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Original Article:

THE INTERPLAY BETWEEN INTIMATE RELATIONSHIP CONFLICT AND SUPPORT ADEQUACY AS PREDICTORS OF DISORDERED EATING SYMPTOMS

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Abstract

The present study examined the interplay between intimate relationship conflict and partner support in connection to disordered eating. Undergraduates (N = 203) in romantic relationships were recruited from a large Midwestern university. Hierarchical regressions were conducted to examine associations between relationship variables and disordered eating symptomatology. Individuals receiving more adequate support from their partners reported lower levels of binge eating regardless of the level of psychological aggression in the relationship; psychological aggression was not uniquely associated with disordered eating. However, a significant positive interaction was observed between negative communication and support adequacy in a model predicting binge eating. Probing of the interaction using the Johnson-Neyman technique revealed (a) a significant negative association between negative communication and binge eating symptoms for individuals with very low levels of support adequacy (2.91 *SD*s below the mean or lower) and (b) a significant negative association between support adequacy and binge eating symptoms for those reporting average or below average levels of negative communication (0.52 *SD*s above the mean or lower). Results suggest that, in rare cases, negative communication (e.g., arguments) may be adaptive in relationships marked by inadequate support; however, the more prominent finding was that individuals were positively influenced by support to the extent that negative communication was relatively low in the relationship.

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Keywords: couples, conflict, partner support, disordered eating, psychological abuse.

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INTRODUCTION

For many, an intimate partner's influence is the strongest among interpersonal relationships and is an important factor in physical and mental health (Robles, Slatcher, Trombello, & McGinn, 2014; Whisman & Baucom, 2012). In turn, researchers are beginning to direct attention to the role of specific couple processes on health behaviors and attitudes. Efforts have included an attempt to understand how partners impact eating disorder symptomatology (Zak-Hunter & Johnson, 2015). Though it is known that intimate relationship functioning and eating behaviors are linked, the specific relational contexts that perpetuate or mitigate eating pathology are unclear.

Disordered eating includes a variety of behaviors, such as purging, bingeing, severe food restriction, as well as any detrimental means of controlling weight or shape (Pereira & Alvarenga, 2007). Reinking and Alexander (2005) found that 12.9% of college women demonstrated behaviors meeting criteria for an eating disorder (ED) diagnosis. Eating pathology is linked to a number of preventable harmful outcomes, such as weight gain and associated health consequences (Neumark-Sztainer, Wall, Guo, Story, Haines, & Eisenberg, 2006; Tanofsky-Kraff et al., 2006). Further, there is evidence that relationship dissatisfaction is higher in young adults with EDs, and dissatisfaction is positively correlated with ED symptom severity (Woodside, Lackstrom, & Shekter-Wolfson, 2000). Indeed, one study found that nearly 70% of women cited intimate relationship distress as a trigger of the onset of their eating disorder symptoms (Kiriike, Nagata, Matsunaga, Tobitan, & Nishiura, 1998).

Couple Processes and Disordered Eating

In general, individuals with eating disorders have more difficulty maintaining relationships than individuals without eating disorders (Ambwani & Hopwood, 2009; Ansell, Grilo, & White, 2012; Arcelus, Haslam, Farrow, & Meyer, 2013). Newton, Boblin, Brown, and Ciliska (2005) reviewed 19 studies of romantic relationships in women with anorexia nervosa (AN) and found a strong presence of relationship dissatisfaction among women with AN. High levels of weight concern are associated with a belief that emotions should be hidden in relationships and displaying emotions are a sign of weakness (Geller, Cockell, & Hewitt, 2000; Meyer, Leung, Barry, & De Feo, 2009). Boyes, Fletcher, and Latner (2007) examined dieting and body image in the context of intimate relationships and found that for female partners, dieting was negatively associated with both body and relationship satisfaction. Further, the authors noted that depressed mood from male partners was associated with higher dieting and lower body satisfaction for female partners.

Relationship Conflict and Support

There have been several studies linking couple conflict to disordered eating and related outcomes. Burke, Randall, Corkery, Young, and Butler (2012) examined the effect

of weight disparity within couples on relational processes. The authors recruited matched healthy (both partners had BMIs ≤ 25), matched overweight (both partners had BMIs > 25), and mixed weight (one partner met "healthy" criteria classification and the other was classified as "overweight") couples based on their assessed BMI indices. Among the couples included, the mixed weight couples in which the woman was overweight and the husband was healthy reported the highest levels of negative communication in the form of arguments, which increased as the frequency of eating together increased. In addition, greater perceived health support (e.g., a person's perception of their partner's encouragement of healthy dieting and exercise) was associated with less relationship conflict and daily arguing for both mixed weight couples and matched healthy couples. These findings suggest that eating behaviors can be a source of relationship conflict for couples, and it is possible that partner support can influence the frequency of conflictual interactions.

In an examination by Shanmugam, Jowett, and Meyer (2012), student athletes were asked about their general feelings in their relationships with their coaches, parents, and teammates. The authors observed that those who perceived their close relationships as being more conflictual and less supportive exhibited higher levels of eating psychopathology. Whisman, Dementyeva, Baucom, and Bulik (2012) found that women with Binge Eating Disorder (BED) reported higher levels of negative interaction with their spouses. The authors suggest that unsatisfactory relationships can be a source of stress for individuals and, in some instances, a risk factor for coping with stress through disordered eating behaviors.

In contrast with the literature linking couple conflict and disordered eating, little is known about the role of partner support on these behaviors. With regard to global social support, less emotional support (i.e., expressing understanding of feelings) and tangible support (i.e. offering direct assistance) from friends and family members is related to eating disorder diagnoses (Grissett & Norvell, 1992). Tiller, Sloane, Schmidt, Troop, Power, and Treasure (1997) found that patients with anorexia were less likely to identify their partner as a source of support than both bulimic patients and a comparison group of students without eating disorders. In addition, women with bulimia were more likely to be dissatisfied with the type of partner support they were receiving. Grissett and Norvell (1992) postulated that the lack of perceived support can lead to vulnerability, and disordered eating can become a form of compensation. Additionally, Linville, Brown, Sturm, and McDougal (2012) examined general social support qualitatively and observed that women who have recovered from an eating disorder list social support as a vital aspect of the recovery process.

Given the wealth of evidence demonstrating the particular impact of *partner* support on physical health (Grewen, Girdler, Amico, & Light, 2005; Uchino, 2006), it seems important to investigate the role of partner support on disordered eating behaviors. Unfortunately, no published studies have included such an investigation. However, partner

support has been examined as it relates to stress more broadly in models of individual wellbeing in terms of both mental and physical health (see Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002 for a review). Specifically, partner support has demonstrated potential defense against stress spillover (i.e., the interference of external stressors on intimate relationship satisfaction; Neff & Karney, 2004). In a sample of 101 couples over the first 5 years of marriage, support adequacy (i.e., the extent to which there is a match between support that is provided and that which is desired) was found to be an important protective factor for stress spillover among wives; with adequate support, wives maintained relationship satisfaction despite escalations in chronic stress (Brock & Lawrence, 2008). Thus, there is evidence that adequate support can act as a buffer for external stressors and mitigate the harmful effects of negative relationship events or interactions. Whether support specifically buffers the impact of maladaptive relationship processes such as conflict on disordered eating symptomatology remains an unresolved question.

Overview of the Present Study

The purpose of the present study was to clarify the associations between relationship processes (partner support and conflict behaviors) and disordered eating among individuals in romantic relationships. We hypothesized that individuals with more destructive patterns of relationship conflict (more negative affect, psychological and physical aggression; e.g., minor disagreements escalating to big arguments, arguments ending up with one or more persons feeling hurt or crying) would report greater levels of disordered eating compared to individuals reporting more constructive patterns of conflict (e.g., sitting down and discussing differences of opinions during arguments, focusing on important issues when arguing). Destructive behaviors in intimate relationships are associated with depleted self-regulation (Baumiester & Heatherton, 1996). Thus, we expected conflictual relationships to deplete self-regulation, which could manifest behaviorally in the form of disordered eating symptoms.

Additionally, we expected that social support would interact with relationship conflict and disordered eating behavior, such that the association would be stronger to the extent that support was less adequate. There is evidence for the "support-as-buffer" hypothesis in connection to a number of health compromising behaviors (Grewen et al., 2005; Kiecolt-Glaser et al., 2002; Uchino, 2006), which suggests partner support can work to reduce the deleterious effects of stress. According to this hypothesis, support could mitigate the impact of relationship conflict on binge eating behaviors and associated negative psychological outcomes. Nevertheless, given the absence of research into the interaction between partner support and disordered eating symptoms, the current investigation sought to explore the possible moderating role of partner support in the link between conflict and ED symptoms.

METHOD

Participants

Participants (N = 203) were recruited from a student research pool of two introductory psychology courses at a large midwestern university. This recruitment strategy was selected as a cost-efficient strategy for recruiting cross-sectional data from a large number of young adults in dating relationships. Introductory psychology courses included a course assignment that required students to volunteer in research studies for at least 4 hours to receive full credit (1 hour = 1 credit). Prospective participants viewed study information on an online portal with a list of potential research studies and were able to enroll in the study if they met eligibility criteria (based on self-reported demographic data available via the online portal). The university's institutional review board approved all study procedures, and the study adhered to ethical standards for research with human subjects (American Psychological Association, 2002). Eligible students were between the ages of 18 to 26 and currently involved in an exclusive intimate relationship greater than 3 months in length. This age range was selected to reflect the typical age range of undergraduate students. Individuals beyond the age restraints or not currently involved in an exclusive romantic relationship were deemed ineligible for participation. Participants received 1 research credit for completion of the study.

Study participants were predominantly in their first year of schooling (n = 115; 58.7% freshmen), and the remainder were classified as sophomores (n = 46; 23.2%), juniors (n = 24; 12.1%), and seniors (n = 10; 5.1%) at the time of the study. Participants were between 18 and 23 years old (Age M = 18.92, SD = 1.19). The sample largely consisted of White, Non-Hispanic students (n = 150; 76%), as well as Hispanic (n = 19; 10%), Asian/Pacific Islander (n = 14; 7%), Black/African American (n = 5; 3%), Biracial (n = 6; 3%), or Other students (n = 5; 3%). Over three-fourths (n= 148; 76%) of the sample were female. Almost all of the students self-identified as predominantly heterosexual (n = 189; 96%) and a small number (n = 6; 4%) reported bisexual sexual orientation. Most (n = 145; 74%) of the participants in the study were classified as having a body mass index (BMI) that was "normal" as judged by the World Health Organization (WHO; World Health Organization, 2014) guidelines. However, BMI scores ranged from 16.17/"Underweight" to 40.35/"Class III Obesity," and the mean for the sample was 23.04 (SD = 0.25). Male and female participants did not significantly differ in terms of BMI, $t(113.22) = 1.10$, $p = .275$.

The study participants enrolled in the present study also reported information on their romantic partners. Partners were predominantly male (n = 146; 75%) reflecting the fact that the majority of participants were females in heterosexual relationships, and partners were 19.26 years old on average (SD = 0.23). Participants almost entirely reported living separately from their partner at the time of the survey (n = 188; 95%). Almost half

(n = 94; 47.5%) of participants stated that they were in a relationship with their current romantic partner for over 1 year.

Materials and Procedure

After the informed consent process, eligible participants completed survey items through an online portal. Participants responded to an array of survey items concerning demographic information, current dating relationship, as well as recent attitudes and behaviors toward diet, exercise, and body image.

Eating disorder symptoms. The *Binge Eating Scale* (BES; Gormally, Black, Daston, & Rardin, 1982) was used to assess binge-eating severity. The BES is a 16-item self-report questionnaire employed as a rapid examination of both behavioral signs (eating large amounts of food) and thoughts or feelings during a binge-eating episode (loss of control). Items are scored from 0 to 3, and higher summed scores indicate greater symptom severity (possible range 0 to 48). Participants selected the statement that best describes their thoughts and feelings. The BES has good test-retest reliability (r = .87, p < .001; Timmerman, 1999), and demonstrated adequate internal consistency in this sample (Cronbach's α = .89).

The *Eating Disorders Examination Questionnaire* (EDEQ; Fairburn & Beglin, 1994) was used to assess disordered eating attitudes and behaviors. The EDEQ is a 36-item self-report questionnaire derived from the Eating Disorder Examination (Cooper & Fairburn, 1987). It assesses behaviors over the last 28 days across four subscales (restraint, eating concerns, shape concerns, weight concerns), and higher scores on the measure reflect higher levels of eating pathology. Response options for EDEQ include a 7-point Likert scale, and range from *no days* to *every day*. Scores could range from 0 to 216. The EDEQ has demonstrated excellent reliability and validity (Luce & Crowther, 1999). The measure exhibited strong internal consistency in this sample (Cronbach's α = .95).

Relationship conflict. The *Marital Satisfaction Inventory: Problem Solving Communication Subscale* (MSI-R, PSC; Snyder, 1997) is commonly used to assess the level of distress in couples along 11 dimensions of relationships. We included the Problem Solving Communication (PSC) subscale to measure the degree of negative communication between partners. The PSC consists of 19 items, and participants answer *true* or *false* to each item. Participants respond to a number of statements including "Minor disagreements with my partner often end up in big arguments," and "Our arguments frequently end up with one of us feeling hurt or crying." Scores can range from 0 to 19 for the PSC, and higher scores indicate more negative communication patterns. Internal consistency was good in this sample (Cronbach's α = .81).

The *Multidimensional Measure Emotional Abuse Scale* (MMEA; Murphy & Hoover, 1999) is a 56-item multi-dimensional scale measuring psychological aggression and abuse. The measure includes 28 items for victimization and 28 items for perpetration. For the current study, only the victimization items were included, and participants

exclusively reported partner behaviors. Participants rated how often each behavior occurred in their relationship in the past 6 months on a 7-point scale including the options *never, once, twice, 3-5 times, 6-10 times, 10 times or more,* and *in the past, but not in the past 6 months*. Example item statements include, "Called you worthless," "Called you ugly," and "Said or implied that you were stupid." Sum scores were calculated by adding the midpoints for each response option (e.g., 4 for *3-5 times*), with the exception of the response options *never* and *in the past, but not in the past 6 months,* which were scored as 0, and *10 items or more,* which was scored as 15. Possible scores range from 0 to 420. The measure exhibited good internal consistency in the present sample (Cronbach's α = .87).

Partner support. The *Support in Intimate Relationships Rating Scale-Revised* (SIRRS-R; Barry, Bunde, Brock, & Lawrence, 2009; Dehle, Larsen, & Landers, 2001) is a 25-item, factor-analytically derived self-report measure of received partner support. Participants responded to items on both the frequency of supportive acts and whether they wished to have more, less, or the same amount of each supportive act (operationally defined as support adequacy). For the present study, only the support adequacy scale was utilized in descriptive and inferential analyses. Participants disclosed their support preferences within the intimate relationship over the past month, and rated specific behavioral statements (e.g., "Said it was OK to feel the way I was feeling," "Hugged me or cuddled with me," and "Did something to help me directly") across four subscales: informational, emotional/esteem, physical comfort, and tangible support. Support adequacy items were coded dichotomously, where 0 indicated that the participant perceived the support to be inadequate (i.e., either more or less support of a specific support behavior was preferred) and 1 indicated that the participant perceived the support to be adequate (i.e. the participant reported that he or she wanted the same type of support). Scores of support adequacy could range from 0 to 25 with higher scores representing more adequate support (i.e., closer match between desired and received levels of support). A factor analysis of the SIRRS-R in samples of dating and married couples strongly supported the reliability and validity of this measure (Barry et al., 2009; Dehle et al., 2001). The sample in the present study showed similar results; the Cronbach's alpha for the support adequacy sum composite was excellent (α = .92).

Relationship quality. The *Perceived Relationship Quality Components Scale* (PRQC; Fletcher, Simpson, & Thomas, 2000) is an 18-item measure of romantic relationship quality. As recommended by Fletcher et al. (2000), six of the items were administered and summed to attain a composite score representing global perceived relationship quality (possible range: 6 to 42); these six items demonstrated adequate internal consistency in the study sample (Cronbach's α = .89). Example items include, "How satisfied are you with your relationship?" and "How committed are you to your relationship?" The PRQC was included in models to control for overall romantic relationship satisfaction.

RESULTS

Preliminary Analyses

Data were analyzed using IBM SPSS version 24 and the PROCESS macro (Hayes, 2013). Due to an error in the online survey logic, some participants were missing response options for the SIRRS-R adequacy scale, and thus were excluded from the analyses (n = 44). Several other measures (PSC, PRQC, BES, and EDEQ) had items missing, and listwise deletion was performed (less than 2.5%). The measure for psychological abuse (MMEA) had 9.8% missing data at the item level, and mean substitution was performed when computing composite scores. Univariate outliers (+/- 3 *SD*s outside of the mean) were identified and removed from the relationship quality (n = 2) and psychological abuse (n = 2) measures. Skewness and kurtosis were within normal limits for all variables except psychological abuse (MMEA); thus, a square root transformation was used for MMEA scores to address non-normality. Participants who did not respond to any survey items (n = 5) were excluded from analyses, resulting in a sample of 146 subjects in the regression analyses.

Means and standard deviations for all predictors and outcomes are reported in Table 1. Disordered eating, as measured by the EDEQ, was nearly equivalent to the averages reported in large samples of undergraduates (Luce, Crowther, & Pole, 2008). In contrast, nearly 14% reported moderate to severe binge-eating symptom severity, and on average, participants endorsed considerably more items on the BES than previous studies of undergraduate students (10.34 in the present study vs. 2.89 for undergraduate women; Sulkowski, Dempsey, & Dempsey, 2011). Participants in the present study also reported less frequent experiences of partner psychological aggression relative to other samples of undergraduate students (i.e., average frequency scores of 10.9 for men and 9.49 for women in the present study vs. 16.7 in undergraduate females; Shorey, Brasfield, Febres, Cornelius, & Stuart, 2012). To assess the comparability of males and females, independent t tests were conducted. Women reported significantly higher levels of disordered eating and binge eating than men (ts ranged from 3.76 to 7.05, ps < .001), as can be expected from previous literature (e.g., Luce et al., 2008).

***Table 1*. Sample Demographics for Relationship and Disordered Eating Variables**

Construct/Measure	Men (n = 48) *M (SD)*	Women (n = 150) *M (SD)*	Group differences
Relationship Quality			
PRQC Satisfaction	36.63 (5.53)	36.66 (6.00)	$t(192) = -0.39$, ns
Relationship Conflict			
PSC Negative Communication	5.51 (3.20)	5.82 (4.10)	$t(98.75) = -0.53$, ns
MMEA Psychological Aggression	10.90 (21.95)	9.49 (17.07)	$t(137) = 0.41$, ns
Partner Support			
SIRRS-R Adequacy	20.13 (4.88)	20.27 (5.94)	$t(151) = -.37$, ns
Eating Disorder Symptoms			
EDEQ Composite	0.65 (0.76)	1.79 (1.45)	$t(154.91) = -7.05$***
BES Binge Eating	6.44 (5.61)	10.34 (7.91)	$t(112.22) = -3.76$***

*$p < .05$. ** $p < .01$. ***$p < .001$.

Level of significance was $\alpha = .05$ for all inferential statistics, and Hinkle, Wiersma, and Jurs' (2003) guidelines were used for determining the size of correlation coefficients and effects. Bivariate correlations are presented in Table 2. Scores were collapsed across men and women for these analyses. Consistent with standard data screening practices (Tabachnick & Fidell, 2013) we reviewed correlations among study variables. Correlations exceeding .70 signal multicollinearity and potential problems with discriminant validity of measures. The correlation between scores of the eating behavior measures (EDEQ and BES) was large in size ($r = .66$, $p < .001$), though it suggested that the measures could be examined as unique constructs. The correlation between scores on relationship conflict measures (PSC negative communication and MMEA partner aggression ratings) was similarly large in size ($r = .53$, $p < .001$), and in the appropriate to examine the measures as separate predictors. We also examined relationship length, BMI, gender, and age in bivariate correlations with predictor and outcome variables for potential inclusion as covariates in regression models. Relationship length was positively associated with relationship satisfaction levels ($r = .37$, $p < .001$) and psychological aggression ($r = .17$, $p < .05$), but was not associated with either of the disordered eating outcome variables. Gender and BMI were associated with outcome variables, such that women and individuals with higher BMI reported greater levels of disordered eating symptoms. Additionally, younger age was associated with higher scores on both measures of disordered eating: the

EDEQ (r = -.18, p < .01) and BES (r = -.20, p < .01). Ultimately, age, BMI, and gender were included as covariates in the models.

***Table 2*. Bivariate Correlations Among Model Constructs**

	1	2	3	4	5	6
1. PRQC Satisfaction	--					
2. PSC Negative Communication	-.42***	--				
3. MMEA Psychological Aggression	-.16*	.53***	--			
4.SIRRS-R Adequacy	.25**	-.47***	-.33***	--		
5. EDEQ Total	-.02	.10	.18*	-.12	--	
6. BES Total	-.11	.16*	.21**	-.23**	.66***	--

*p<.05. ** p<.01. ***p<.001.

Beyond Hierarchical regressions were performed with disordered eating variables entered as outcome measures and negative communication and psychological abuse as predictors. Two dimensions of conflictual behavior were examined: negative communication styles (PSC) and psychological abuse perpetrated by a romantic partner (MMEA). Regressions were performed including several covariates in the first step of the models (Age, BMI, Gender, and PRQC Relationship Satisfaction). In the second step of the models, relationship conflict measures (PSC and MMEA) were entered as predictors of disordered eating symptoms (EDEQ and BES), followed by partner support (SIRRS-R) in the following step, and then the interaction term. Separate moderation models were tested with each of our measures of relationship conflict: negative communication (PSC) and psychological aggression (MMEA). Interaction terms were generated with standardized variables, and all variables were standardized prior to entry in the regression. Results are presented in Table 3.

***Table 3*. Hierarchical Regressions Predicting Disordered Eating Variables, Controlling for Subject Age, BMI, Gender, and Relationship Satisfaction (PRQC)**

		Criterion: Binge-eating (BES)			Criterion: Eating Pathology (EDEQ)		
Step	Predictors	β	ΔR^2	ΔF	β	ΔR^2	ΔF
Negative Communication[1]							
2	PSC	.06	.05	$F(2, 136) = 3.86$*	.01	.00	$F(2, 138) = 0.41$
	SIRRS-R	-.18*			-.06		
3	PSC	.06	.04	$F(1, 135) = 4.85$**	.03	.02	$F(1, 135) = 4.17$*
	SIRRS-R	-.27**			-.13		
	INT[a]	.17**			.17		
Psychological Aggression							
2	MMEA	.13	.06**	$F(2, 138) = 5.11$**	.08	.01	$F(2, 138) = 1.18$
	SIRRS-R	-.17*			-.06		
3	MMEA	.19*	.01	$F(1, 137) = 1.97$	.11	.00	$F(1, 137) = 0.43$
	SIRRS-R	-.20*			-.07		
	INT[b]	.13			.06		

*p<.05. ** p<.01. ***p<.001.
[a]PSC x SIRRS-R interaction. [b]MMEA x SIRRS-R interaction.
[1]Higher Scores on the PSC reflect higher levels of endorsed negative communication

To better elucidate the conditional effects of conflict on disordered eating symptoms at varying levels of support, we examined significant interaction effects using a Regions of Significance (RoS) approach (Preacher, Curran, & Bauer, 2006). Regression analyses revealed a significant positive interaction between support adequacy and negative communication, standardized beta (β) = .20, $p < .01$, in a model predicting binge eating symptoms. Using the PROCESS macro for SPSS (Hayes, 2013) we utilized the Johnson-Neyman technique to examine the regions of significance for the conditional effects of conflict on binge eating behaviors at different levels of support adequacy. This technique revealed that negative communication was negatively associated with binge eating when support adequacy ratings were -2.91 *SD*s below the mean, β = -.38, $p < .05$, or lower; however, it is notable that this negative effect (i.e., more negative communication associated with lower levels of binge eating) was only observed in 2.94% ($n = 6$) of the present sample. To further investigate this significant interaction, we also calculated the

conditional effects of support adequacy on binge eating at various levels of negative communication. The conditional effects of support adequacy on binge eating symptoms were observed at 0.52 SDs above the mean of negative communication (PSC), $\beta = -.26$, $p < .05$, and lower, such that more adequate support was associated with lower levels of binge eating to the extent that couples engaged in less negative communication. Approximately 76% of the sample ($n = 110$) had negative communication scores in this range. No other significant interactions were observed.

Psychological aggression perpetrated by romantic partners (MMEA) did not predict binge eating (BES) or general disordered eating (EDEQ) symptoms after accounting for covariates (see Table 3), nor did it interact with support adequacy, $\beta = .13$, $p > .05$. However, support adequacy (SIRRS-R) independently predicted binge eating symptom severity when entered in the second-stage of a model with psychological aggression (MMEA), $\beta = -.20$, $p < .01$.

DISCUSSION

The purpose of the present study was to investigate the roles of intimate relationship conflict and partner support in connection with disordered eating symptoms in college students. Additionally, we sought to investigate whether support adequacy moderated the hypothesized association between relationship conflict and disordered eating, such that greater support adequacy mitigated the negative impact of conflictual interactions. The results of the present study provided some support for our hypotheses and suggest that relationship processes (support and conflict) are connected to eating pathology in college dating samples.

We observed a significant interaction between negative communication and support adequacy in the model predicting levels of binge eating, such that for individuals with very low support adequacy (-2.91 SDs below the mean or lower), negative communication was a significant negative predictor of binge eating, such that *higher* levels of negative communication were associated with *lower* levels of binge eating. This association was significant after accounting for age, gender, BMI, and self-reported relationship satisfaction. Nonetheless, it is notable that a very small proportion of the sample, less than 3%, actually fell within this range of low support adequacy. In contrast, when examining conditional effects of support adequacy on binge eating at various levels of negative communication, a more prominent pattern of results emerged that helped to disentangle the implications of this interaction effect. For individuals reporting low or average levels of negative communication with their partners (0.54 *SD*s above the mean or lower), receiving more adequate support was associated with less binge eating; however, when negative communication was high, support adequacy was not associated with eating pathology, suggesting that individuals do not benefit from the protective effects of adequate

partner support if they are also engaging in high levels of negative communication with their partners. Thus, despite a lack of evidence for our hypothesized buffering effect (i.e., support mitigates the link between conflict and eating symptoms), results do indicate that partner support plays a protective role in eating disorders, but only to the extent that couples have effective conflict management skills.

The present study has implications for the broader literature on disordered eating. Results demonstrate the importance of examining multiple dimensions of intimate relationships in connection to self-reported eating disorder symptoms. One of the most notable findings in the present study suggested that individuals might be more sensitive to the protective effects of support when negative, conflictual interactions are relatively low or minimal. Conversely, when levels of negative interaction are high, individuals may be less protected by the positive influence of support from their partner. Greater negative communication was also associated with *lower* binge eating symptoms for individuals with very low support adequacy. This pattern of results was contradictory to our hypotheses and warrants further investigation; however, this effect was only present for a very small proportion of the study (less than 3%) and should be interpreted with caution. Nonetheless, one possible interpretation is that individuals in this low range of support scores are more disengaged and, consequently, more likely to avoid relationship problems. Thus, engaging in arguments, even if issues are not resolved in the most skillful manner, might serve to address underlying relationship problems that would otherwise enhance eating pathology. Future research is necessary to replicate this effect and investigate the processes underlying this unexpected pattern of results.

Though our analyses yielded a number of interesting results, it is possible that survey and sample limitations impacted our investigation. Participants endorsed high support satisfaction in our sample, and the observed associations may differ for samples reporting less adequate support. Additionally, the SIRRS-R assesses general relationship support, and may have been too broad to assess support appropriately in connection to eating behaviors or not sensitive enough to parse out differences in our sample of dating couples. Further, a more complicated possibility lies in participants' support preferences, which may vary depending on the context of support transaction (i.e., related vs. nonrelated to diet, exercise, or body image). Additional work is needed to investigate the context of support transactions in direct connection to eating disorders. Our survey battery also failed to include a general measure of social support. It is possible that low frequency of partner support can be compensated with assistance from broader support networks including family and friends. Additionally, since dyadic information was not collected, inferences could not be made as to the bidirectional influence of relationship processes and eating patterns. Future studies should be conducted with dyadic samples to continue to investigate the role of romantic relationships in eating behavior. Our study also did not examine potential comorbidity between eating pathology and a number of health behaviors (sexual behaviors, alcohol and drug use) that have been explored in undergraduate samples. As

well, the current study assessed individuals at a single time point, and the authors could not determine how the health behaviors or relationship variables changed in frequency or association over time. Relationship stage should also be examined in future studies, as the present focus was on dating couples, and results may not generalize to relationships of considerable length or level of commitment. Despite these limitations, our findings begin to demonstrate the unique roles of conflict and support in disordered eating pathology.

Conclusion

The present study illustrated the role of relationship conflict and support as predictors of disordered eating in a sample of college student adults. Though our study demonstrated the protective role of support, in the absence of negative communication, future studies are needed to elucidate the role of support as a potential buffer against other risk factors for eating pathology, and to investigate the observed associations in cohabitating couples and clinical populations. Notably, the current study has implications for social scientists studying romantic relationships and health. Results demonstrate the utility of examining multiple dimensions of intimate relationships and examining the complex interplay between relational processes to clarify under what conditions partners are at greatest risk for adverse health outcomes and identify the optimal conditions for promoting health.

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