six continuous interventions, one caused long-term conflict, three resulted in short-term conflict, and two had not led to conflict "yet". Although the main purpose of this project was not to identify aspects of interventions that lead to behaviour change, it seems useful to point out that interveners who carried out continuous interventions were much less likely to know whether the recipient changed the targeted behaviour following the intervention.

More conflict occurred when interventions were conducted over one or two interactions and in interventions with more than one intervener.

Factors concerning the targeted health behaviours

"Behaviour" factors included: (1) the intervener having had personal experience with the targeted behaviour; (2) whether the recipient acknowledged that his or her targeted health behaviour was a problem; (3) whether the targeted behaviour changed as a result of the intervention.

Only one factor concerning the targeted behaviour was related to conflict in health interventions. Interestingly and perhaps counterintuitively, an intervener having prior personal experience with the health behaviour was related to increased conflict in the intervention. Interveners in four interventions had personal experience with the behaviours that they were trying to change in others; two of these interventions resulted in long-term conflict and the other two led to short-term conflict. One intervener had stopped using drugs himself before intervening in his roommate's drug use; when asked whether his experiences had become a part of the intervention, he responded, "aside from the fact that he was calling me a hypocrite [*laughs*], um, not really" (A6). A recipient whose father intervened in her weight management describes that he tried to incorporate his own struggles with weight into the intervention: "he would try to sort of relate it to him, in a way, like 'see? I'm not perfect either'" (B1), but that his suggestions about the importance of managing weight were unclear to her. At one point she injured her back, and her father related that he injured his his back less frequently when he had been in good physical shape. The recipient was confused as to how to use this information: "I was like, 'okay… I get … that maybe they're related somehow … if you want me to get it you need to be way

more clear. Like, is this the line I'm supposed to be drawing?'" This intervention led to long-term conflict between the parties. One participant, a former smoker, intervened twice in her father's smoking behaviour. The first intervention caused some short-term conflict and following it, her father stopped smoking; however, he began smoking again after a stressful life event, and after the second intervention, he did not stop smoking. The intervener referred to her experiences in the intervention: "I did tell him that I knew how hard it was. That I understood. And that - and that I knew that what I was asking wasn't easy" (A1). She felt that incorporating this information may have been helpful in the first intervention, but it did not make an impact in the second intervention.

Interveners' failure to acknowledge that they had had personal experiences with the targeted health behaviour was a source of conflict in another intervention. The recipient felt that in her sisters' intervention regarding her alcohol consumption, the sisters failed to acknowledge that they had had similar experiences with alcohol as she had: "[W]e all went out every Friday and Saturday night and drank together, so I don't know if they had thought about their actions, that were the exact same as mine" (B3).

In eight interventions, interveners did not have personal experience with the behaviours they were attempting to change; six of these interventions led to short-term conflict and two did not result in conflict. Interventions in which interveners have personal experience with the targeted health behaviours (for instance, a former smoker intervening in a loved one's smoking behaviour) seem to be at an increased risk for resulting in interpersonal conflict.

In sum, the respondents described conflict arising more often in the following circumstances:

- parties were family members or significant others, particularly parties were parents and offspring
- there was more than one intervener
- the intervention took place within one or two interactions
- the recipient of the intervention did not agree that the targeted health behaviour was a problem
- the intervener had personal history with the targeted behaviour
- the intervener had no intervention training or experience (independent of having previously intervened in a loved one's behaviour)
- the intervener had previously intervened in the same health behaviour with another individual
- the parties' relationship was already strained or conflicted before the intervention

Facets of interventions that were not associated with conflict occurring as a result of the interventions will be discussed in the next section. All of the relationship factors studied were found to be related to conflict in interventions and thus, none appear in the following section. Characteristics related to individuals, to the interventions and to the targeted behaviour will be discussed.

Factors concerning the individuals involved in interventions

The extent to which interveners prepared for the interventions was not related to conflict occurring as a result of the interventions. Interveners varied considerably in their preparation for the interventions. One presented the recipient with his medical records and information about quitting smoking (A1), one gathered a group of the recipient's

most trusted friends and enlisted a facilitator to lead the intervention (A4), and one group of interveners ensured that one family member was absent at the time of the intervention (A7). Four interveners prepared by giving the intervention considerable thought (A3, A5, A8, A10), and three did not prepare – their interventions were spontaneous (A2, A6, A9). However, the type or extent of preparation was not correlated with conflict due to the intervention.

Interveners' goals as they approached their interventions were also unrelated to the occurrence of conflict. While interveners aspired to change the recipients' specific behaviours, nine of the ten interveners also stated such goals as persuading a recipient to be honest about the targeted health behaviour (A7), hoping to change "the complete disregard for his health and any concern that we have for his health" (A9), "[wanting] to change his thought process" (A5), and "[letting] them know that this can become a problem if they don't think it is a problem" (A10). Three interveners also expressed concerns that recipients' health behaviours were impacting them financially (A3, A6, A9) and one frankly stated, "I wanted him to look the way he looked when we first started dating" (A3), though that continuous intervention later became more health-focused. The type and specificity of the intervener's goals had no evident relationship with whether the intervention led to conflict.

Respondents' involvement in separate lay health behaviour interventions was also not related to conflict in the interventions described. Despite the occurrence of conflict in most of the interventions studied, ten respondents, both interveners and recipients, reported that they have been involved in other health behaviour interventions with family members or friends either before or since the ones they discussed in their interviews.

Three respondents, all interveners, had received interventions; eight respondents had been interveners, and two respondents had been in both positions. One intervener said that based on the intervention that she discussed in her interview, she would make a point of avoiding involvement in future interventions. Whether respondents participated in other lay interventions was not correlated with conflict occurring in the interventions they described; however, this phenomenon is separate from respondents having had formal training and professional intervention experiences, as was discussed earlier,.

Individual-related factors that were not associated with post-intervention conflict included the extent of interveners' preparation for the interventions, interveners' pre-intervention goals and interveners' involvement in other lay health behaviour interventions.

Factors concerning the intervention

Interveners' demeanours were salient to recipients but were not consistently related to the extent of conflict occurring in their interventions. Interveners adopted a wide variety of demeanors in the interventions. Most tried to tailor the intervention to the recipients' personalities:

> [T]he three of us [interveners] decided that we would be … cohesive and firm with the fact that we felt that he needed to quit [smoking], and that we would also, you know, be prepared … We had all of our facts and … he was a linear, logical person. … while he had a lot of love, he was not a very emotional type of guy, you know [*laughs*], so we tried not to be emotional ourselves, because I could just see myself just being downright 'no, Daddy, please don't!', you

> know? [*laughs*] So … we didn't want to do that, we wanted to definitely present to him the way that he normally dealt with facts and the world. (A1)

Other interveners tried different approaches, such as trying "to like fold it into the conversation that [*sic*] it wasn't like imposed" (A2); and trying "to present myself to my mother as someone who cared about her, and I was not her… enemy, I was not, you know, the bad guy … I was genuinely concerned" (A4). One intervener initially approached the recipient "sort of like [I was] the victim… like, 'this is really uncomfortable for me to be talking about, and I'd really rather not be talking about this, so [*laughs*], it'd be best for you to make sure that … this conversation doesn't happen again'" (A3); one tried to level with his friend, saying, "'listen, we're on the same … playing field, I'm just letting you vent to me, so you can … say what you want to say'" (A5). One participant intervened when she saw her brother engage in the targeted health behaviour: "I…took a very, like, non-combative approach to it at first and I asked in a very - not in sort of an aggressive… I said it in a really kind of friendly way, like I lightened my voice a bit and… I was like, 'what're you doing over there?'" (A9).

The interviewed recipients reported that the demeanours of the people who had intervened in their behaviours left deep impressions. One participant, a recipient of her mother's intervention about anorexia nervosa, recounted a noticeable change in the intervener's demeanour from the first to the second intervention:

> [In] the first attempts that weren't so successful [her demeanour] was more kind of stern, almost kind of trying to still … be like 'I'm your mother and I know what's right for you and you're doing something that's hurtful and you don't realize it and I realize it and you need to change it', and then by the end it

> was kind of desperate. So I kind of saw the prior dynamics shift … [I]t was like she knew she wasn't in control either. Um, which I guess… touched me more, that my own mother didn't know how to help me. (B2)

One participant, whose sisters intervened concerning her alcohol consumption, recalled:

> They were both standing side-by-side with their arms crossed. Very [*Int.: Wow*] - right, like, like blocking me. Like the kitchen wasn't very big, it was like a little hallway thing… and, like, it was like this wide [*gestures, spreading out her arms*], so two people standing there would've blocked my way. And they both were standing there like that, with their arms across their chest. So when I turned around after getting something to drink that's what I saw. [*laughs*] Was a door. A - a human door. (B3)

A participant whose boyfriend was trying to get her to seek medical treatment remembers his demeanour as:

> [V]ery, um, forceful… it's like the way he presented it to me, it wasn't an option. It was, 'you need to go. You have to go. You should go immediately.' Um, so it wasn't a suggestion. It was definitely something that he was telling me to do. Which … added to my annoyance, because I'm like, "I'm a strong woman, you don't tell me what to do" (B4).

Although interveners' demeanours seemed to leave profound impressions on intervention recipients, there was no consistent relationship between interveners' demeanours and conflict resulting from the interventions.

The amounts and types of factual information used by interveners were also unrelated to the occurrence of conflict in the interventions. Some interveners invoked

extensive information specific to the recipient; one recipient, who had anorexia nervosa and whose mother intervened in her behaviour, reports extensive external information as having been very important to her in terms of how she reacted to her intervention:

> [A]ctually what kind of helped … was we went to a doctor and I had blood tests done, and … I saw "my blood count is down, my red blood cells are down, my white blood - like, all my blood cells, like, my, I'm just not a healthy person" … I was being irrational, but I couldn't see it until I got like a symbol of it with my blood counts and everything to show "really, you're not healthy" … I also knew, I was doing track at the time and my times were getting slower - I was actually getting slower 'cause I was losing muscle so I wasn't able to run anymore, so I was able to kind of connect the lot of the different signs (B2).

In another example of using factual information, one intervener had her father's current medical information in front of her during the intervention (A1). In three cases, interveners explained the risks that are generally associated with the targeted health behaviours (A7, A8, A10). Three interveners mentioned the financial costs to the recipient in continuing the health behaviours (A3, A6, A9). Some interveners asked parties outside of the intervention for advice in intervening (A3, A4, A5), and some interventions did not include external information (A2, B1, B3, B4). There was no clear relationship between the use of external information and conflict in the intervention.

Upon reflection, most interveners said that in hindsight, they would make changes to how they conducted the intervention; however, there was no connection between the types of changes that they would make and the occurrence of conflict as a result of the

intervention. One intervener who did no preparation felt that he should have prepared more for the intervention, should have included the recipient's wife in the intervention, and should have waited for a more opportune time to intervene, as the parties had argued about the recipient's health behaviour shortly before the intervention (A6). Another participant also felt that her intervention might have gone more smoothly if she waited for a better time and/or had enlisted more parties (A9). Knowing how the intervention turned out, one intervener reported that he would have removed himself from the intervention and left it to professionals (A4). One intervener would have been more sensitive toward the recipient (A3) and another would have focused on the recipient's previous successes in conquering the health behaviour (A1). Recipients were divided in how they would have preferred the interventions to unfold: one felt that her interveners were unnecessarily harsh (B3) and another felt that her intervener was unclear in how he wanted her to adjust her behaviour (B1). Two wished that their interveners would have tried harder to change their behaviours but acknowledged that those efforts probably would not have been successful (B2, B4). Only one participant responded that he would not change anything about his intervention (A2). There was no clear correlation between changes that the intervener would have made and conflict in the intervention.

Whether interveners enlisted professional help for the intervention was also unrelated to whether an intervention led to conflict. Most interveners did not consult with facilitators or health professionals in conjunction with their interventions. One intervener consulted with a facilitator before the intervention out of concern that his intervention would negatively impact his relationship with the recipient (A4). One intervener consulted a dietitian who was also a member of the recipient's family (A3). One

intervener, at the time a high school student, consulted a teacher when he felt that the recipient's suicidal threats were escalating (A5). Two interventions involved medical professionals in some capacity; interveners gathered information from the recipient's doctor's office in one intervention, and in the example described above, medical reports were a central part of one recipient coming to agree that her behaviour was unhealthy (B2). Of the interveners who did not enlist a professional, one speculated: "I don't think he would ever - he wouldn't have stayed in a room, you know, if I had brought in anybody else … there's no way he would've gone through with it" (A6). Whether or not a professional was included in the intervention did not correlate with more or less conflict occurring.

Also unrelated to whether interventions led to conflict were the events that inspired them. The interventions described were precipitated by a variety of events. In two cases, interveners had been thinking about the health problem for some time and intervened when the recipient mentioned it (A3, A10). Two interventions occurred when on the parties, who lived in different states, were in the same place (A9, B1). In a similar case, an intervention occurred among sisters who lived together but did not see each other often - one sister came home earlier than usual and her sisters were still awake, affording them the opportunity to stage their intervention (B3). One intervention occurred because the parties had had an argument about the health behaviour shortly before (A6), and one occurred shortly after the recipient had received medical news relevant to the targeted behaviour (A1). One intervener simply felt that "the atmosphere was right" (A2). The most common reason for the timing of interventions was that interveners felt that the targeted

behaviours warranted immediate action (A4, A5, A7, A8, B2, B4). There was no clear connection between intervention timing and post-intervention conflict.

The factors concerning the interventions that were unrelated to the occurrence of conflict included the interveners' demeanours; the interveners' use of factual information in the intervention; the changes that interveners would make in hindsight; professionals' influence on the interventions; and the timing of the interventions.

Behaviour Factors

There was no clear connection between conflict and behaviour change. Of the 14 cases that were studied, four resulted in straightforward behaviour changes (A4, A5, B1, B4). In one case, the first intervention resulted in an initial behaviour change which was then abandoned; the second intervention between these parties did not result in the recipient changing the behaviour a second time (A1). In another case, the recipient's behaviour did not change after the first intervention but did change after the second (B2). One continuous intervention resulted in the recipient gradually changing his behaviour (A3). Three interveners did not know whether their interventions' recipients had changed their behaviour (A2, A7, A10), and four interventions did not lead to behaviour change (A6, A8, A9, B3). There was no relationship between conflict resulting from the intervention and recipients changing the targeted behaviours.

Also, the recipient's agreement or disagreement that the behaviour needed to be changed was not consistently related to conflict within the intervention, despite several recipients identifying this factor as having been important to them personally. One

recipient identified this distinction as it became clear between her mother's first and second interventions with her:

> [S]he intervened early, but that was unsuccessful because … she already at that point saw it as a problem but I did not, and then when she intervened again and … said, "you are really, really sick now and you can see you're really sick", and I also knew … I was able to kind of connect the lot of the different signs. … [I]t had intensified enough that, at that point… it was gonna get I guess dangerous, or more dangerous. (B2)

Another recipient expressed that she could not take her sisters' intervention seriously because she disagreed that the behaviour was a problem:

> Int.: [Y]our response to it you said initially was laughing.
>
> B3: Mm-hmm, yes.
>
> Int.: And you … disagreed that it was -
>
> B3: Completely, absolutely, no thought, no doubt, didn't have to think about anything, didn't wonder, "could they be right?" No. Absolutely nothing. Nothing. No. [*laughs*] Just completely, "they're wrong, and they're so wrong that it's comical" (B3).

Another recipient expressed having had difficulty taking the intervener seriously because she did not believe that her behaviour was a problem; however, she later admitted that the reason she changed her behaviour in response was that "I think maybe on some tiny level I knew something was wrong and that I needed to [seek medical attention]" (B4). However, one intervener describes that in her continuous intervention, the recipient disagrees that his drinking is a problem and conflict has not occurred between them:

> I was like, just like, from a friend to a friend, "well you know you need to control that, like, and plus … it's gonna affect your job" and he kept on saying like "I know, I know", this and that, and I'm like, "okay, well, just letting you know", and then I just fiddled around a couple of questions, like "do your family drink, like does anybody in your family drink" and all that stuff, and he's like, "no, I'm fine, like, it's no biggie" and all that stuff, and I'm like "okay".
>
> Int.: So it doesn't sound like he would agree that he had a problem.
>
> A10: Yeah. Like he didn't say "yes, I'm gonna stop", like [he finally said], "I'm gonna control my drinking a little bit, because I'm getting older, I don't want it to affect me", but … I felt like he just said that so I could shut up. (A10)

Recipients' agreement that their targeted health behaviours needed to be changed was not related to conflict arising from their interventions.

The factors concerning the targeted health behaviours that were not related to conflict occurring as a result of the intervention were whether the recipient changed the behaviour and whether the recipient agreed that the behaviour needed to be changed.

In sum, these factors were not clearly related to whether conflict resulted from the intervention:

- intervener preparation
- specificity of intervener goals
- intervener demeanour
- intervener's use of external information
- types of changes the intervener would make in hindsight
- inclusion of a professional

- interventions' precipitating factors
- the intervention leading to the intended behaviour change

Discussion

This project has identified several factors that were and that were not associated with conflict resulting from health behaviour interventions. Some of these findings were consistent with literature in the field, and some discrepancies existed as well.

The data corroborated Worchel's (1984) findings about the potential for helping to strain relationships and lead to hostility between parties as well as Holden's (1991) conclusion that patients and caregivers may differ in their perspectives and priorities about managing their illnesses. Respondents also confirmed the usefulness of training and experience in interventions (King, Vidourek, & Strader, 2008).

Consistent with Dakof & Taylor (1990), Martin et al. (1994), and Treasure, Macdonald and Goddard (2010), some evidence suggested a lack of consensus about what is helpful in the intervention setting. For instance, interveners' demeanours had no clear connection to conflict; however, recipients' accounts of their interventions mentioned intervener demeanour extensively and described them in rich detail. Demeanour may be a factor that is important to an intervention experience but that is specific to the individual or the relationship.

Congruent with Searcy and Eisenberg's (1992) findings, more conflict arose in relationships that were described as having been laden with conflict before the interventions than it did in relationships that were not described as being conflicted before the interventions. In contrast with different findings from Searcy and Eisenberg's study, though, older female siblings as interveners did not elicit less defensiveness in

interventions than did interveners with different relationships to their recipients. In the current study, two interveners were the recipients' older female siblings, and both of these interventions engendered conflict (A9, B3); however, both of these interventions also occurred within relationships that were already fraught with conflict. This suggests that the existence of conflict within an intervener-recipient relationship is more important to the conflict outcome of the intervention than the specific relationship type.

The link between interveners having personal experience with the targeted health behaviours and conflict was unexpected and counterintuitive. Interveners incorporated their experiences into the interventions to try to express empathy for recipients and to demonstrate that changing that behaviour was possible; however, these interventions consistently resulted in more conflict following the interventions. One recipient interpreted the intervention as an act of hypocrisy on the part of the intervener who had engaged in the targeted behaviour before, while another was perturbed when the interveners did not acknowledge that they themselves had previously participated in the negative health practices that were the topic of the intervention. The initial intervention between one such intervener and her father was initially successful in that he quit smoking; however, following a stressful life event, he began smoking again and his daughter's experience did not seem to impact him in the second intervention. Potentially, this recipient could have felt that he had tried and failed at quitting smoking, and that this experience of his own was more relevant to him than his daughter's experience was. Another possible explanation of this finding could be that interveners' attempts to relate to the recipients were interpreted by recipients as interveners trying to insert themselves into the intervention, making their concern for the recipients less clear. Further research could better explore this

phenomenon and identify the dynamics at play when the intervener has engaged in the behaviour that (s)he is trying to change in the recipient.

Although these factors were not controlled in the project, and with the small sample size in mind, this study identified few trends pertaining to conflict and ethnicity, gender or age. The only demographic-based category that was related to conflict occurring in the interventions was that intergenerational interventions between family members were associated with more conflict than were interventions between individuals of similar ages and interventions between friends. Whether this finding was related more to parent-child relationships or related to the age discrepancy between generations is unknown, as interventions between friends and significant others occurred between individuals who were no more than ten years apart in age.

Although continuous interventions were related to less conflict than were interventions that occurred in one or two interactions, they were also more likely to leave the intervener uncertain as to whether the targeted behaviour had been changed. One possibility is that, as suggested by the Maudsley Method for treating eating disorders, engaging in ongoing dialogues about health behaviours manages interpersonal conflict more effectively than does more short-term intervention, but may be less efficient in promoting behaviour change. The current study's findings suggest that preserving the parties' relationship via continuous interventions may mean that the intervener sacrifices clarity concerning his or her knowledge about the effectiveness of the intervention.

It is worth reiterating that while the possibility of conflict was a concern for most of the interveners who were interviewed, behaviour change is another main goal of interventions, and no straightforward way of avoiding conflict while changing the targeted

behaviour presented itself in this study. Further research to assess which factors of health behaviour interventions are applicable across participants and across interventions and which factors depend more on the individual and the specific relationship would benefit both this field of study and potential interveners seeking training, education or advice as to how best to proceed in helping their family members or friends.

Limitations and Future Directions

Recruiting participants for this study revealed that interveners were significantly more willing to be interviewed about their intervention experiences than were recipients of interventions. Time constraints inherent to this project meant that only four intervention recipients were interviewed compared with ten interveners, complicating the data analysis and the generalizability of the project. This asymmetry may have been a product of social desirability bias, a phenomenon wherein participants are inclined to present themselves favourably in research contexts (Marlowe & Crowne, 1961). In accordance with this theory, participants who perceived themselves as having been helpful, concerned and well-intentioned enough to intervene in their loved ones' health behaviours may have been more eager to discuss these experiences than were recipients, who may have felt that the interventions took place because of their behaviours needing correction or adjustment. Along the same lines, potential recipients may also have had very negative intervention experiences and have been unwilling to talk about them. An alternative possibility is that intervention recipients may not have self-identified as intervention recipients and as a result did not consider themselves eligible to participate in the study. Although one of the current study's recipients did describe a continuous intervention that lasted for several years, in interventions that occurred over many conversations and long

periods of time, recipients may not have classified discussions about the health with their friends and family members as "interventions" per se. Since recipients who did not come forward cannot be identified and asked why they did not come forward, it is impossible to say whether any of these explanations is accurate; however, future researchers are advised to increase their recruitment efforts and to clearly define "intervention" when recruiting intervention recipient participants.

The content of the recruitment material may also have influenced the types of participants who agreed to be part of the study. Due to the information shared in the recruitment material (Appendix A), potential respondents knew that this project was being done by a researcher from the department of conflict resolution. This could have attracted a sample that experienced more conflict in their interventions and/or discouraged potential participants who did not experience conflict in their interventions. Sharing less about research objectives and departmental affiliations with potential participants may be advisable for future researchers in this area.

This project was intended to be a broad, exploratory one and the interventions studied concerned a wide variety of health behaviours. In part inspired by Park & Gaffey (2007), this project had hoped to answer the question of whether conflict in interventions was associated with any particular types of health behaviours; however, the number of individuals willing to participate in the study was not high enough to control for types of health behaviours and thus, drawing any conclusions about this aspect of interventions is not possible. The current study did find conflict in interventions that concerned a wide variety of health behaviours; however, it does not allow more nuanced conclusions to be

drawn about conflict and any specific health behaviours. Future research in this area might focus more on the specific types of health behaviour that is intervened upon.

Research concerning roommate relationships could also be beneficial to this discussion. One of this study's respondents intervened in his roommate's drug use, and that intervention was the only one between friends a) that led to long-term conflict and b) in which conflict was present in the relationship before the intervention occurred. Apart from this intervention, long-term conflict and pre-intervention conflict were present only in interventions between family members. Research concerning the extent to which roommate relationships are similar to family relationships and different from relationships between friends who do not cohabit may provide some interesting insights into this phenomenon.

These respondents may also have corroborated Worchel's (1984) findings regarding the urgency of the recipient's need for help; however, as the current study did not explicitly measure this cannot be confirmed absolutely. Recipients whose interventions targeted especially pressing health concerns wished, in hindsight, that their interveners had tried harder to change their behaviours despite the conflict that they acknowledge would have been created. The exception to the trend of one-on-one interventions causing less conflict was illustrated by a recipient who was reluctant to seek medical care for what turned out to be a very urgent problem. She expressed that she wished that her boyfriend, who was intervening via telephone from another state, had "called someone to come over and make me go to the hospital that night" (B4). In contrast, recipients with less critical health conditions criticized their interveners for not having taken gentler, more sensitive approaches. The current study's interviews relied completely on respondents' accounts of

the interventions and the contexts of the interventions. It was not possible to interview both parties from the same intervention, and asking interveners about the urgency of recipients' health problems seemed likely to yield biased accounts. Future research might more thoroughly explore whether a connection exists between the urgency of the health problem and conflict resulting from the intervention.

Further research in this area may also benefit from interviewing both parties to a single intervention; this was a goal of the current project that was not realized due to the limited nature of the participant pool. Studying each party's perception of an intervention could provide valuable insights about specific causes of conflict and about the disparities that can exist in this type of interaction. For instance, one intervener, when asked about the demeanour that she projected during the intervention, responded:

> I felt extremely tense, like very distressed, also, um, probably angry, especially when she would not respond… I felt like the stakes were so high that to have her just kind of sit there was really just - it made me feel really outraged, especially what she was putting my parents through emotionally, that was what made me really angry, so I - I kind of felt like in those situations, I feel like my ears just kind of block, and I take very, very little in (A7).

She added, "I'm not sure how it came out". Being able to speak with the recipient in that intervention would have been valuable not only for research purposes, but also potentially instructive to this intervener as her self-presentation was concerned.

Although one respondent involved a facilitator in the intervention that he discussed, none of the respondents reported using mediation services for their interventions. Since mediators can be valuable in helping parties navigate difficult

conversations, researching their current or potential roles in health interventions may prove quite valuable.

Several elements of interventions leading and not leading to conflict have been identified within this project; hopefully more research in this area will be feasible so that concerned individuals can better prepare themselves for difficult but effective conversations with their loved ones.

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Appendix A

Hello, UMass Boston!

A study is being conducted by a graduate student in the department of Dispute Resolution that focuses on health behavior interventions between family members and friends. If you are 18 or older and:

-you have intervened in a friend or a family member's health behavior, or

-a friend or a family member has intervened in a health behavior of yours

and you're willing to be interviewed about the intervention experience, please contact Sheilah Davidson at sheilah.davidson001@umb.edu . The researcher is interested in hearing about health behavior interventions that met with varying degrees of success.

"Health behavior", by the researcher's definition, refers to any behavior that is felt to impact an individual's health. It could include diet, exercise or lifestyle choices, substance use, risk behaviors, adherence to medical treatment, or perhaps other behaviors. If you are interested in participating in this study but are not sure whether your experiences would be relevant, please contact Sheilah Davidson at sheilah.davidson001@umb.edu .

The interviews will last no longer than 90 minutes. Your participation in this study will be totally voluntary. You will be free to skip any questions that you do not wish to answer, and you may stop the interview at any time. No identifying information will appear in the written report - your identity will remain confidential.

This study has been approved by the University of Massachusetts Boston Institutional Review Board.

Appendix B

Questions for Master's Project Interviews

When people become concerned about the health of a family members or friend – whether their concern is about substance use, lifestyle choices, adherence to medical advice, mental health, or any number of other health-related issues - they often want to try to help this person to improve their health. Sometimes these attempts at intervening are helpful, sometimes they are not, and sometimes what happens is that the intervention ends up damaging the relationship that existed between the people involved in it. You've indicated to me that you have been involved in an intervention with a family member or a friend of yours. Can you share your intervention experience with me?

What was the setting of the intervention?

Questions for the Intervener:

What is your relationship to the recipient of the intervention?

What health behaviour(s) was/were you trying to change? Why?

What made you intervene in this case?

What were your goals going into this intervention?

Were you surprised by the recipient's response to your intervention?

Did you prepare for the intervention?
-if so, how?

Did you intervene by yourself? If other people were involved, who were they? What was their relationship to the recipient of the intervention?

How did you approach the intervention?
-How did you present yourself in the intervention? (thinking of demeanor)
-Did you incorporate factual information into the intervention?

Do you have any formal training in intervention?

Do you have any personal history with the targeted health behaviour(s)?

Did you enlist an intervention expert, a health professional, a mediator or another professional in the intervention?

To the best of your knowledge, did the recipient change the health behaviour(s) that was/were the subject(s) of the intervention?

Questions for the Recipient:

What is your relationship to the intervener?

How did you feel about the intervention?

How did you respond to the intervention?

What health behaviour(s) of yours was/were the intervener trying to change? Why?

From your impressions of the intervention, why did the intervener intervene in this case?

How would you describe the intervener's approach?
-What was his/her demeanor like?
-Did he/she incorporate external information into the intervention?

Was there one intervener or more than one? If other people were involved, who were they? What was your relationship to them?

To the best of your knowledge, did the intervener have any formal training in intervention?

To the best of your knowledge, did the intervener have any personal history with the targeted health behaviour(s)?

Was an intervention expert, a health professional, a mediator, or another professional present?

Did you change the health behaviour(s) that was/were the subject(s) of the intervention?
-Why/why not?

Questions for Both Parties:

Looking back, is there anything that you now think that you should have done differently in the intervention?
-If so, what?

Did the intervention cause conflict between you and the other party?
-short-term?
-long-term?

Has your relationship changed since the intervention?

-if so, in what way?

Had you tried to intervene in someone else's health behaviour(s) before or since this intervention?

-If so, did the intervention cause conflict in that relationship?

Have you been a recipient of a health behaviour intervention before or since this intervention?

- If so, did the intervention cause conflict in that relationship?

Demographic information – genders, ages, ethnicities of both parties

Appendix C

Debriefing Form - Conflict in Lay Health Behavior Interventions

Thank you very much for your participation in this project. We hope that this has been a positive and interesting process for you. The goal of this project is to identify factors that lead to conflict in health behavior interventions between family members and friends. We greatly appreciate your willingness to share your story for this purpose. The primary researcher is Sheilah Davidson, a graduate student in Dispute Resolution in the Department of Conflict Resolution, Human Security and Global Governance. Her advisor is Dr. Rezarta Bilali. Please read this form and feel free to ask any questions that you have. If you have further questions later, please contact Sheilah Davidson at sheilah.davidson001@umb.edu or Dr. Rezarta Bilali at rezarta.bilali@umb.edu or (617) 287-7165.

This project has been approved by the University of Massachusetts Institutional Review Board, and we do not anticipate any physical, social or psychological ramifications to your participation in this interview. If you are experiencing any type of distress following this interview, we encourage you to contact University Health Services at http://www.healthservices.umb.edu/. General Medicine is located in Suite 2-040 in the Quinn Administration Building and can be reached at 617-287-5660. Mental Health and Counseling Services are located on the second floor of the Quinn Administration Building and can be reached at 617-287-5690.

If you are interested in receiving a copy of the completed project, please email Sheilah Davidson at sheilah.davidson001@umb.edu.

If you are interested in reviewing some academic sources relevant to this project, these might be of interest to you:

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Appendix D

Coding Scheme

Characteristics of the intervener

-family member or friend
-training in / experience with interventions
-personal experience with targeted health behaviour
-intervening alone or with others

Characteristics of the recipient

-agreement/disagreement that the health behaviour is a problem
-reaction to intervention (positive/negative/mixed)
-explanation of reaction
-change of health behaviour (yes/no/somewhat)

Characteristics of relationship

-longevity of relationship
-status imbalance between the parties (yes/no)
    -age difference
    -generational difference
-gender (same/different)
-ethnicity (same/different)
-relationship change since intervention (yes/no)

Characteristics of intervention

-did intervention cause conflict?
    -yes/no
    -short-term/long-term
-intervener's preparation (prepared/spontaneous)
        -demeanor
        -information
        -use of factual information (yes/no)
    -involvement of a professional
        -mediator
        -health professional
        -intervention professional

-behaviour change post-intervention?

Characteristics of the targeted health behaviour

-specific behaviour
-type of behaviour
    -catastrophic / non-catastrophic
    -high-risk / low-risk
    -locus of recipient's control over behaviour (more internal/more external)

Reflections on intervention

    -looking back, would respondent change anything about the intervention?
    -has respondent tried to intervene in others' health behaviours since intervention?
        -yes/no
            -if yes, did this intervention cause conflict?
                -yes/no
                -short-term/long-term
            -if yes, did recipient change the behaviour? (yes/no/somewhat)