Dieting Also Starves Romantic Relationships: The Association between Dieting and Romantic Relationship Quality

by

MacKenzie D. A. Robertson
B.A. (Hons.), Simon Fraser University, 2015

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We acknowledge with respect the Lekwungen-speaking peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

The negative health consequences of dieting for individuals are well established. Yet little is known about the interpersonal consequences of dieting for romantic couples. This study utilized self-report questionnaire data from undergraduate students (N = 221) and their romantic partners (N = 74) to examine whether dieting is associated with romantic relationship processes. I hypothesized that dieting engagement would indirectly predict worse relationship outcomes. Body dissatisfaction is a core dimension of self-esteem, and people with low self-esteem often project their self-doubts onto their partner. Because dieting is strongly associated with body dissatisfaction, I hypothesized that people who engaged in more extreme dieting may project their negative self-evaluations of their bodies onto their partners, resulting in negative evaluations of their romantic partner's attractiveness. Moreover, I expected that negative partner evaluations would predict worse relationship outcomes for both partners. As hypothesized, participants who engaged in more dieting (e.g., restricting food intake, feeling guilty after eating, compensatory behaviors) experienced higher body dissatisfaction, which predicted more negative evaluations of their romantic partner's physical attractiveness. In turn, finding their partner less attractive predicted more negative evaluations of their partner's worth, increased conflict, and lower commitment to their relationship. Moreover, romantic partners who were rated as less attractive perceived participants' negative evaluations of their attractiveness, and experienced lower self-esteem. However, participant dieting did not predict relationship outcomes for their romantic partners. Overall, results indicate that dieting is negatively

associated with both individual and interpersonal well-being. Findings must be replicated in longitudinal research, but highlight the potential for the negative consequences of dieting to extend beyond the individual to influence close relationship processes. This research also contradicts dominant models of dieting and close relationships that frame dieting in a positive light.

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Dedication

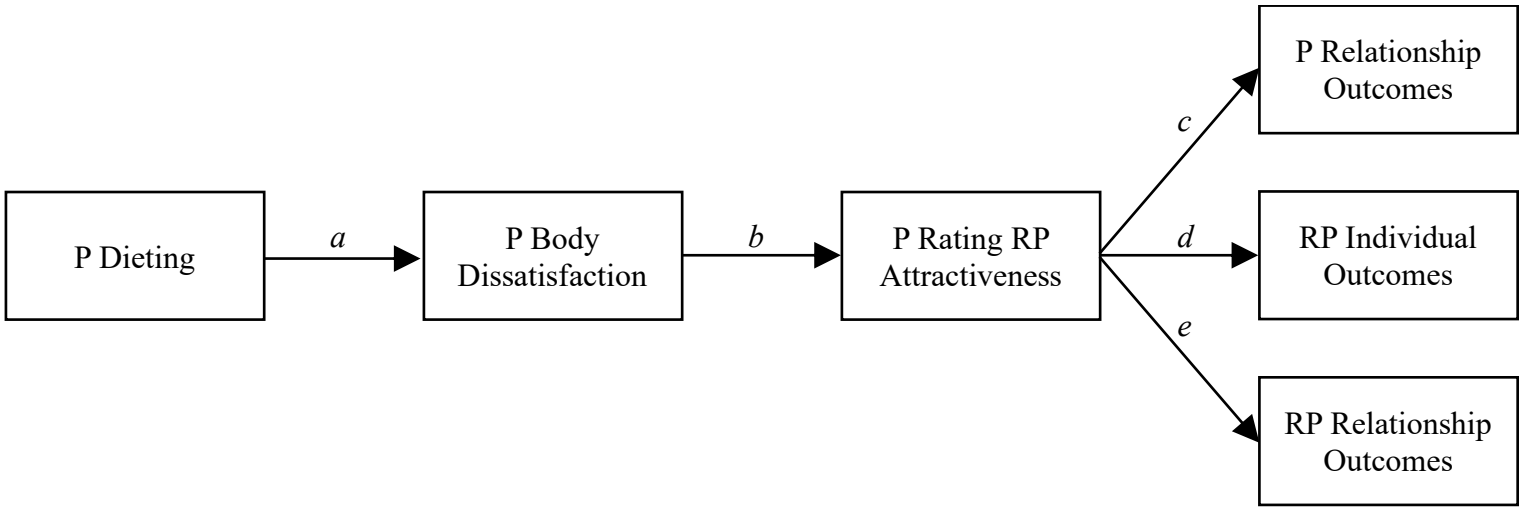
To anyone who has been led down the path of self-hatred by diet culture, and to all participants who have generously allowed us inside their minds so that we may better understand our own.

Research Overview

It is well-established that dieting is hazardous to the physical and mental health of individuals (e.g., Bacon & Aphramor, 2011). Dieting is a form of maladaptive eating that involves following external rules about eating—such as restricting the amount or types of food that one eats—and is often motivated by a desire to lose weight (e.g., Kerin, Webb, & Zimmer-Gembeck, 2019; Stice, Fisher, & Lowe, 2004). Dieting can be contrasted with intuitive eating, which is an adaptive eating practice where people use their internal hunger and fullness cues to guide what, when, and how much they eat (Tribole & Resch, 2012). Dieting behaviour predicts increased morbidity and mortality, likely due to complications arising from nutritional deficiencies (Daee et al., 2002). Dieting also predicts eating disorders, depression, and anxiety (Patton, Selzer, Coffey, Carlin, & Wolfe, 1999; Stice, Hayward, Cameron, Killen, & Taylor, 2000). However, the link between dieting and interpersonal processes is less well-understood. For example, do the negative psychological consequences of dieting influence how dieters evaluate and engage with other people? This lack of understanding is especially stark for romantic relationships, where past research has predominantly focused on *health-related social control*, or how people can influence their partner's eating behaviour, rather than studying broader relationship dynamics. Moreover, such research has adopted an exclusively positive perspective on dieting, positioning romantic relationships as a potential mechanism for supporting dieting behaviour (e.g., Markey, Gomel, & Markey, 2008). Although a few studies have examined the negative influence of specific behaviours, such as one partner's attempts to influence the other partner's eating behaviours, no studies have explicitly examined the possible negative consequences of dieting for romantic relationships.

Such empirical oversight matters because dieting is linked to a number of negative psychological health consequences that could influence romantic relationship outcomes. Notably, dieting is strongly associated with body image dissatisfaction (e.g., Neumark-Sztainer et al., 2006). Because body image is a core component of dimensional models of self-esteem (Crocker & Wolfe, 2001; Franzoi & Shields, 1984), I propose that body image will predict relationship outcomes in much the same way that self-esteem predicts relationship outcomes. For example, people with lower self-esteem have a heightened fear of rejection, perceive more real and imagined rejection threats, and react to perceived threats in self-protective ways, which can include derogating their partner (e.g., Murray, Holmes, & Collins, 2006). I propose that similar processes may also lead people with more negative body image to derogate their partner's appearance. In turn, negatively evaluating a partner's physical attractiveness will predict negative relationship outcomes for both partners, including lower commitment and higher conflict levels (Murray et al., 2006; Sangrador & Yela, 2000; Yela & Sangrador, 2001). In sum, being more critical of their own bodies might lead dieters to be more critical of their romantic partner's bodies as well, which could undermine the well-being of the relationship. Figure 1 depicts this proposed model, which I will test in the current research. Table 1 describes the hypotheses that are generated by this model which I will detail shortly.

Figure 1
Conceptual Study Model



Note. P = Participant; RP = Romantic Partner.

Table 1
Study Hypotheses

Hypothesis 1	People who diet more severely will have higher body dissatisfaction.
Hypothesis 2	People with more body dissatisfaction will be more critical of their romantic partner's appearance.
Hypothesis 3	People who rate their romantic partner as less physically attractive will have a lower relationship quality.
Hypothesis 4	People who rate their romantic partner as less physically attractive will make more negative evaluations of their partner's global worth.
Hypothesis 5	Romantic partners rated as less physically attractive will report lower global self-esteem.
Hypothesis 6	Romantic partners rated as less physically attractive will report that the participant would rate them as less attractive.
Hypothesis 7	Romantic partners rated as less physically attractive will report lower relationship quality.

Path *a*: Dieting Predicts Body Dissatisfaction

Compared to non-dieters, dieters typically experience higher levels of body dissatisfaction (Neumark-Sztainer et al., 2006). Although it is theorized that body dissatisfaction generally predates dieting (e.g., Cooley & Toray, 2001), the direction of this association is unknown and it is probable that the two have a recursive relationship. Thus, people who feel negatively about their bodies might try to change their bodies by dieting, which might further entrench negative thoughts about their body. Because dieters are preoccupied with their appearance, and because dieting increases the salience of cues related to one's body (e.g., Cooper & Fairburn, 1992; Green & Rogers, 1993; Jiang & Vartanian, 2012), dieters might notice self-perceived flaws in their appearance more frequently than non-dieters, leading to further body dissatisfaction. Therefore, I hypothesize that more severe dieting will predict higher body dissatisfaction (Hypothesis 1 [H1]; see path *a* in Figure 1).

What is Dieting?

Dieting is a form of maladaptive eating that has traditionally been defined as intentionally changing the way that one eats in an effort to lose weight (e.g., Brownell & Rodin, 1994; Laessle, Tuschl, Kotthaus, & Pirke, 1989; McLaughlin et al., 2018; Stice, 1998, 2001; Stice et al., 2004). Although dieting has generally been defined in terms of behaviours and motivations, in my research I have defined it as a form of maladaptive eating that incorporates behavioural, motivational, cognitive, and emotional components.

Behaviour. Behaviourally, I define dieting as the adoption of external rules for eating that typically override, ignore, or take the place of internal, uncontrolled/automatic hunger and fullness cues. This definition was formulated using a combination of sources including past behavioural definitions of dieting (e.g., Stice et al., 2004) and the literature on intuitive eating

Table 2
List of Dieting Behaviours

Dieting Behaviours	Binge eating
	Chewing and spitting out food
	Compensatory exercise
	Counting the content of one's food (e.g., kilocalories, fat, carbohydrates, sugar, etc.)
	Drinking water to suppress appetite
	Eating diet foods
	Eating less than usual and/or not eating until satiated
	Eating only at scheduled times
	Fasting
	Meticulously planning meals
	Monitoring and/or recording food intake
	Obsessively weighing oneself/monitoring one's weight
	Reducing snack intake
	Restricting one's intake of kilocalories
	Restricting the types of food one consumes
	Self-induced vomiting
	Skipping meals
	Using appetite suppressants
	Using diet teas or cleanses
	Using diet/weight loss pills or supplements
	Using laxatives or diuretics
	Using meal substitutes

Note. I developed this list with the help of the checklists used in French, Jeffery, & Murray, 1999; French, Perry, Leon, & Fulkerson, 1995; Malinauskas, Raedeke, Aeby, Smith, & Dallas, 2006; and Presnell, Stice, & Tristan, 2008.

(Tribole & Resch, 2012). Dieting behaviours vary widely, and range from the archetypal caloric restriction to behaviours like fasting, laxative/diuretic use, self-induced vomiting, and binge-eating episodes. Table 2 presents a comprehensive list of common dieting behaviours.

Notably, Table 2 includes behaviours such as binge eating and self-induced vomiting that are also associated with clinical eating disorders. This inclusion is in line with previous dieting research (e.g., French, Perry, Leon, & Fulkerson, 1995; Gillen, Markey & Markey, 2012; Nichter, Ritenbaugh, Nichter, Vuckovic, & Aickin, 1995; Reynolds & Meltzer, 2017), and it is

also in line with the *eating disorder continuum model* (Kerin, Webb, & Zimmer-Gembeck, 2019; Mintz & Betz, 1988; Mintz, O'Halloran, Mulholland, & Schneider, 1997; Tylka & Subich, 1999; Tylka & Subich, 2002). According to the eating disorder continuum model, maladaptive eating exists along a continuum. At one end is adaptive, unrestrained eating and at the other end are the most severe and life-threatening forms of clinical eating disorders. The kinds of maladaptive behaviors that characterize normative dieting practices in Western culture fall somewhere between those two ends of the spectrum. The continuum model proposes that all forms of maladaptive eating that fall along the continuum share core psychological characteristics and eating disturbances, what varies is the severity and frequency of those characteristics and disturbances (Mintz & Betz, 1988; Tylka & Subich, 2002). That is, people with clinical eating disorders are not qualitatively different from people with milder forms of maladaptive eating, they simply differ in terms of the severity of their psychological distress[1] and the severity of their eating disturbance. Therefore, more extreme dieting behaviours may occur more frequently in eating disorder populations, but they also occur among people who engage in more normative forms of dieting. This distinction is evident in the use of terms like *subclinical* or *disordered eating* in research representing people who engage in more extreme dieting behaviours but not frequently enough to meet criteria for a clinical diagnosis.

For example, someone with a clinical eating disorder may misuse over-the-counter or

[1] The high rates of comorbidity between maladaptive eating and other mental illnesses also supports the eating disorder continuum model. People with clinical and subclinical forms of eating disorders have higher rates of comorbid mental disorders compared to people who do not have an eating disorder (e.g., Crow, Agras, Halmi, Mitchell, & Kraemer, 2002; Gadalla & Piran, 2007; Gadalla & Piran, 2008; Godart, Flament, Perdereau, & Jeammet, 2002; Godart et al., 2007; Krahn, Kurth, Gomberg, & Drewnoski, 2005; Touchette et al., 2011). Moreover, the risk of having a comorbid mental disorder appears to increase incrementally as the severity of maladaptive eating increases. Aspen and colleagues (2014) found that people who were at a high risk of developing an eating disorder (i.e., high weight and shape concerns) were more likely to have a comorbid mental disorder compared to those who did not have an eating disorder and were at a low risk of developing an eating disorder (i.e., low weight and shape concerns), but were less likely to have a comorbid disorder than people who had a subclinical or clinical eating disorder.

prescription laxatives multiple times a day or fast for multiple days, whereas dieters with subclinical disordered eating may drink the laxative teas that are currently being promoted by celebrities (e.g., "flat tummy teas") or engage in the recent trend of "intermittent fasting" (Ro, 2018). These behaviors were evident when Neumark-Sztainer and colleagues (2011) examined the prevalence of maladaptive weight control behaviours in a community sample of 2287 young adults. Among the 59% of women and 35% of men who had dieted, 21% of women and 7% of men had engaged in at least one extreme weight control behaviour, such as taking diet pills (16% women, 7% men), laxatives (5% women, 2% men), or diuretics (4% women, 1% men), and engaging in self-induced vomiting (8% women, 1% men). Another 16% of women and 6% of men reported binge-eating episodes. Similarly, in their community sample of 14,322 young adults, Liechty and Lee (2013) found that 27% of women and 11% of men had dieted to lose weight, 6% of women and 1% of men had used extreme weight loss behaviours, and 7% of women and 5% of men had experienced binge-eating episodes. Thus, more extreme weight control behaviours occur commonly among non-clinical populations.

Motivation. Dieting motivations explain why people are dieting. When asked directly why they are dieting people often express a desire to lose weight or maintain weight loss, improve their physical or mental health, or some combination of these goals (Clarke, 2002; Grogan, 2017). It is possible, however, that at the core of these reasons is a more fundamental underlying motivation: the desire for worthiness, acceptance, love, and happiness. Advertisers commonly use messaging that equates thinness with virtue, happiness, success, beauty, and health to sell products (Gillan, 2000; Halliwell & Dittmar, 2004). In conjunction, fatter[2] people

[2] I have chosen to use the term "fat" throughout this paper because alternative terms such as "overweight" and "obese" are stigmatizing and represent arbitrarily defined classification categories (Blodorn, Major, Hunger, & Miller, 2016; Logel, Stinson, & Brochu, 2015).

are highly underrepresented in the media, and when they are represented, they are often presented as unhappy, unattractive, and unhealthy (Lafrance, Lafrance, & Norman, 2015; Puhl, Peterson, DePierre, & Luedicke, 2013). This is especially evident in the dieting industry where every product and plan is marketed as a way to be "a better, healthier, happier you" (Bacon, 2010, p. xxiii; Lafrance et al., 2015). These media representations could condition people to associate thinness with positive qualities and fatness with negative qualities. Indeed, numerous studies have found that people associate more negative attributes to fatness (e.g., lazy, unhappy, unloved, lacking self-control, unhealthy, unintelligent, dirty, smelly, etc.) and more positive attributes to thinness (e.g., health, morality, success, happiness, attractiveness, intelligence, etc.; e.g., Cash, 1990; Tiggemann & Rothblum, 1988). Thus, advertisers sell the message that thinness is equivalent to worthiness, acceptance, love, and happiness and that dieting is a guaranteed way to attain these things. In turn, people, and in particular, women (Buote, Wilson, Strahan, Gazzola, & Papps, 2011) may internalize this messaging and diet in an attempt to get these fundamental needs met.

Although this worthiness hypothesis concerning people's motivations for dieting remains to be empirically tested, there are a number of personal accounts from past dieters that have acknowledged this reality. For example, author and fat activist Virgie Tovar wrote, "Yes, I dieted because I believed that it was only through weight loss that I could deserve to travel, wear cute clothes, and go on lots of dates with people I was hot for. But more than that, I wanted the stuff that those things represented: happiness, love, joy, and most importantly, freedom. … I realize now that all those times I had said, 'I want to be thin,' I actually meant: I want to be loved. I want to be happy. I want to be seen. I want to be free." (2018, pp. 109-111). Similarly, a personal account from a woman named Kelly (presented in *Health at Every Size*, Bacon, 2010) illustrates

this point "…why [do] I keep trying so desperately to lose weight. Inside, I believe that weight loss is the only thing standing between me and happiness. So if I never get thin, I can never be happy, I can never become the person I want to be." (p. 5). Because of Virgie Tovar's involvement in fat activism, and Kelly's participation in a Health at Every Size (HAES) program trial, both of these women were exposed to ideas and concepts that most dieters are not privy to. Therefore, the idea that engaging in dieting is motivated by a desire for love may not be salient to most dieters. However, given that Kelly made this realization after only one HAES session, it is possible that with further probing, peoples' responses might reveal a deeper motivation for dieting. This possibility is in line with research showing that people make inferences about their own motives—rather than having direct access to them—that are more or less accurate depending on how salient and plausible influential stimuli are (Nisbett & Wilson, 1977). Thus, if the link between dieting and worthiness, acceptance, love, and happiness were made more salient and plausible for people, they might more accurately recount them as the motivation behind their dieting behaviours.

Cognition and emotion. Although dieting behaviours and motivations dominate measures to assess dieting, these measures often evaluate cognitions and emotions as well. For example, the Restraint Scale (Herman & Polivy, 1980) includes items assessing dieting cognitions (e.g., "Do you give too much time and thought to food?") and dieting emotions (e.g., "Do you have feelings of guilt after overeating?"). Other researchers have also used items assessing a preoccupation with food and weight, feeling guilty after eating, and a fear of gaining weight (e.g., Reynolds & Meltzer, 2017). Additionally, nutritional deprivation due to caloric restriction has been shown to increase irritability, nervousness, anxiety, apathy, and depression (Keys, Brožek, Henschel, Mickelsen, & Taylor, 1950). Thus, dieting is likely a multifaceted and

comprehensive construct that includes motivational, behavioural, affective, and cognitive components. In this research, I define dieting as a maladaptive psychological orientation towards food and eating that includes well-validated dieting behaviours and motivations, and the few cognitions and emotions that have been empirically examined. Specifically, these dieting cognitions and emotions are: a preoccupation with one's food intake and weight, and feeling guilty after eating.

Prevalence of Dieting

Dieting is a common practice in Western cultures (Grogan, 2017). Dieting behaviours may begin at a young age and continue throughout one's life (Fayet, Petocz, & Samman, 2012). Girls as young as five years old have indicated consciousness of dieting practices and dieting has been documented in children as young as nine (Balantekin, Savage, Marini, & Birch, 2014; Grogan & Wainwright, 1996; Maloney, McGuire, Daniels, & Specker, 1989; Robinson, Chang, Haydel, & Killen, 2001). Chronic dieters commonly experience considerable weight fluctuations as a result of alternating between periods of dieting and non-dieting throughout their lives, a process called *weight cycling* or *yo-yo dieting* (Bacon & Aphramor, 2011; Brownell, Greenwood, Stellar, & Shrager, 1986). Approximately 20% to 60% of young adult women and 8% to 35% of young adult men have dieted (Liechty & Lee, 2013; Neumark-Sztainer et al., 2011; Slof-Op 't Landt et al., 2017). The prevalence of dieting varies by age, gender, sexuality and body size.

In all age groups, cisgender[3] (cis) women are more likely to diet than cis men (Gillen, Markey, & Markey, 2012; Jeffery, Adlis, Forster, 1991; Kjelsas, Bjørnstrøm, & Götestam, 2004; Liechty & Lee 2013; Mangweth-Matzek et al., 2006; Neumark-Sztainer, Wall, Larson,

[3] Cisgender people's gender identity corresponds with the gender/sex they were assigned at birth; whereas, transgender people's gender identity differs from the gender/sex they were assigned at birth (Calzo, Blashill, Brown, & Argenal, 2017).

Eisenberg, & Loth, 2007; Slof-Op ‘t Landt et al., 2017). Cis women are also more likely to diet at increasingly severe levels (Slof-Op ‘t Landt et al., 2017), and are more likely to persist in dieting at a lower body mass index (BMI; kg/m^2) compared to cis men (Fayet et al., 2012). No studies have explicitly examined whether rates of dieting differ between cis and transgender (trans) individuals. However, given the higher rates of body dissatisfaction and heightened risk of eating disorders observed in trans populations, it is likely that they also experience higher rates of dieting compared to cis people (Ålgars, Alanko, Santtila, & Sandnabba, 2012; McClain & Peebles, 2016; Witcomb et al., 2015). Similarly, people who identify as lesbian, gay, or bisexual (LGB) have elevated rates of dieting and eating disorders compared to people who identify as straight (Calzo et al., 2015; Hadland, Austin, Goodenow, & Calzo, 2014; Matthews-Ewald, Zullig, & Ward, 2014; McClain & Peebles, 2016; Robin et al., 2002). Rates of dieting also vary by age groups. Cis women between the ages of 35 and 65 and cis men between the ages of 45 and 65 report the highest rates of dieting (Slof-Op ‘t Landt et al., 2017). No studies have examined age differences in trans populations. Rates of dieting are also positively associated with body size. Fatter people are more likely to diet than thinner people (Balantekin et al., 2014; Gillen et al., 2012; Neumark-Sztainer & Hannan, 2000; Rodgers et al., 2017; Shiraishi et al., 2014). In sum, cis women, transgender people, LGB people, middle-aged people, and fatter people are more likely to diet, and as a result, these groups are more likely to experience the negative consequences associated with dieting.

Consequences of Dieting

According to the dominant Western health paradigm, dieting is lauded as a way to ensure weight loss, which is viewed as the panacea for all health concerns of fatter people (Bacon & Aphramor, 2011). As a result, dieting is viewed positively in most academic articles and

continues to be prescribed by health care practitioners and promoted in public health campaigns (Bacon & Aphramor, 2011; Balantekin et al., 2014; Fayet et al., 2012; Shiraishi et al., 2014). There is compelling evidence, however, that the benefits proclaimed by health authorities are unfounded and that dieting leads to long-term weight gain as well as significant negative physical and mental health consequences.

Weight-centered health paradigm. The dominant health paradigm is a weight-centered approach that utilizes BMI to determine people's health status. Specifically, it mandates that people fall within a certain BMI range to be considered healthy, and that anyone below or above this range is considered to be unhealthy (Centers for Disease Control and Prevention, 2016). It is considered to be especially unhealthy to weigh more than the ideal, and the weight-centered health paradigm mandates that higher weight individuals lose weight to attain health. One of the most commonly recommended ways to achieve weight loss is by dieting. There are at least two major issues with this perspective.

First, dieting does not produce long-term weight loss. In 95-97% of cases, dieting does not producing long-term weight loss and instead often leads to weight gain (Cooper et al., 2010; Cussler et al., 2008; Dansinger, Tatsioni, Wong, Chung, & Balk, 2007; Field et al., 2003; Kafka, 1992; Mann et al., 2007; Miller, 1999; Savage, Hoffman, & Birch, 2009; Stahre, Tärnell, Håkanson, & Hällström, 2007; Stice, Cameron, Killen, Hayward, & Taylor, 1999; Svetkey et al., 2008). To help ensure survival during periods of famine, humans have evolved complex biological systems that prevent weight loss and maintain weight homeostasis (Bacon, 2010). When people diet, the resulting deficient nutritional intake and diminishing fat stores triggers physiological mechanisms designed to help the body survive during times of famine (Bacon, 2010). The further weight falls below the body's set-point weight range (Schwartz, 2001), the

harder the body will work to bring weight back in line and the stronger these weight-restoration mechanisms will become (Bacon, 2010). This explains why virtually all dieters can experience short-term weight loss, but virtually no one can (safely) maintain long-term weight loss (Bacon, 2010). Furthermore, the biological changes that occur as a result of dieting can trigger people's set point weight range to increase to protect against future deprivation threats (Bild, Sholinsky, Smith, & Lewis, 1996; Coakley, Rimm, Colditz, Kawachi, & Willett, 1998; French et al., 1994; Korkeila, Rissanen, Kaprio, Sørensen, & Koskenvuo, 1999; Shunk & Birch, 2004; Stice et al., 1999; Stice, Presnell, Shaw, & Rohde, 2005). This is why dieting predicts weight gain in the long-term.

Second, BMI is only weakly associated with morbidity and mortality rates. For most people, BMI is not a helpful predictor of longevity (Flegal, Graubard, Williamson, & Gail, 2005). BMI is only an accurate predictor of mortality for people at the very lowest and highest ends of the spectrum (Flegal et al., 2005). When other risk factors are statistically controlled (e.g., socioeconomic status [SES], dieting, physical activity levels, weight cycling, etc.) people categorized as "overweight" or "moderately obese" have equivalent or lower mortality rates compared to people categorized as "normal weight" (Durazo-Arvizu, McGee, Cooper, Liao, & Luke, 1998; Flegal et al., 2005; Janssen & Mark, 2007; Lantz, Golberstein, House, & Morenoff, 2010; McGee & The Diverse Populations Collaboration, 2005; Troiano, Frongillo, Sobal, & Levitsky, 1996). Additionally, for many chronic diseases, including type II diabetes, hypertension, cardiovascular disease, and chronic kidney disease, fatter people experience lower mortality rates than their thinner counterparts (Barrett-Connor, 1985; Barrett-Connor & Khaw, 1985; Beddhu, 2004; Childers & Allison, 2010; Kang et al., 2006; Morse, Gulati, & Reisin, 2010; Ross, Langer, & Barrett-Connor, 1997). People who are categorized as "obese" do have

higher morbidity rates. However, studies that account for confounding variables that predict both weight and morbidity—such as SES, dieting history, physical activity level, and weight cycling––typically observe that the increased morbidity risk either no longer exists or is severely attenuated (Bacon & Aphramor, 2011; Diaz, Mainous, & Everett, 2005).

In summary, dieting does not lead to long-term weight loss and often results in long-term weight gain; the link between weight and health is complex; and any increased risk of disease that is associated with higher weights has not been adequately studied to rule out potential confounding factors. Finally, even if long-term weight loss was possible and the associations between BMI and health outcomes were strong, there is no evidence to suggest that fatter people who maintain weight loss would attain the same health benefits as people who are naturally thin (Bacon, 2010). Thus, there is little support for the health benefits of dieting. Conversely, dieting is associated with a number of serious negative physical and psychological health outcomes (Bacon & Aphramor, 2011).

Negative health consequences of dieting. Level of dieting engagement predicts increased morbidity and mortality (Daee et al., 2002; Shiraishi et al., 2014). The increased risk of disease and death associated with dieting engagement may be explained by dieting-induced nutritional deficiencies. Nutritional deficiencies can lead to a number of adverse consequences, including delayed growth and pubarche in adolescence, electrolyte imbalances, and decreased bone mass (Bacon, Stern, Keim, & Van Loan, 2004; Barr, Prior, & Vigna, 1994; Davis, Apley, Fill, & Grimaldi, 1978; French & Jeffery, 1994; Pugliese, Lifshitz, Grad, Fort, & Marks-Katz, 1983; Shiraishi et al., 2014; Van Loan, Bachrach, Want, & Crawford, 2000; Van Loan & Keim, 2000). Dieting is also associated with gastrointestinal disorders (Satherley, Howard, & Higgs, 2015) which have also been found in up to 98% of patients with clinical eating disorders (Boyd,

Abraham, & Kellow, 2009; Janssen, 2010)—suggesting a strong link between maladaptive eating and gastrointestinal disorders. In turn, these negative consequences can increase mortality and morbidity rates. For example, electrolyte imbalances can cause dangerous heart conditions that cause the heart to beat abnormally fast or abnormally slow—tachycardia and bradycardia respectively—and increase the risk of premature death. Furthermore, if left untreated, electrolyte imbalances in and of themselves can be fatal (Balci et al., 2013).

Dieting engagement is also associated with negative mental health outcomes including serious psychological disorders. Dieting is predictive of further entrenchment and increased severity of eating pathology. In a large prospective study with adolescents, dieting level was the strongest predictor of developing an eating disorder (Patton, Selzer, Coffey, Carlin, & Wolfe, 1999). Specifically, dieters were between five and 18 times more likely to develop eating disorders compared to their non-dieting counterparts. Other psychological disorders such as depression and anxiety are also linked to dieting (Crow, Eisenberg, Story, & Neumark-Sztainer, 2006; French & Jeffery, 1994; Stice, Hayward, Cameron, Killen, & Taylor, 2000). In addition, heightened and persistent irritability (French, Story, Downes, Resnick, & Blum, 1995), emotion dysregulation and poor impulse control (Ackard, Croll, & Kearney-Cooke, 2002; Polivy, 1996) can manifest in dieters. Most relevant to my proposed research, dieting is also associated with worse self-perceptions, including lower self-esteem (Daee et al., 2002; Serdar et al., 2011) and negative body image (Neumark-Sztainer et al., 2006).

Dieting and Body Image

Body image is conceptualized as the perceptions that people have of their body and the thoughts, feelings, and emotions related to those perceptions (Grogan, 2017). It is a multifaceted construct and generally is divided into two dimensions: perception and attitude. These

dimensions are hypothesized to be independent, such that people may experience distress in one dimension without experiencing distress in the other (Gardner, 2012). Perceptual body image is composed of the psychological processes used to understand, organize, and interpret the sensory input about one's body (i.e., "how people physically experience their body"; Cash, 2012; Gardner, 2012). The predominant focus of perceptual body image research is body size estimation. Attitudinal body image reflects a person's degree of satisfaction with their body and the extent to which their appearance determines their self-worth (Cash, 2012; Grogan, 2017). This facet of body image is divided into three components: affective, behavioural, and cognitive (Cash, 2012; Grogan, 2017). The affective component of attitudinal body image corresponds to the feelings people have towards their bodies. The cognitive component of attitudinal body image includes the thoughts and beliefs people have about their bodies and the importance they place on appearance in determining their self-worth. Finally, the behavioural component of attitudinal body image involves the engagement in, or avoidance of, certain behaviours relevant to one's appearance. This includes body-checking behaviours such as repeatedly checking one's appearance or pinching or measuring various body parts with one's hands. It also incorporates avoiding one's reflection in mirrors, being seen in public, and situations where one's body is exposed (e.g., swimming). There are various instruments available to assess one or more of the individual body image components (see Gardner, 2012 for a comprehensive table of attitudinal body image measures). My research focuses on attitudinal body image.

Body dissatisfaction prevalence. Body dissatisfaction has been described as a "normative discontent" among American women (Rodin, Silberstein, & Streigel-Moore, 1984). That is, body dissatisfaction is so common that it represents the experiences of the average person rather than a select few. However, no recent nationally representative studies exist to

confirm this assertion and results vary widely between non-representative samples (Fallon, Harris, Johnson, 2014; Frederick, Jafary, Gruys, & Daniels, 2012). Thus, body dissatisfaction may not be as prevalent as previously assumed. Regardless of the exact estimates, body dissatisfaction is detrimental to individual health and is disproportionately experienced by cis women, transgender people, gay men, and fatter people.

Cis women experience more pressure to conform to beauty ideals and more body dissatisfaction than cis men (e.g., Frederick, Forbes, Grigorian, & Jarcho, 2007; Frederick, Peplau, & Lever, 2006; Frederick, Sandhu, Morse, & Swami, 2016). Cis women are more likely to evaluate their bodies based on appearance rather than function; whereas the opposite is true for cis men (Grogan, 2017; Ricciardelli, McCabe, Lillis, & Thomas, 2006). Additionally, since cis men hold a much larger portion of the world's wealth, they are less dependent on appearance as a form of social currency (Grogan, 2017). Conversely, cis women have less access to financial resources and are taught to view their appearance as their main source of social currency (Orbach, 1993; Orbach, 2009). Moreover, cis men's bodies have only relatively recently started to be presented in the media in increasingly unrealistic, idealized, and objectifying ways; whereas cis women's bodies have traditionally been presented in this way (Diedrichs, 2012; Grogan, 2017). Furthermore, it is even more recently that straight cis men have become the target of such unrealistic and objectifying media representations. Previously, these portrayals were only targeted towards gay cis men. Exposure to objectifying and idealized portrayals of bodies in the media is associated with higher levels of body dissatisfaction (e.g., Botta, 2000; Grabe, Ward, & Hyde, 2008; Groesz, Levine, & Murnen, 2002). Thus, it is possible that rates of body dissatisfaction in straight cis men will gradually increase as the length of time they are exposed to unrealistic media images increases.

The primary subject of cis women's and cis men's body image concerns also differs. Whereas cis women typically indicate a desire to be thinner, reflecting the thin female ideal, cis men equally indicate a desire to be thinner and a desire to be larger and more muscular, reflecting the lean muscular male ideal (Ricciardelli & McCabe, 2003; Schur, Sanders, & Steiner, 2000). Similar patterns emerge in trans populations. However, because trans people can experience gender-based discomfort and distress in relation to their bodies (van de Grift et al., 2016), they often experience heightened rates of body dissatisfaction compared to cis people (van de Grift et al., 2016). Broadly, trans women often desire to be thinner to appear more "feminine" and trans men may desire to become thinner or more muscular to appear more "masculine" (Bockting & Allen, 2012).

Body size is also an important predictor of body image concerns. Overall, fatter people experience greater rates of body dissatisfaction compared to thinner people (Schwartz & Brownell, 2004). Since fat individuals are further away from societal body ideals, and experience stigma as a result of their size, they are more likely to experience discomfort and distress in relation to their body. Body dissatisfaction occurs across the lifespan and rates of body dissatisfaction do not appear to differ between age categories up to age 60 (Tiggemann, 2004; Tiggemann, Martins, & Kirkbride, 2007). However, past the age of 60, body dissatisfaction appears to decrease for women and increase for men as they get older (Tiggemann, 2004; Tiggemann et al., 2007). In summary, we know that cis women, gay cis men, trans people, and fat individuals experience more body dissatisfaction on average than straight cis men, cis people, and thin people, respectively.

Body dissatisfaction correlates. A number of negative health outcomes are linked to poor body image, including, but not limited to, depression (Johnson & Wardle, 2005; Stice &

Bearman, 2001), social anxiety (Tantleff-Dunn & Lindner, 2011), lower self-esteem (Darby, Hay, Mond, Rodgers, & Owen, 2007; O'Dea, 2012; van den Berg, Mond, Eisenberg, Ackard, & Neumark- Sztainer, 2010), subjective well-being (DeNeve & Cooper, 1998) and overall quality of life (Cash & Fleming, 2002; Mond et al., 2013). Most relevant to my research, negative body image is also strongly associated with dieting (Neumark-Sztainer et al., 2006; Stice & Shaw, 2002; Thompson, Heinberg, Altabe, Tantleff-Dunn, 1999).

Although most studies are correlational and therefore cannot determine the directionality of the association between dieting and body image, researchers theorize that a poor body image precedes dieting and is a fundamental antecedent to clinical eating disorders (Cooley & Toray, 2001; Johnson & Wardle, 2005; Polivy & Herman, 2002). It takes a powerful driving force to endure the often arduous and painful dieting behaviours. A negative body image may be just such a force, especially if dieting and weight loss are perceived to be a way to relieve body image distress. Thus, body dissatisfaction can prompt people to start dieting. However, after onset, dieting may further undermine body image. Dieting requires intense self-surveillance, and it can increase the salience of cues related to food, eating, and one's body, causing people to notice body concerns more frequently (e.g., Cooper & Fairburn, 1992; Green & Rogers, 1993; Jiang & Vartanian, 2012). In turn, increased exposure to negative thoughts and feelings about one's body may increase body dissatisfaction. Thus, in the present research, I hypothesize that dieting will predict heightened body dissatisfaction (H1; see path *a* in Figure 1).

Path *b*: Negative Body Image Predicts Negative Evaluations of Partner Attractiveness

Personal accounts of body dissatisfaction propose a direct relationship between how people view their own bodies and how they view the bodies of others. For instance, in *The Body is Not an Apology*, Sonya Renee Taylor (2018) writes, "Our relationships with our own bodies inform our relationships with others. … When we are saddled with body shame, we see other bodies as things to covet or judge." (p. 9). In essence, Taylor is suggesting that people who are more critical of their own bodies are likely to be more critical of other's bodies as well. Drawing from self-esteem research, I predict that people who have more body dissatisfaction are also more critical of their romantic partner's appearance (H2; see path *b* in Figure 1).

The Nature and Importance of Romantic Bonds

People have an inherent need to form intimate bonds with others (i.e., "a need to belong"; Baumeister & Leary, 1995; Deci & Ryan, 2000). People tend to form social bonds easily and often experience intense emotional reactions and go to great lengths to protect these bonds when threatened (Miller, 2014). Individuals with fewer intimate bonds demonstrate an increased risk for a number of health issues, including higher mortality rates (Berkman & Glass, 2000; Coyne et al., 2001; Hawkley & Cacippo, 2010; Pressman et al., 2005). People with more intimate bonds tend to experience more happiness, health, and longevity than individuals with fewer intimate connections (Gouin et al., 2010; Kern, Porta, & Friedman, 2014). The quality of people's intimate relationships also contributes to their physical and psychological health (Robles, Slatcher, Trombello, & McGinn, 2014). For instance, people with more negative intimate relationships generally experience higher rates of anxiety disorders and substance abuse compared to people with more positive intimate relationships (Whisman, 2013). In sum, people may have an implicit desire to form intimate relationships and the quantity and quality of

intimate bonds are important determinants of people's well-being. As such, it is important to understand what factors might contribute to, or interfere with, positive relationship interactions. One of the goals of my thesis research is to contribute to this area of inquiry.

Intimate relationships are distinguishable from casual relationships by the degree of knowledge shared between intimates and the level of interdependence, care, trust, responsiveness, mutuality, and commitment present in the relationship (Lavee & Ben-Ari, 2007, as cited in Miller, 2014). That is, people share more with, know more about, and care more about their intimate partners than other people. They also trust their intimate partners more and are more responsive to their partners' needs compared to other people. Intimates often think of themselves as an item (i.e., "us") rather than two independent individuals (i.e., "me" and "her/him/them"), and rely on and influence each other more often, more intensely, in more ways, and over longer periods of time compared to other people. Finally, intimate relationships are characterized by a high degree of commitment between partners, who often believe that their relationship will last forever.

Romantic relationships are a subset of intimate relationships characterized by a powerful attraction to, or feeling of love for, one's partner, as well as the courting behaviours used to convey such feelings (Miller, 2014). Romantic relationships also commonly include feelings of sexual attraction and sexual behaviour, although such feelings and behaviours are not always present and are not necessary to distinguish romantic relationships from other intimate bonds. People's romantic relationships also influence, and are influenced by, their feelings of self-worth.

Self-Esteem and Relationships

Self-esteem is commonly defined as a person's subjective evaluation of their worth as a person (Leary & Baumeister, 2000). Self-esteem has chronic and acute components. *State self-esteem* reflects a person's evaluation of their self-worth at any given point in time; whereas, *global self-esteem* reflects a person's general, overall, long-term evaluation of their self-worth. Global self-esteem is largely determined by factors that influence the likelihood of social inclusion (Leary & Baumeister, 2000). Namely, global self-esteem is determined by the degree that people perceive themselves to be likeable, competent, physically attractive, and moral, because these traits are more likely to lead to social inclusion. These traits also reflect the primary *domains* of self-esteem (Fleming & Courtney, 1984; Harter, 1993). Thus, people have specific evaluations of their worth in domains such as likeability (e.g., friendliness, congeniality), competence (e.g., intellect, athleticism), body and appearance, and interpersonal skills, and each of these domains is predictive of global self-esteem (Crocker & Wolfe, 2001; Harter, 1993; Pelham & Swann, 1989). Most germane to my research, a person's body and appearance self-esteem is one of the strongest predictors of their global self-esteem (Anthony, Holmes, & Wood, 2007; Crocker & Wolfe, 2001; O'Dea, 2012). Moreover, research concerning self-esteem and relationships suggests that people may project their own self-doubts about their body and appearance onto their partner.

Self-Protective Partner-Derogation

Romantic partners are constantly facing two competing goals: one of protecting themselves against rejection and the other of building satisfying intimate bonds (Murray et al., 2006). To build and maintain satisfying relationships, people must trust and depend on their partners to accept and fulfill their needs (Baumeister & Leary, 1995; Kelley, 1979). At the same

time, doing so puts them at significant risk for rejection and threats to their self-esteem. Such is the classic dilemma of interdependence: what increases intimacy also increases the risk of rejection (Murray et al., 2006). Self-esteem plays an important role in determining how people generally respond to this interdependence conflict.

In general, people with higher global self-esteem respond to interdependence conflicts by drawing closer to their partner and increasing dependence (Murray, Bellavia, Rose, & Griffin, 2003; Murray et al., 2006; Murray, Griffin, Rose, & Bellavia, 2003; Murray, Holmes, & Griffin, 1996a, 1996b, 2000; Murray, Holmes, Griffin, Bellavia, & Rose, 2001; Murray, Holmes, MacDonald, Ellsworth, 1998; Murray, Rose, Bellavia, Holmes, & Kusche, 2002). That is, confidence in a romantic partner's regard allows people with higher global self-esteem to accept the risk of rejection and engage in relationship promoting behaviours, even when their self-esteem is threatened. As a result, people with higher global self-esteem hold positive perceptions of their partner and their relationship. In contrast, people with lower global self-esteem prioritize self-protection goals over relationship promoting goals when faced with an interdependence conflict. In an attempt to protect themselves from the pain of rejection, people with lower self-esteem respond to perceived rejection threats in one of two ways (Murray et al., 1998; Murray et al., 2002; Murray et al., 2006; Murray, Griffin, et al., 2003). They may decrease their dependence on the relationship by seeking alternative sources of support or disclosing less to their romantic partner. Alternatively, they may diminish the importance or value of their partner and their relationship by derogating their partner and devaluing their relationship. By these means, lower self-esteem people aim to protect their sense of self-worth as a valued romantic partner and minimize the pain of any future rejection (Murray et al., 2006).

The research concerning self-esteem and interdependence conflicts suggests that lower self-esteem people often project their own negative global self-evaluation onto their romantic partner by engaging in partner derogation. I suggest that this same process may occur in the domain of body and appearance self-esteem. As I have already reviewed, global self-esteem is a global evaluation of self-worth, and body and appearance self-esteem is an important domain of self-worth (Anthony, Holmes, & Wood, 2007; Crocker & Wolfe, 2001; O'Dea, 2012; van den Berg et al., 2010). Therefore, it is reasonable to propose that in the same way that lower self-esteem people often project their negative global self-evaluations onto their partner, and thus derogate their partner's global worth, people with negative body and appearance self-esteem may project their specific negative self-evaluations onto their partner, and thus derogate their partner's attractiveness. Furthermore, body and appearance self-esteem overlaps conceptually with attitudinal body image, which is a specific self-evaluation of one's body and includes beliefs about the importance of appearance for self-worth. Thus, appearance and body self-esteem and attitudinal body image are similar in that they are both evaluative domains of a person's global self-esteem. Therefore, I predict that experiencing heightened body image dissatisfaction will lead people to be more critical of their romantic partner's appearance (H2; see path *b* in Figure 1).

Path *c*, *d*, *e*: Negative Partner Evaluations Predict Negative Relationship Outcomes

Physical attraction is an important factor for both the initiation and maintenance of romantic relationships (Miller, 2014). People desire physically attractive romantic partners (e.g., Buss, 1989) and want romantic partners to find them attractive (Swann, Bosson, & Pelham, 2002). Furthermore, when people find their romantic partners more attractive they also experience higher relationship quality (Sangrador & Yela, 2000). Additionally, individuals assign more positive characteristics to people who are more physically attractive (e.g., Dion, Berscheid, & Walster, 1972). Therefore, I hypothesize that people who make more negative evaluations of their partner's physical attractiveness will have lower relationship quality and rate their partner as having less global worth. Individuals' evaluations of their partner's attractiveness might also predict outcomes reported by their partners. For instance, romantic partners might perceive that their partner does not find them attractive. Additionally, perceptions of a romantic partner's regard can influence self-esteem and relationship quality (Murray et al., 2006; Murray, Griffin et al., 2003). Thus, I hypothesize that negative evaluations of a romantic partner's attractiveness will also predict negative relationship outcomes for romantic partners including perceiving these negative evaluations, lower self-esteem, and diminished relationship quality. I will discuss these hypotheses in more detail below.

Own Relationship Outcomes

Relationship quality. People are biased towards viewing their romantic partner in the best possible light (Miller, 2014). That is, people often hold *positive illusions* of their romantic partner whereby they downplay their faults and emphasize their virtues (Murray et al., 1996b). People also interpret their partner's actions more generously and rate their partner more positively compared to other people (Conley, Roesch, Peplau, & Gold, 2009; Gagné & Lydon,

2003). Moreover, people often evaluate their partner more favourably than their partner rates themselves (Murray et al., 1996a). Positive illusions likely function to protect romantic relationships from deterioration or dissolution (Murray et al., 1996a). Namely, positive illusions are valuable to the well-being and longevity of relationships because they help combat doubts about mate selection and protect against the damage of conflicts (Murray et al., 1999b). People who are inclined to interpret their partner's negative attributes and transgressions less critically are more likely to feel secure in their choice of partner and remain committed to their relationship. In general, more positive evaluations of a romantic partner tend to be good for the well-being of a relationship (Murray et al., 1996a). Romantic partners who idealize one another tend to have longer, more satisfying, and more secure relationships, with less conflict (Murray et al., 1996a). Most relevant to my research, people often hold positive illusions about their romantic partner's physical attractiveness.

People tend to rate their partner as more attractive than their partner rates themselves (Barelds-Dijkstra & Barelds, 2008), and these idealizations appear to protect against the damage of negative relationship events (Barelds, Dijkstra, Koudenburg, & Swami, 2011). Specifically, people who rate their romantic partner as more physically attractive generally have more positive relationship outcomes—including higher levels of passion, intimacy, commitment, and satisfaction—compared to people who rate their partner as less physically attractive (Sangrador & Yela, 2000; Yela & Sangrador, 2001). Therefore, I hypothesize that people who rate their romantic partner as less physically attractive will report lower relationship quality (H3; Path *c* in Figure 1).

Evaluations of partner worth. People strongly value physical attractiveness as an attribute in a romantic partner (Buss, 1989; Buss, Larsen, Westen, & Semmelroth, 1992; Dijkstra

& Buunk, 1998; Feingold, 1990), and automatically attribute more desirable interpersonal qualities to beautiful others (i.e., the "what is beautiful is good" effect; Dion, Berscheid, & Walster, 1972; Langlois et al., 2000). For example, people rate physically attractive individuals as more faithful, conscientious, trustworthy, agreeable, open, extraverted, socially competent, happier, and emotionally stable compared to unattractive people (Brewer & Archer, 2007; Eagly, Ashmore, Makhijani, & Longo, 1991). As a result, I hypothesize that people who rate their romantic partner as less physically attractive will make more negative evaluations of their partner's global worth (H4; Path *c* in Figure 1).

Romantic Partner Outcomes

Self-esteem. How people evaluate themselves is determined, in part, by how they are evaluated by other people (Leary & Baumeister, 2000). Evaluations from romantic partners can be an especially potent force in determining self-esteem (Murray et al., 1996b; Murray et al., 2006). People's perceptions of their romantic partner's regard can trigger feelings of acceptance or rejection from their partner which can lead to gains or losses in self-esteem (Murray et al., 2006; Murray, Griffin et al., 2003). People want to be seen as attractive by their partners (Swann, Bosson, & Pelham, 2002), and can experience more negative self-perceptions if they are not (Overall & Fletcher, 2010). Thus, I hypothesize that romantic partners rated as less physically attractive will report lower global self-esteem (H5; Path *d* in Figure 1).

Reflected attractiveness appraisals. People who find their romantic partners unattractive often try to conceal these negative evaluations from their partner, especially if they strongly value attractiveness in a romantic partner, are not highly committed to their relationship, or strongly care about their partner (Lemay, Bechis, Martin, Neal, & Coyne, 2013). However, it is also common for people to try and change their partner's eating behaviours especially when

they are unsatisfied with their partner's body and if their partner is fatter (Markey et al., 2008). People who perceive that their partner is trying to change something about them tend to assume that they are not meeting their partner's ideal in that domain (Overall & Fletcher, 2010). Therefore, people whose partners are attempting to influence them to diet might assume that they are not meeting their partner's standards in attractiveness. Thus, I predict that dieters will reveal their negative evaluations of their partner's attractiveness in everyday behaviours and that their romantic partners will perceive these negative evaluations. That is, I hypothesize that if participants rate their romantic partners as less attractive, their partners will also report that the participant would rate them as less attractive (H6; Path *d* in Figure 1).

Relationship outcomes. How people believe their partner feels about them also influences their perceived relationship quality (Murray et al., 2006; Murray, Griffin et al., 2003). People who believe that their partner evaluates them more favourably make more positive evaluations of their partner and their relationship (Murray et al., 2006). Most relevant to this study, feeling attractive can help someone feel like a more valuable relationship partner and increase their confidence in their partner's level of commitment (Lemay et al., 2013). In contrast, someone who feels that their partner is not attracted to them can question their partner's commitment to the relationship (Overall & Fletcher, 2010). As discussed in the previous section, I believe that romantic partners will perceive how the participants rate their attractiveness. Thus, I predict that romantic partners rated as less physically attractive will report lower relationship quality (H7; Path *e* in Figure 1).

The Current Research

The purpose of my thesis research is to examine whether dieting indirectly predicts the relationship outcomes of individuals and their romantic partners. I utilize dyadic questionnaire data to examine whether dieters' negative body image predicts more critical evaluations of their romantic partner's appearance, which in turn predicts negative relationship outcomes for both the dieter and their partner (see Figure 1). My research is a novel addition to the dieting and relationships literature because I adopt the uncommon position that dieting is detrimental to well-being. This position allows for a new perspective that generates novel hypotheses concerning the negative consequences of dieting for dyadic couple well-being. To my knowledge, no research has ever sought to document the potential negative outcomes of dieting for relational well-being, most likely because previous research has not considered the possibility that dieting could be harmful for relationships.

It is important to understand the potential negative consequences of dieting to more accurately advise individuals about the costs of dieting behaviour. The general public remains largely ignorant concerning the negative physical health consequences of dieting, perhaps because health care professionals and public health campaigns still frame dieting as an entirely positive health behaviour. Learning about the potential interpersonal costs of dieting may help to increase public concern surrounding dieting behaviour. Furthermore, intimate relationships are thought to be a fundamental human need (i.e., "a need to belong;" Baumeister & Leary, 1995) and the quantity and quality of such bonds are important predictors of well-being (e.g., Gouin et al., 2010). As a result, it is important to understand the factors that contribute to healthy romantic relationships, and my research will help to further this important goal.

Methods

Participants and Procedure

For my thesis, I will be analyzing data that was collected as part of a larger study of young adults' social networks. Undergraduate students at the University of Waterloo (Ontario, Canada), who previously participated in a large-scale longitudinal study (the Research on Early Adult Life project, see Stinson et al., 2008), were invited via email to participate in a subsequent study examining the social networks of young adults. Additional undergraduate student participants were recruited through the University of Waterloo Psychology Department research experiences group. Data were collected from two cohorts during the Winter (February/March) and Fall (October/November) semesters of 2004. Participants completed questionnaires on a range of topics including demographic information (e.g., age, height, weight), dieting, body dissatisfaction, self-esteem, ratings of their partner's physical attractiveness, evaluations of their partner's worth, commitment to their romantic relationship, and conflict within their romantic relationship (see Appendix for full list of items).

Participants were also asked to nominate, where applicable, a romantic partner[4], a friend, and a parent or guardian to participate in the study. Nominees were contacted by the research team and invited to participate in the study. Those interested in participating filled out questionnaires online. The content of the questionnaires varied depending on the type of nominee. My thesis will focus on data collected from participants and their romantic partners. Romantic partners answered questions about both themselves as well as their partner (i.e., the participant). Relevant to this study, romantic partners provided responses to self-report items

[4]Participants nominated anyone they determined they were in a romantic relationship with (i.e., "romantic partner" was self-defined by participants) and were not required to have been in a relationship for a certain period of time to be eligible to participate. Participants could only nominate one romantic partner and there was no option to provide information about multiple romantic partners for polyamorous relationships.

assessing demographic information (e.g., age, height, weight), self-esteem, a reflected appraisal of how they think their partner would rate their physical attractiveness, commitment to their relationship, and conflict levels within their relationship (see Appendix for full list of items).

Written informed consent was obtained from all subjects before the study. Questionnaires were completed online and took approximately 25 minutes to complete. All subjects were entered into a draw for prizes in appreciation for completing the questionnaire, and participants recruited through the Research Experienced Group also received course credit in appreciation for their time. The original research team included Joanne V. Wood, John G. Holmes, Danu Anthony Stinson, Christine Logel, and Jessica J. Cameron. Ethical approval for this study was granted by the University of Waterloo's Research Ethics Board and the University of Victoria's Human Research Ethics Board.

A total of 221 participants (71.00% female, 29.00% male; 1.80% Asian, 2.30% Black, 6.30% Chinese, 0.90% East Asian, 1.40% First Nations, 0.90% Korean, 0.90% Middle Eastern, 3.20% mixed ethnicity/race, 5.40% South Asian 1.40% South-East Asian, 0.50% West Asian, 68.30% white, 6.80% missing; M_{age} = 18.78, SD_{age} = 1.04) and 74 romantic partners (33.33% female, 66.67% male; 2.67% Asian, 10.67% Chinese, 1.33% Filipino, 1.33% other, 1.33% South Asian, 1.33% South-East Asian, 60.00% white, 21.33% missing; M_{age} = 19.11, SD_{age} = 1.41) took part in the study. These ethnicity statistics are similar to the Canadian population where 19.10% of the population self-identifies as a visible minority, with the majority (61.30%) identifying as South Asian, Chinese, or Black (Statistics Canada, 2011).

Measures

Demographics. Participants and romantic partners self-reported their own gender, age, ethnicity, height (in feet and inches), and weight (in lbs). Respondents' body mass index (BMI;

[$weight\ (kg) \div height\ (m^2)$]) was calculated using their self-reported height (converted to m) and weight (converted to kg).

Dieting. All seven items asked participants to report their dieting thoughts, feelings, and behaviours during their current semester of study (i.e., "Since the Winter term began…" or "Since the Fall term began…"). Participants reported their dieting thoughts ("I have worried about my diet and/or weight"), emotions ("I have felt guilty after eating"), and behaviours ("I have refrained from eating when I was hungry" and "I have punished myself for eating more than I should have") using a five-point scale (1 – *Never*, 5 – *Always*). Participants also reported their weighing behaviour using a six-point scale (1 – *I never weighed myself*, 6 – *I weighed myself more than once a day*), and reported whether they used self-induced vomiting as a method to lose weight using a six-point scale (1 – *I never considered vomiting to lose weight*, 6 – *I vomited every day*). They also reported binge eating using a six-point scale (1 – *I never considered bingeing (eating an excessive amount)*, 6 – *I binged every day*). Items were created specifically for use in this study. Item responses were standardized and averaged to create a reliable *dieting* score (α = .80). Higher scores indicate a more severe level of dieting.

Body dissatisfaction. Participants answered six items from the Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987; e.g., "Do you feel ashamed of your body?") using a modified five-point scale (1 – *Never*, 5 – *Always*)[5]. Participants also indicated their level of weight satisfaction ("In general, I am satisfied with my weight.") using a seven-point scale (1 – *Strongly Disagree*, 7 – *Strongly Agree*). Participants reported the level of weight related distress they experienced ("If your weight is not what you would ideally like it to

[5] Typically the BSQ uses a 6-point Likert scale (1 'Never', 2 'Rarely', 3 'Sometimes', 4 'Often', 5 'Very Often', 6 'Always'). However, the current study used a 5-point Likert scale by dropping the 'Very Often' response option from the original scaling (i.e., 1 'Never', 2 'Rarely', 3 'Sometimes', 4 'Often', 5 'Always').

be, does it bother you that you do not weigh what you ideally desire?") using a five-point scale (1– *It does not bother me at all*, 5 – *It bothers me a lot*). The weight satisfaction item was reverse coded and all item responses were standardized and averaged to create a reliable *body dissatisfaction* score (α = .94). Higher scores reflect more body dissatisfaction.

Ratings of physical attractiveness. Participants and romantic partners rated how "physically attractive" and "sexy" they found themselves and their romantic partners relative to the general population using a one-hundred-one-point scale (0 – *you think you/your partner is lower than the rest of the population on that trait*, 50 – *you think you/your partner is average for that characteristic*, 100 – *you think you/your partner is higher than the rest of the population on that trait*). These two items were taken from the Social Attributes and Skills Inventory (SASI; Anthony, Holmes, & Wood, 2007), which was included in the survey. These ratings were averaged to create a reliable score of participants' perceptions of their own attractiveness (α = .86) and their romantic partner's attractiveness (α = .91), and romantic partner's perceptions of their own attractiveness (α = .86) and the participant's attractiveness (α = .95). Using the same items and scale, romantic partners were asked two questions assessing their belief that they are viewed as physically attractive by the participant (i.e., reflected attractiveness appraisal; "how do you think your current romantic partner would rate you…1) physically attractive, 2) sexy). These items were averaged to create a reliable index of romantic partners' reflected attractiveness appraisal (α = .88). For all indices, higher scores reflect higher ratings of attractiveness.

Self-esteem. Participants and romantic partners completed the ten item Rosenberg Self-Esteem scale (RSE; Rosenberg, 1965) using a nine-point scale (1 – *Very Strongly Disagree*, 9 – *Very Strongly Agree*). Five items were reverse coded so that higher scores would reflect higher

self-esteem. Items were averaged to create a total score of *global self-esteem* ($\alpha_{participant}$ = .91, $\alpha_{partner}$ = .89).

Ratings of romantic partner's worth. Participants answered four questions from the RSE (Rosenberg, 1965) using a seven-point scale (1 – *Strongly Disagree*, 7 – *Strongly Agree*). Items were modified to measure participants' evaluations of their romantic partners worth (e.g., "I feel that my partner is a person of worth, at least on an equal basis with others."). Two items were reverse coded so that higher scores would reflect greater perceived worth. Items were averaged to create a reliable rating of *worth* (α = .69).

Relationship quality.

Relationship commitment. Participants and romantic partners answered four questions measuring relationship satisfaction (e.g., "I am extremely happy with our relationship.") using a nine-point scale (1 – *Not True*, 9 – *Very True*). They also responded to two items measuring relationship commitment ("Will the two of you remain together and get married?" and "Will the two of you remain together for a lifetime?") using an eleven-point scale (1 – *Absolutely certain that the relationship will end before this time*, 11 – *100% absolutely certain that we will still remain together*). Additionally, respondents answered six questions assessing their comparison level of alternatives (e.g., "The people other than my partner who I might become involved with are very appealing.") and three items measuring their investment in their current romantic relationship (e.g., "I have put a great deal into my relationship that I would lose if this relationship were to end.") using a seven-point scale (1 – *Strongly Disagree*, 7 – *Strongly Agree*). One satisfaction item and four comparison level of alternative items were reverse coded so that higher scores would reflect a more positive relationship quality. All fifteen items were

standardized and averaged to create reliable scores of *relationship commitment* for each partner ($\alpha_{participant}$ = .78, $\alpha_{partner}$ = .72).

Relationship conflict. Participants and romantic partners answered twelve questions examining conflict within their relationship using a seven-point scale (1 – *Strongly Disagree*, 7 – *Strongly Agree*). Four items that assessed global frequency of conflict (e.g., "My partner and I frequently argue with each other.") were utilized to create a composite score because they were most directly relevant to the current study (the other 8 items assessed conflict style). The four global items were averaged to create reliable scores of *relationship conflict* for each partner ($\alpha_{participant}$ = .82, $\alpha_{partner}$ = .78). Higher scores reflect more reported conflict in the relationship.

Data Analytic Plan

Preliminary Analyses

I first examined the descriptive statistics of the sample. The means and standard deviations of all continuous variables were calculated and the frequencies of each categorical variable were calculated. Next, I examined Pearson product-moment correlations between all study variables. I also tested for any effects of gender or BMI on the main study variables, including moderating effects. Independent samples *t*-tests were used to explore whether any differences exist on participant continuous variables between participants whose romantic partners completed questionnaires (group 1, $n = 74$) and participants whose partners did not participate in the study (group 2, $n = 147$). To test whether there were any significant differences between the two groups in terms of participant ethnicity[6], chi-square tests were conducted.

Main Analyses

I used hierarchical linear regression to test my proposed model. Pairwise deletion was utilized for analyses, such that, if a participant was missing data on a particular variable their data was only excluded from calculations involving the variable from which they did not have a score. To optimize power, I performed two sets of analyses. Data for all participants ($N = 221$) were used to estimate the paths involving participant outcomes, comprising paths *a* to *c* in Figure 1. The first set of analyses have a power of .99 to detect the smallest departure from the null found in this set of analyses ($f^2 = .10$), with five predictors in the model and $\alpha = .05$. The second

[6] Despite the prevailing view that white women have more body dissatisfaction compared to women of colour (e.g., Reboussin et al., 2000; Wildes, Emery, & Simons, 2001), I chose not control for ethnicity/race in my analyses. Researchers have shown that there are more similarities than differences between ethnic groups on levels of body dissatisfaction (Grabe & Hyde, 2006; Wilkosz, Chen, Kenndey, & Rankin, 2011). A meta-analysis conducted by Grabe and Hyde (2006) found that all observed differences are small and many are close to zero. Additionally, ethnic differences have been shown to influence body dissatisfaction less than other demographic variables such as age, gender, and weight (Wilkosz, Chen, Kenndey, & Rankin, 2011). Rather than the levels of body dissatisfaction being different between ethnic groups it is possible that the specific factors that influence body dissatisfaction might differ (e.g., Black people might be more concerned with skin colour and hair type compared to other groups).

set of analyses used data from the 74 dyads (148 individuals) available, and tested paths *d* and *e* in Figure 1. Post-hoc power analyses show that these tests have a power of .85 to detect the smallest departure from the null found in this set of analyses (f^2 = .10) with five predictors in the model and α = .05. I used Hayes' (2018) PROCESS macro from SPSS to test the significance of the indirect pathways in my model. PROCESS is "an observed variable ordinary least squares and logistic regression path analysis modeling tool for SPSS and SAS" that is often utilized for mediation, moderation, and conditional process analyses (Hayes, 2019, para. 1; Hayes, 2018). PROCESS is free to download online. Users can either write syntax to control PROCESS, or install it as a custom extension within SPSS that can be accessed within the graphical user interface. I opted to use PROCESS rather than run a path analysis because when dealing with observed variable models the two methods produce nearly identical results (often the same up to 3 decimal places) and PROCESS is a more accessible and user-friendly tool (Hayes, 2018; Hayes, Montoya, & Rockwood, 2017).

Results

Preliminary Analyses

Most dyads were women-men[7] pairings ($N = 70$); however, there were four same-gender pairings (two women-women pairings and two men-men pairings). Although participants' gender and sexual orientation could moderate my results, the researchers who originally collected the data did not assess participants' sexual orientation, I did not have any a priori hypotheses about sexual orientation, and there were not enough same-gender pairings to test for moderating effects of type of gender pairing. Therefore, I included all dyads in my analyses.

Means, standard deviations, and zero-order correlations among variables are presented in Table 3. A few of these associations are worth highlighting. First, regarding BMI, this sample is relatively thin on average ($M_{women} = 22.11$, $M_{men} = 23.69$) compared to adults in the general public between the ages of 20 and 39 ($M_{women} = 25.90$, $M_{men} = 26.50$; Shields et al., 2010). However, the average BMI of this sample is similar to the average BMI of youth aged 16 to 19 ($M_{women} = 21.11$, $M_{men} = 21.38$; World Health Organization, 2019a, 2019b) which might be a better reference group for this sample which ranged from 16 to 23 years old ($M = 18.79$). Thus, it is possible that my findings will not generalize to older, fatter populations and any reference to fatter or thinner participants is relative to the sample distribution.

Second, as is common in non-distressed samples, on average, participants reported that their partners were physically attractive and worthy individuals, and tended to report high levels of commitment to, and low levels of conflict within, their relationship. Similarly, romantic partners reported high self-esteem, high relationship commitment, and low relationship conflict, on average. Thus, my findings may not generalize to more distressed couples. Any comparisons

[7] All participants and romantic partners identified as cisgender women or cisgender men. As such, the usage of "women" and "men" in this document are referring to cisgender women and men.

Table 3
Means and Correlations of Continuous Study Variables

Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12
1. P BMI	22.57	3.43	1	.14*	.22**	.03	.14	.00	-.11	.20	-.01	-.04	.05	.09
2. P Dieting	0.00	0.67		1	.71**	-.16*	-.12	.01	.16*	.22	-.11	-.16	-.02	.24
3. P Body Dissatisfaction	0.00	0.66			1	-.25**	-.11	.00	.17*	.16	.04	-.01	-.08	.28*
4. P rating RP attractiveness	81.01	15.64				1	.30**	.33**	-.22**	-.23	.21	.26*	.10	-.15
5. P rating RP worth	6.55	0.72					1	.51**	-.40**	-.12	.22	.08	.01	-.11
6. P commitment	-0.03	0.82						1	-.22**	.22	-.01	-.08	.24*	.04
7. P conflict	2.87	1.39							1	.11	-.02	.01	.04	.44**
8. RP BMI	24.35	3.97								1	.11	-.24	-.09	-.02
9. RP RSE	6.97	1.48									1	.26*	-.08	-.22
10. RP RA attractiveness	73.13	17.47										1	.16	-.27*
11. RP commitment	0.00	0.74											1	-.32**
12. RP conflict	2.84	1.34												1

Note. *$p < .05$; **$p < .01$; ***$p < .001$. P = participant, RP = romantic partner; RA = reflected appraisal; BMI = body mass index (kg/m^2); RSE = Rosenberg self-esteem scale. BMI has been mean centered.

between participants with higher and lower scores on these variables are also relative to the sample distribution.

Third, consistent with previous research (e.g., Gillen et al., 2012; Schwartz & Brownell, 2004), fatter participants dieted more severely and had more body dissatisfaction (see Table 3). As a result, I controlled for participant BMI in all of my main analyses, reported below, and tested for moderating effects. Participant BMI did not moderate any pathways in my model. Romantic partners' BMI was not associated with any other study variables, so I did not control for this variable in subsequent analyses.

Fourth, the exceptionally strong positive correlation between dieting and body dissatisfaction suggests that these variables often co-occur within individuals. In other words, it would be unusual to find someone who was dieting who did not also dislike their body, and vice versa. This strong correlation occurred despite the fact that the dieting items assess thoughts, feelings, and behaviours related to food and eating; whereas, the body dissatisfaction items assess thoughts, feelings, and behaviours evaluating the body. So shared methods variance is an unlikely explanation for this association. Additionally, participants who dieted more severely, experienced more body dissatisfaction, or both, also rated their partners more negatively and reported lower relationship quality, validating my proposed link between dieting, body dissatisfaction, and interpersonal processes. To better understand these connections, I explored the kinds of dieting behaviours that participants reported (see Table 4). The majority of participants' dieting engagement came in the form of dieting cognitions, emotions, and restrictive behaviour (see Table 4). The most commonly endorsed dieting items were worrying about their dieting and/or weight, feeling guilty after eating, weighing themselves, and restricting their food intake. Only 30 participants indicated that they had *never* worried about their diet

and/or weight. Additionally, most participants endorsed less severe levels of engagement in the dieting items, and more severe dieting behaviors like punishing themselves after eating more than desired, binge eating, and self-induced vomiting were relatively less common.

Fifth, in line with my predictions, participants who rated their partner as more physically attractive also reported a better relationship quality. Participants and romantic partners who reported being more committed to their relationship also reported less conflict in their relationship. However, participants who reported more commitment did not have partners who reported less conflict, and participants who reported less conflict did not have partners who reported more commitment. Reports of commitment and conflict by participants were positively correlated with their romantic partner's ratings of the same variable. These small to moderate positive correlations suggests some general agreement in the raters' reports.

Table 4
Dieting Items Means, Standard Deviations, and Frequencies of Response Options (In Order From Most Commonly Endorsed to Least Commonly Endorsed)

				Frequency of Response Options							
Dieting Item	Scale	*M*	*SD*	1	2	3	4	5	6	Missing	Total
Worry	1-5	3.03	1.20	30	37	71	54	25	N/A	4	221
Guilt	1-5	2.28	1.08	67	56	63	28	3	N/A	4	221
Weighing	1-6	2.24	1.11	67	62	70	10	4	4	4	221
Restricting	1-5	1.69	0.86	117	56	38	6	0	N/A	4	221
Punishing	1-5	1.49	0.85	153	28	27	8	0	N/A	5	221
Bingeing	1-6	1.60	1.08	156	21	14	23	3	0	4	221
Vomiting	1-6	1.19	0.52	186	21	7	2	0	0	5	221

Note. Worry, guilt, restricting, & punishing scale: 1 – *Never*, 2 – *Rarely*, 3 – *Sometimes*, 4 – *Often*, 5 – *Always*. Weighing scale: 1 – *Never*, 2 – *Once*, 3 – *Several times*, 4 – *Several times each week*, 5 – *Everyday*, 6 – *More than once a day*. Binge eating & self-induced vomiting scales: 1 – *Never considered*, 2 – *Felt tempted*, 3 – *Once*, 4 – *Several times this month*, 5 – *Several times each week*, 6 – *Everyday*.

Table 5
Descriptive Statistics for Women and Men

Variable	*M*	*SD*
P BMI**		
Women	22.11	3.31
Men	23.69	3.48
P Dieting*		
Women	0.06	0.68
Men	-0.16	0.65
P Body dissatisfaction***		
Women	0.11	0.62
Men	-0.27	0.70
P rating RP attractiveness		
Women	79.74	16.67
Men	84.28	12.14
P rating RP worth		
Women	6.57	0.71
Men	6.50	0.74
P commitment*		
Women	0.05	0.78
Men	-0.24	0.88
P conflict		
Women	2.90	1.39
Men	2.80	1.39
RP RA attractiveness		
Women	74.19	17.10
Men	71.20	18.37
RP SE		
Women	7.11	1.40
Men	6.68	1.63
RP commitment		
Women	-0.04	0.77
Men	0.08	0.69
RP conflict		
Women	3.04	1.43
Men	2.51	1.09

Note. *$p < .05$; **$p < .01$; ***$p < .001$. P = Participant; RP = Romantic Partner; BMI = body mass index (kg/m^2); RA = Reflected Appraisal; SE = Self-Esteem.

Sixth, participants who rated their partners as less attractive had partners who perceived this lower attractiveness evaluation. In general, romantic partners' perceptions of how the participants would rate their attractiveness (M = 73.13) were lower than the participants actual ratings (M = 81.00), $t(62) = 3.09$, 95% CI [2.74, 12.79], d = .39. Further analyses revealed that positive illusions were present, such that participants rated their romantic partners (M = 81.00) as more attractive than their partners rated themselves (M = 62.87), $t(72) = 7.76$, 95% CI [13.36, 22.61], d = .91. Finally, romantic partners that believed their partner (the participants) found them less attractive also had lower self-esteem.

I also explored for gender differences among participants using a series of independent-samples t-tests (see Table 5). As expected, women had lower BMIs than men, $t(214) = -3.12$, 95% CI [-2.57, -0.58], d = .47. Additionally, consistent with prior research, women reported more extreme dieting, $t(213) = 2.21$, 95% CI [0.02, 0.42], d = .33, and experienced more body dissatisfaction in comparison to men, $t(215) = 3.96$, 95% CI [0.19, 0.57], d = .59. Women also reported more commitment to their relationship compared to men, $t(202) = 2.32$, 95% CI [0.04, 0.54], d = .36. To account for these important differences, I controlled for participant gender in all analyses. Gender did not moderate any of the results that follow.

Participants whose romantic partners participated in the study did not differ from participants whose partners did not participate in the study in terms of gender, BMI, dieting, body dissatisfaction, evaluations of their romantic partners attractiveness, ratings of partners worth, or relationship commitment, all ps > .05. However, these two groups of participants did differ in relational conflict, $t(199) = 3.45$, 95% CI = [0.29, 1.07], d = 0.52, such that participants whose partners did not participate in the study reported more conflict (M = 3.12, SD = 1.44) than participants whose partners did participated in the study (M = 2.44, SD = 1.17). Thus, the results

of my research concerning partner effects (i.e., paths *d* and *e* in Figure 1) may not generalize to people who experience higher levels of relationship conflict.

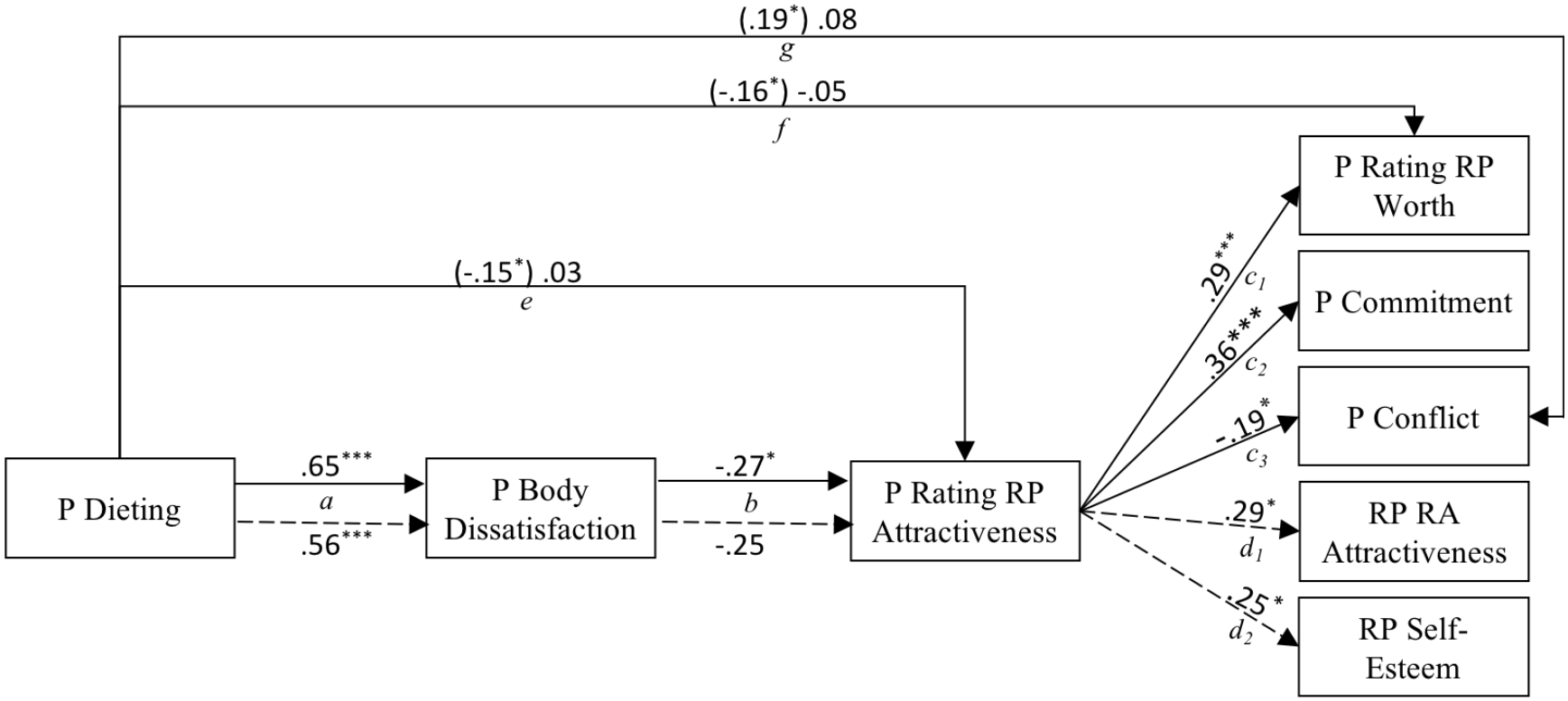
Main Analyses

The results of the main analyses are depicted in Figure 2. I will describe the analyses that were conducted to obtain those results in the following sections.

Individual model. I hypothesized that participants who dieted more severely would have higher body dissatisfaction compared to participants who reported less severe levels of dieting (H1; see Table 1 to review the full list of my hypotheses). To test this hypothesis, I regressed participants' body dissatisfaction onto: Step 1) control variables (i.e., participants' gender [dummy coded, 0 = woman, 1 = man] and mean-centered participant BMI); Step 2) participants' mean-centered dieting. The second step of the model was best fitting and explained approximately 55% of the variance in participants' body dissatisfaction (see the top panel of Table 6). All variables predicted body dissatisfaction. Consistent with past literature, participants who identified as women and fatter participants experienced more body dissatisfaction compared to participants who identified as men and thinner participants. Furthermore, in support of H1, participants who engaged in more severe levels of dieting also experienced more body dissatisfaction. As I described previously when discussing the correlational results in Table 3, the sizeable strength of this effect indicates that body dissatisfaction nearly always accompanies dieting.

I also predicted that participants with higher body dissatisfaction would evaluate their partner's attractiveness more negatively compared to participants with lower body dissatisfaction (H2). To test this hypothesis, I regressed participants' ratings of their romantic partner's physical attractiveness onto: Step 1) control variables; Step 2) participants' mean-centered dieting; Step 3)

Figure 2
Results of Hierarchical Linear Regression Analyses



Note. $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$. P = Participant, RP = Romantic Partner, RA = Reflected Appraisal. Solid paths were estimated from the full sample; dashed paths were estimated from the sub-sample with partner data.

Table 6
Results of Hierarchical Regression Predicting Participants' Body Dissatisfaction and Evaluations of Their Romantic Partner's Physical Attractiveness

	Body Dissatisfaction						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 205)						.15	.17
Gender	-0.33	-0.48	[-0.67, -0.29]	-4.94	< .001		
BMI	0.28	0.06	[0.03, 0.08]	4.34	< .001		
Step 2 (*df* = 204)						.40***	.88
Dieting	0.65	0.64	[0.55, 0.74]	13.62	< .001		

	Evaluation of RP Attractiveness						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 192)						.02	.02
Gender	0.13	4.44	[-0.52, 9.41]	1.77	.08		
BMI	0.01	0.03	[-0.63, 0.69]	0.09	.93		
Step 2 (*df* = 191)						.02*	.02
Dieting	-0.15	-3.42	[-6.77, -0.08]	-2.02	.045		
Step 3 (*df* = 190)						.03*	.03
Body Dissatisfaction	-0.27	-6.36	[-11.21, -1.51]	-2.59	.01		

Note. *$p < .05$; **$p < .01$; ***$p < .001$. BMI = Body Mass Index (kg/m^2); RP = Romantic Partner.

participants' mean-centered body dissatisfaction. The final step of the model was significant and best fitting, explaining approximately 7% of the variance in participants' ratings of their romantic partners' physical attractiveness (see the bottom panel of Table 6). Although dieting initially predicted participants' evaluations of their romantic partner's physical attractiveness, once body dissatisfaction was added into the model, dieting no longer directly predicted evaluations, lending some support to the order of variables in my proposed model. I used Hayes' (2018) PROCESS macro from SPSS (Model 4) using 10,000 bootstrap samples to estimate the 95% bias-corrected confidence interval (CI) of the indirect path predicting participants' evaluations of their romantic partner's attractiveness (i.e., path *a* x *b* in Figure 2). Results revealed that the CI or the indirect path did not include zero, meaning that the indirect path was

Table 7
Tests of Indirect Effects Using Hayes' (2018) PROCESS Macro from SPSS

Outcome Variable	*B*	*SE*	95% CI
P Ratings RP Attractiveness (path *a* x *b*)	-4.56	1.61	[-7.81, -1.41]
P Commitment (path *a* x *b* x c_1)	-0.08	0.03	[-0.16, -0.02]
P Conflict (path *a* x *b* x c_2)	0.08	0.04	[0.02, 0.20]
P Ratings RP Worth (path *a* x *b* x c_3)	-0.03	0.02	[-0.10, -0.003]
RP Self-Esteem (path *a* x *b* x d_1)	-0.13	0.10	[-0.45, -0.01]
RP RA Attractiveness (path *a* x *b* x d_2)	-2.36	1.67	[-7.35, -0.25]

Note. P = Participant, RP = Romantic Partner, RA = Reflected Appraisal.

significant (see Table 7). These results supported H2: Participants who dieted more severely experienced more body dissatisfaction, and participants with more body dissatisfaction evaluated their romantic partner's physical attractiveness more negatively.

Next, I hypothesized that participants' evaluations of their romantic partner's physical attractiveness would predict participants' evaluations of their partner's worth and their self-reported relationship quality (H3). To test these hypotheses I ran a series of three hierarchical regressions predicting each of the outcome variables reported by participants: (1) commitment to their romantic relationship, (2) reported conflict levels within their relationship, and (3) evaluations of their romantic partner's worth. Each relationship quality variable was individually regressed onto: Step 1) control variables; Step 2) participants' dieting; Step 3) participants' body dissatisfaction; Step 4) participants' ratings of their romantic partner's physical attractiveness. Results from the regression analysis predicting participants' relationship commitment support H3 and are presented in the first panel of Table 8. The final step of the model fit the data best, explaining 15% of the variance in the participants' commitment to their romantic relationship. Participants' gender and their ratings of their partner's physical attractiveness were the only

Table 8
Results of Hierarchical Regression Predicting Participants' Relationship Quality

	Commitment						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 192)						.03	0.03
Gender	-0.17	-0.30	[-0.56, -0.05]	-2.32	.02		
BMI	0.04	0.01	[-0.03, 0.04]	0.49	.62		
Step 2 (*df* = 191)						.00	0.03
Dieting	-0.02	-0.03	[-0.20, 0.15]	-0.28	.78		
Step 3 (*df* = 190)						.00	0.03
Body Dissatisfaction	-0.08	-0.10	[-0.36, 0.16]	-0.73	.47		
Step 4 (*df* = 189)						.12***	.14
Rating of RP attractiveness	0.36	0.02	[0.01, 0.03]	5.20	< .001		

	Conflict						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 192)						.01	0.01
Gender	-0.01	-0.03	[-0.47, 0.41]	-0.14	.89		
BMI	-0.11	-0.04	[-0.10, 0.02]	-1.43	.15		
Step 2 (*df* = 191)						.03*	0.05
Dieting	0.19	0.38	[0.09, 0.68]	2.55	.01		
Step 3 (*df* = 190)						.01	0.06
Body Dissatisfaction	0.17	0.35	[-0.08, 0.78]	1.59	.11		
Step 4 (*df* = 189)						.03*	0.03
Rating of RP attractiveness	-0.19	-0.02	[-0.03, -0.00]	-2.59	.01		

Predictor	Evaluations of RPs Worth						
	β	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 192)						.02	0.02
Gender	-0.08	-0.12	[-0.35, 0.11]	-1.02	.31		
BMI	0.15	0.03	[0.00, 0.06]	2.08	.04		
Step 2 (*df* = 191)						.03*	0.05
Dieting	-0.16	-0.17	[-0.33, -0.02]	-2.25	.03		
Step 3 (*df* = 190)						.01	0.06
Body Dissatisfaction	-0.13	-0.14	[-0.36, 0.09]	-1.21	.23		
Step 4 (*df* = 189)						.08***	0.09
Rating of RP attractiveness	0.29	0.01	[0.01, 0.02]	4.07	< .001		

Note. *p < .05; **p < .01; ***p < .001. BMI = Body Mass Index (kg/m^2); RP = romantic partner.

significant predictors in the model. I already discussed the gender effect when I discussed the correlations among variables, reported in Table 3. As predicted, and holding constant the variables that preceded ratings of romantic partner's attractiveness in the model, participants who evaluated their partner's physical attractiveness more positively were also more committed to their relationship on average compared to participants who evaluated their partners' physical attractiveness more negatively. I used Hayes' (2018) PROCESS macro (Model 6) using 10,000 bootstrap samples to estimate the 95% bias-corrected CI of the indirect path connecting participant dieting to their relationship commitment (i.e., path *a* x *b* x c_1 in Figure 2). Results revealed that the CI or the indirect path did not include zero, meaning that the indirect path was significant (see Table 7). These results support H3: Participants who engaged in more severe levels of dieting had more body dissatisfaction, and participants with more body dissatisfaction rated their romantic partners as less attractive, which in turn predicted less commitment to their relationship.

The second hierarchical regression with participant reports of relationship conflict as the outcome variable also supported H3 (see the second panel of Table 8). The final step of the hierarchical regression predicting participant relationship conflict was best fitting, explaining 9% of the total variance in participant ratings of conflict within their romantic relationship. The only significant predictors were participant BMI and ratings of their romantic partner's attractiveness. Participants with lower BMIs experienced higher levels of relationship conflict. As predicted, participants who perceived their partner to be more physically attractive reported lower levels of conflict in their relationship compared to participants who perceived their partner to be less physically attractive. I used Hayes' (2018) PROCESS macro (Model 6) using 10,000 bootstrap samples to estimate the 95% bias-corrected CI of the indirect path connecting participant dieting

to relationship conflict levels reported by participants (i.e., path *a* x *b* x c_2 in Figure 2). Results revealed that the CI or the indirect path did not include zero, meaning that the indirect path was significant (see Table 7). These results further support H3: Participants who engaged in more severe levels of dieting had more body dissatisfaction, and participants with more body dissatisfaction rated their romantic partners as less attractive, which in turn predicted higher relationship conflict levels for participants.

Likewise, the results of the third hierarchical regression with participant evaluations of romantic partner's worth as the outcome variable supported H3 (see the third panel of Table 8). The final step of the model was best fitting explaining 13% of the total variance in participant evaluations of their romantic partner's worth. The only significant predictors in the model were BMI and participant ratings of their romantic partner's physical attractiveness. Fatter participants thought their partners were more worthy, compared to thinner participants. Consistent with H3, the path from attractiveness evaluations to participant evaluations of romantic partner's worth was also significant and positive. I used Hayes' (2018) PROCESS macro (Model 6) using 10,000 bootstrap samples to estimate the 95% bias-corrected CI of the indirect path connecting dieting to evaluations of romantic partner's worth (i.e., path *a* x *b* x c_3 in Figure 2). Results revealed that the CI or the indirect path did not include zero, meaning that the indirect path was significant (see Table 7). These results support H4: Participants who engaged in more severe levels of dieting had more body dissatisfaction, and participants with more body dissatisfaction rated their romantic partners as less attractive which predicted them evaluating their partners as being less worthy.

Summary of individual effects. These results indicate that individuals' dieting engagement is directly associated with negative self-evaluations and indirectly associated with

negative evaluations of their romantic partner and their relationship. Participants who engaged in more extreme forms of dieting evaluated their own bodies more negatively, and evaluated their romantic partner's attractiveness more negatively. In turn, participants who rated their romantic partners as less attractive also rate them as being less worthy individuals, were less committed to their relationship, and experienced higher conflict levels in their relationship. Thus, it is possible that dieters project their own negative self-evaluation of their body and appearance onto their romantic partner by engaging in partner derogation which undermines relationship quality.

Dyadic model. As described in Table 1, I predicted that participant ratings of their romantic partner's attractiveness would predict outcomes reported by romantic partners. Specifically, the outcome variables included: (1) romantic partner's reflected physical attractiveness appraisals, (2) romantic partner's self-esteem, (3) romantic partner's relationship commitment, and (4) romantic partner's relationship conflict. These hypotheses could only be tested using data for the 74 dyads who took part in the study.

To test H5 through H7, I used a series of hierarchical regressions predicting each of the outcome variables reported by romantic partners (see Table 9 & 10). Each of the outcome variables were individually regressed onto: Step 1) control variables; Step 2) participants' mean-centered dieting; Step 3) participants' mean-centered body dissatisfaction; Step 4) participants' mean-centered ratings of their romantic partner's physical attractiveness. Participant ratings of their romantic partner's physical attractiveness explained approximately 6% of the variance in their partner's self-esteem (see the first panel of Table 9). Supporting H5, participants who rated their romantic partners as less physically attractive had partners with lower self-esteem compared to participants who rated their partners as more physically attractive. Participant evaluations of their romantic partner's physical attractiveness also explained 8% of the variance in their

Table 9
Results of Hierarchical Regression Predicting Romantic Partner Individual Outcomes

	RP Self-Esteem						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 70)						.02	0.02
Gender	-0.14	-0.46	[-1.25, 0.33]	-1.17	.25		
BMI	0.02	0.01	[-0.10, 0.11]	0.17	.87		
Step 2 (*df* = 69)						.02	0.04
Dieting	-0.14	-0.31	[-0.85, 0.22]	-1.18	.24		
Step 3 (*df* = 68)						.02	0.06
Body Dissatisfaction	0.19	0.42	[-0.37, 1.20]	1.06	.29		
Step 4 (*df* = 67)						.06*	0.07
Rating of RP attractiveness	0.25	0.02	[0.001, 0.05]	2.12	.04		

	RP Reflected Appraisal of Physical Attractiveness						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 60)						.01	0.01
Gender	-0.08	-3.02	[-13.13, 7.10]	-0.60	.55		
BMI	-0.02	-0.10	[-1.44, 1.24]	-0.15	.88		
Step 2 (*df* = 59)						.03	0.04
Dieting	-0.18	-4.58	[-11.40, 2.24]	-1.34	.18		
Step 3 (*df* = 58)						.01	0.05
Body Dissatisfaction	0.18	4.67	[-5.39, 14.73]	0.93	.36		
Step 4 (*df* = 57)						.08*	0.09
Rating of RP attractiveness	0.29	0.32	[0.03, 0.61]	2.23	.03		

Note. *p < .05; **p < .01; ***p < .001. All predictors are self-reported by participants. RP = Romantic Partner; BMI = Body Mass Index (kg/m^2).

partner's reflected physical attractiveness appraisal (see the second panel of Table 9). In support of H6, participants who rated their romantic partner as less physically attractive had partners who reported lower reflected appraisals of their attractiveness. That is, ostensibly romantic partners knew when participants had rated their physical appearance more negatively. I used Hayes' (2018) PROCESS macro (Model 6) using 10,000 bootstrap samples to estimate the 95% bias-corrected CI of the indirect path connecting participant dieting to romantic partner's self-esteem and romantic partner's reflected attractiveness appraisals (i.e., path *a* x *b* x d_1 and path *a* x *b* x d_2 in Figure 2). Results revealed that the CIs did not include zero, meaning that the indirect paths

were significant (see Table 7)—further supporting H5 and H6. Participants who engaged in more severe levels of dieting had more body dissatisfaction, and participants with more body dissatisfaction rated their romantic partners as less attractive which predicted romantic partner's perceiving these negative attractiveness evaluations and having lower self-esteem.

Participant ratings of their romantic partner's attractiveness were not associated with their romantic partner's commitment to their relationship or the relational conflict levels reported by their romantic partners (see Table 10).

Table 10
Results of Hierarchical Regression Predicting Romantic Partner Relationship Quality

	RP Commitment						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 66)						.01	0.01
Gender	0.07	0.11	[-0.30, 0.52]	0.53	.60		
BMI	0.03	0.01	[-0.05, 0.06]	0.26	.80		
Step 2 (*df* = 65)						.00	0.01
Dieting	-0.02	-0.02	[-0.30, 0.26]	-0.14	.89		
Step 3 (*df* = 64)						.01	0.01
Body Dissatisfaction	-0.12	-0.13	[-0.55, 0.28]	-0.64	.53		
Step 4 (*df* = 63)						.01	0.02
Rating of RP attractiveness	0.08	0.00	[-0.01, 0.02]	0.60	.55		
	RP Conflict						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 61)						.06	0.06
Gender	-0.22	-0.65	[-1.40, 0.10]	-1.74	.09		
BMI	0.14	0.05	[-0.05, 0.15]	1.10	.28		
Step 2 (*df* = 60)						.04	0.10
Dieting	0.19	0.38	[-0.12, 0.89]	1.53	.13		
Step 3 (*df* = 59)						.01	0.11
Body Dissatisfaction	0.15	0.30	[-0.44, 1.04]	0.82	.42		
Step 4 (*df* = 58)						.01	0.12
Rating of RP attractiveness	-0.08	-0.01	[-0.03, 0.02]	-0.64	.53		

Note. All predictors are self-reported by participants. RP = Romantic Partner; BMI = Body Mass Index (kg/m^2).

Summary of dyadic effects. Romantic partners appeared to be cognizant of participant evaluations of their attractiveness: Partners rated as less physically attractive believed that their partner (the participant) would rate them as less attractive, and partners rated as more physically attractive believed that their partner (the participant) would rate them as more attractive. Participant dieting was also indirectly associated with romantic partner self-esteem. Participants who dieted more severely were more critical of their own body and their partners attractiveness, which predicted lower self-esteem for their romantic partners. Whereas, participants who engaged in less dieting evaluated themselves and their romantic partner more favourably, which predicted higher self-esteem for their romantic partners. Despite these negative individual outcomes for romantic partners, romantic partners did not report lower relationship quality when participants dieted more severely and rated them as less attractive. Thus, the extent that a person diets may be associated with some negative outcomes for their romantic partners, but not others.

Testing Alternative Models and Interpretations

Does participant global self-esteem effect study results? Because body dissatisfaction is characterized as a component of global self-esteem, and global self-esteem is known to influence relationship dynamics, it is important to explore how global self-esteem might influence my model. To explore this possibility, I re-ran the regression analyses described in detail above with the addition of participant global self-esteem as a control variable in Step 1. Results from these regression analyses are presented in Tables 11–13. Since analyses examining romantic partner relationship quality were not significant in the main analyses they were not repeated here. Overall, most associations remained significant. However, when participant global self-esteem was controlled, participant body dissatisfaction no longer predicted participant evaluations of romantic partner's physical attractiveness. In my model, body dissatisfaction is

hypothesized to function similarly to global self-esteem precisely because it is framed as a dimension of global self-esteem. As such, controlling for global self-esteem likely diminishes the association between body dissatisfaction and ratings of romantic partner's attractiveness because it removes the shared variance between body dissatisfaction and global self-esteem, and that shared variance may be the most important variance in the construct of body dissatisfaction. Indeed, body dissatisfaction is significantly negatively correlated with global self-esteem (r = -0.49, $p < .001$). When I tried substituting global self-esteem for body dissatisfaction in the regression predicting ratings of romantic partner's attractiveness, results revealed that global self-esteem predicted participant evaluations of their romantic partner's attractiveness, $\beta = 0.21$, $t(190) = 2.67$, $p = .008$. When I controlled for body dissatisfaction in this alternative model, results showed that global self-esteem was no longer a significant predictor of participant ratings of their romantic partner's attractiveness, $\beta = 0.16$, $t(189) = 1.87$, $p = .06$. Although self-esteem and body dissatisfaction can be substituted for one another in my analyses, they are not the same construct. For example, the Cronbach's alphas for self-esteem and body dissatisfaction are higher ($\alpha_{BD} = .94$, $\alpha_{SE} = .91$) than the Chronbach's alpha for a composite including items assessing both constructs ($\alpha_{BD\&SE} = .77$). Taken together, this pattern of results suggests that it is the components of body dissatisfaction that overlap with global self-esteem that predominantly drive the effects in my model.

Table 11

Results of Hierarchical Regression Predicting Participant Body Dissatisfaction and Evaluations of Romantic Partner Attractiveness Controlling for Participant Global Self-Esteem

	Body Dissatisfaction						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 207)						0.40***	0.67
Gender	-0.33	-0.48	[-0.64, -0.32]	-5.93	< .001		
BMI	0.31	0.06	[0.04, 0.08]	5.61	< .001		
Self-Esteem	-0.50	-0.23	[-0.27, -0.18]	-9.30	< .001		
Step 2 (*df* = 206)						0.21***	0.54
Dieting	0.53	0.52	[0.42, 0.62]	10.56	< .001		
	Evaluation of RP Attractiveness						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 191)						.07**	0.07
Gender	0.13	4.56	[-0.28, 9.40]	1.86	.07		
BMI	-0.01	-0.03	[-0.67, 0.62]	-0.08	.94		
Self-Esteem	0.23	2.45	[0.99, 3.91]	3.31	.001		
Step 2 (*df* = 190)						.002	0.002
Dieting	-0.05	-1.21	[-4.88, 2.47]	-0.65	.52		
Step 3 (*df* = 189)						.02	0.02
Body Dissatisfaction	-0.19	-4.58	[-9.75, 0.60]	-1.74	.08		

Note. *$p < .05$; **$p < .01$; ***$p < .001$. All predictors are self-reported by participants. BMI = Body Mass Index (kg/m^2); RP = Romantic Partner.

Table 12

Results of Hierarchical Regression Predicting Participant Outcomes Controlling for Participant Global Self-Esteem

	Evaluations of RPs Worth						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 191)						.08**	0.09
Gender	-0.07	-0.11	[-0.33, 0.11]	-1.00	.32		
BMI	0.14	0.03	[0.00, 0.06]	1.97	.05		
Self-Esteem	0.24	0.11	[0.05, 0.18]	3.38	.001		
Step 2 (*df* = 190)						.004	0.004
Dieting	-0.07	-0.07	[-0.24, 0.09]	-0.88	.38		
Step 3 (*df* = 189)						.000	0.004
Body Dissatisfaction	-0.03	-0.04	[-0.27, 0.20]	-0.29	.77		
Step 4 (*df* = 188)						.07***	0.08
Rating of RP attractiveness	0.27	0.01	[0.01, 0.02]	3.81	< .001		
	Commitment						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 191)						.03	0.03
Gender	-0.17	-0.30	[-0.56, -0.04]	-2.30	.02		
BMI	0.03	0.01	[0.04, 0.08]	0.47	.64		
Self-Esteem	0.04	0.02	[-0.06, 0.10]	0.53	.60		
Step 2 (*df* = 190)						.00	0.03
Dieting	-0.004	-0.004	[-0.20, 0.19]	-0.04	.97		
Step 3 (*df* = 189)						.002	0.002
Body Dissatisfaction	-0.07	-0.09	[-0.36, 0.20]	-0.60	.55		
Step 4 (*df* = 188)						.12***	0.14
Rating of RP attractiveness	0.37	0.02	[0.01, 0.03]	5.20	< .001		
	Conflict						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 191)						.05*	0.05
Gender	-0.01	-0.04	[-0.47, 0.40]	-0.18	.86		
BMI	-0.10	-0.04	[-0.10, 0.02]	-1.32	.19		
Self-Esteem	-0.19	-0.18	[-0.31, -0.05]	-2.67	.008		
Step 2 (*df* = 190)						.01	0.01
Dieting	0.12	0.25	[-0.07, 0.58]	1.53	.13		
Step 3 (*df* = 189)						.01	0.01
Body Dissatisfaction	0.12	0.24	[-0.22, 0.71]	1.04	.30		
Step 4 (*df* = 188)						.03*	0.03
Rating of RP attractiveness	-0.18	-0.02	[-0.03, -0.003]	-2.44	.02		

Note. *$p < .05$; **$p < .01$; ***$p < .001$. All predictors are self-reported by participants. BMI = Body Mass Index (kg/m^2); RP = Romantic Partner.

Table 13
Results of Hierarchical Regression Predicting Romantic Partner Individual Outcomes Controlling for Participant Global Self-Esteem

	RP Self-Esteem						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 69)						.04	0.04
Gender	-0.14	-0.46	[-1.24, 0.33]	-1.16	.25		
BMI	0.01	0.01	[-0.10, 0.11]	0.11	.92		
Self-Esteem	0.16	0.16	[-0.08, 0.39]	1.32	.19		
Step 2 (*df* = 68)						.006	0.006
Dieting	-0.09	-0.20	[-0.79, 0.40]	-0.66	.51		
Step 3 (*df* = 67)						.03	0.03
Body Dissatisfaction	0.28	0.63	[-0.21, 1.47]	1.49	.14		
Step 4 (*df* = 66)						.05	0.06
Rating of RP attractiveness	0.23	0.02	[-0.001, 0.05]	1.95	.06		
	RP Reflected Appraisal of Physical Attractiveness						
Predictor	*β*	*b*	95% CI	*t*	*p*	ΔR^2	f^2
Step 1 (*df* = 59)						.007	0.007
Gender	-0.08	-3.02	[-13.22, 7.18]	-0.59	.56		
BMI	-0.02	-0.10	[-1.45, 1.26]	-0.15	.89		
Self-Esteem	-0.01	-0.13	[-3.20, 2.94]	-0.08	.93		
Step 2 (*df* = 58)						.04	0.04
Dieting	-0.09	-3.47	[-13.53, 1.77]	-1.54	.13		
Step 3 (*df* = 57)						.008	0.008
Body Dissatisfaction	0.14	3.78	[-7.11, 14.66]	0.70	.49		
Step 4 (*df* = 56)						.08*	0.09
Rating of RP attractiveness	0.30	0.34	[0.04, 0.63]	2.31	.03		

Note. *$p < .05$; **$p < .01$; ***$p < .001$. All predictors are self-reported by participants. BMI = Body Mass Index (kg/m^2); RP = Romantic Partner.

Do people who diet more severely date less attractive people? It is also important to explore whether participants who diet more severely, and experience more body dissatisfaction, are not simply partnering with less attractive individuals (whom they accurately perceive to be less attractive). Ideally to test for this possibility I would use attractiveness evaluations of participants and romantic partners from objective raters (i.e., people outside of the relationship). Since this is unavailable in the current data set, the next best alternative is to see whether

romantic partner's self-ratings of attractiveness can be substituted for participant ratings of romantic partner's attractiveness. This will help distinguish whether it is internal processes within participants, or something external to participants—such as romantic partner's self-rated physical attractiveness—responsible for the study effects. To test this hypothesis, I regressed romantic partner's self-rated attractiveness onto: Step 1) control variables; Step 2) participants' mean-centered dieting; Step 3) participants' mean-centered body dissatisfaction. Overall, the model did not explain a significant percentage of variance in romantic partner's self-rated attractiveness ($R^2 = 0.05$, $F_{(1, 68)} = 2.49$, $p = 0.12$). Neither participant dieting nor participant body dissatisfaction predicted romantic partner self-rated attractiveness, $\beta_{dieting} = -0.11$, $t(69) = -0.93$, $p = .36$; $\beta_{BD} = 0.28$, $t(69) = 1.58$, $p = .12$. I also tested the indirect pathway using Hayes' (2018) PROCESS macro from SPSS (Model 4) using 10,000 bootstrap samples to estimate the 95% bias-corrected CI which contained zero (a x $b = 4.23$, $SE = 2.98$, 95% CI [-1.47, 10.34]), meaning that the indirect path was not significant. Thus, participants who dieted more severely and have higher body dissatisfaction did not have partners who rated themselves lower in physical attractiveness, and partner self-rated attractiveness cannot be substituted for participant ratings of partner attractiveness in the model.

Can dieting and body dissatisfaction change places in the model? Because I have theorized that dieting and body dissatisfaction have a reciprocal relationship, and my study utilized cross-sectional data, the causal order of variables in my model cannot be determined absolutely. As such, it is possible that body dissatisfaction is actually predicting dieting in this data, which in turn predicts the other variables in my model (i.e., body dissatisfaction → dieting → ratings of romantic partner's attractiveness). To address this alternative, I explored whether these two variables could switch locations in the model. I tested the alternative indirect pathway

using Hayes' (2018) PROCESS macro from SPSS (Model 4) using 10,000 bootstrap samples to estimate the 95% bias-corrected CI. The results did not support the alternative model because the 95% CI included zero, estimate = 0.71, *SE* = 2.01, 95% CI [-3.57, 4.41]). Moreover, whereas dieting did not directly predict ratings of romantic partner's attractiveness when body dissatisfaction was included in my proposed model, body dissatisfaction still directly predicted evaluations of partner attractiveness when dieting was included as a mediator in the alternative model. Thus, dieting and body dissatisfaction cannot change places in the model—strengthening the hypothesized direction of the associations in my model.

Can evaluations of partner attractiveness and body dissatisfaction change places in the model? Similarly, given the cross-sectional nature of the data, I tested whether body dissatisfaction and evaluations of partner's attractiveness could switch places in the model (i.e., dieting → ratings of romantic partner's attractiveness → body dissatisfaction). Once again, I used Hayes' (2018) PROCESS macro from SPSS (Model 4) to test the alternative indirect path using 10,000 bootstrap samples to estimate the 95% bias-corrected CI. The results did not support the alternative model because the 95% CI included zero, estimate = 0.02, *SE* = 0.02, 95% CI [-0.004, 0.06]. Therefore, participant body dissatisfaction and participant ratings of partner attractiveness cannot change places in the model. This finding lends support to the study model.

Can participant ratings of romantic partner attractiveness and participant relationship commitment and conflict switch places in the model? Again, given the cross-sectional nature of the data, it is possible that the associations in my study model are actually in the reverse direction than what I proposed. Thus, it could be that a lower relationship quality leads people to evaluate their romantic partner's attractiveness more negatively. To increase confidence in the direction of my paths, I examined whether participant ratings of their romantic

partner's attractiveness and participant relationship commitment or conflict could switch places in the model. I used Hayes' (2018) PROCESS macro from SPSS (Model 6) to test the alternative indirect paths using 10,000 bootstrap samples to estimate the 95% bias-corrected CI. The results did not support the first alternative model (i.e., dieting → body dissatisfaction → commitment → ratings of romantic partner's attractiveness; estimate = -0.54, *SE* = 0.66, 95% CI [-1.97, 0.69]) or the second alternative model (i.e., dieting → body dissatisfaction → conflict → ratings of romantic partner's attractiveness), estimate = -0.59, *SE* = 0.42, 95% CI [-1.55, 0.09]). Therefore, participant ratings of romantic partner's attractiveness and participant commitment to their relationship cannot change places in the model, nor can participant evaluations of their partner's attractiveness and their relationship conflict change places in the model. These findings support the proposed direction of the pathways in the study model.

General Discussion

Research Summary and Implications

Extant research has predominantly focused on the consequences of dieting for individuals. However, there is significant evidence to suggest that dieting might also interfere with interpersonal relationship functioning. Although some researchers have examined how an individual can influence their romantic partner's eating habits (discussed in more detail below), no research has specifically examined the potentially negative consequences of dieting for romantic relationship dynamics. My study sought to help bridge this gap in the literature by investigating whether dieting severity would indirectly predict relationship outcomes for romantic couples. My results support my thesis that people who engage in more severe dieting, and thus experience more body dissatisfaction, are more critical of their partner's appearance, which in turn predicts negative relationship outcomes. Overall, more severe dieting engagement indirectly predicted worse relationship outcomes for participants and worse individual outcomes for romantic partners; however, it did not appear to predict relationship outcomes for romantic partners.

My results suggest that dieters may project their negative evaluations of their own bodies onto their romantic partners. Consistent with self-esteem research showing that people with lower global self-esteem derogate their partner's global worth (Murray et al., 2006), people with a more negative body image derogated their partner's physical attractiveness. Given that controlling for global self-esteem diminished this effect, it is likely that body dissatisfaction functions similar to global self-esteem, and that the component of body image that overlaps with global self-esteem might be responsible for this association. As such, this self-protective partner-derogation likely functions to protect people with higher body dissatisfaction from perceived

rejection threats in their romantic relationships. By diminishing the value of their partner, people with higher body dissatisfaction can effectively protect their sense of worth as a romantic partner and reduce the pain they anticipate experiencing from future rejection. In other words, people with higher body dissatisfaction might devalue their partner in an effort to mitigate personal feelings of inadequacy and to lessen their pain in the event that their relationship dissolves. Unfortunately, what is seemingly protective for the individual is ultimately detrimental to their relationship. Results indicated that more severe dieting engagement—via body dissatisfaction and self-protective partner derogation—ultimately harmed the quality of romantic bonds. Individuals who dieted more severely had worse relationship outcomes and their partners had worse individual outcomes. There are five major implications of my findings.

Individual well-being. The first major implication of this research is for individual well-being. Dieting is bad for individual mental and physical health (Bacon & Aphramor, 2011), yet people are still frequently dieting and doctors still support and encourage many dieting behaviours. The fact that dieting negatively predicts romantic relationship outcomes could be used as incentive to decrease people's dieting engagement. Telling people that their own dieting behaviour is harmful to their partner and their relationship might be an effective means for decreasing the prevalence of dieting and the negative consequences of dieting which would benefit people's overall health. Given the immense societal pressures to be thin (Schaefer et al., 2015), knowing the individual risks associated with dieting might not be enough to deter people from engaging in it, but perhaps understanding the interpersonal risks would be. Knowing how dieting and body dissatisfaction are associated with their relationships might also encourage people to seek professional help for these issues, which would improve their overall well-being.

Romantic partner involvement may also be beneficial in treating negative body image and maladaptive eating practices as they can act as a source of social support during psychological treatment. Effective interventions for improving health behaviours such as medication compliance have utilized social support (DiMatteo, 2004), and researchers have begun to integrate couples into the treatment of eating disorders with promising initial findings (Kirby, Runfola, Fischer, Baucom, & Bulik, 2015). For example, Bulik and Baucom (2012) found that adult participants in their couple-based intervention (Uniting Couples in the treatment of Anorexia Nervosa) gained more weight over the course of treatment, had lower eating disorder symptomatology, and had a lower dropout rate compared to individual treatment options (as cited in Kirby et al., 2015). Couples also reported improved relationship quality over the course of treatment. Additionally, interventions targeting the couple rather than the individual have been shown to help with preventative efforts for health behaviours. For instance, targeting couples was more effective than targeting individuals at increasing Human Immunodeficiency Virus (HIV) prevention efforts such as regular HIV testing and medication adherence in high-risk groups (Jiwatram-Negrón & El-Bassel, 2014). Thus, partners could be utilized in treatment as incentive, a source of social support during individual treatment, or incorporated into a couple-based intervention. The benefits of including romantic partners in interventions is likely why researchers have attempted to utilize couples to increase dieting behaviour in the past (e.g., Markey et al., 2008). Romantic partners can be effective aids for creating lasting change. However, based on the results from this study, and the evidence regarding the adverse effects of dieting for individuals, it is evident that research should be focusing on how intimate bonds can help decrease dieting engagement and promote overall health.

Partner well-being. Results from my research also revealed that romantic partners who were rated as less attractive—by participants who dieted more severely—perceived that they were rated as less attractive by their partner and had lower self-esteem. This finding suggests that an individual's dieting engagement may have negative implications for their romantic partner. It is possible that people pick up on negative evaluations throughout regular day-to-day interactions with their partner and that this slowly deteriorates their self-esteem. However, given the correlational nature of this data, this hypothesis needs to be confirmed using longitudinal data which can help confirm the directionality of this association. Interestingly, dieting engagement did not predict relationship outcomes for romantic partners. It is possible that negative evaluations from one's partner affects feelings about the self before influencing views about their relationship. Alternatively, there could be more complicated processes that are responsible for this null effect that were not modeled in the current study. For example, factors like the length of dieting engagement and whether or not the romantic partner is also dieting might influence these results. Finally, it is possible that the study had insufficient power to detect the size of this effect (Power = .33 with $f^2 = 0.02$, 5 predictors, $\alpha = .05$). Future research should work to confirm this finding with a larger sample size, longitudinal data, and more dyadic variables. If the finding persists future work should aim to understand why it occurs.

Couples dieting together. Third, my findings suggest that attempts by researchers to exploit a romantic bond for the purposes of increasing dieting behaviour, under the guise of improving health benefits, should be abandoned. For example, Markey and colleagues (2008) examined whether people in monogamous relationships between women and men attempted to regulate their romantic partner's eating behaviours, and what strategies yielded the best results in

terms of increasing their romantic partner's "healthy"[8] dieting behaviours. They found that people commonly tried to influence their romantic partner's eating behaviours and that people were more likely to try and influence their partner's eating behaviours when they reported being dissatisfied with their partner's bodies or if their partner was fatter. They also found that women's, but not men's, attempts to control their partner's eating behaviour was successful in increasing "healthy" dieting behaviour but that it was also associated with men's weight concerns. Despite the positive association between women's attempts to influence their partner's eating behaviour and weight concerns for their romantic partners, the authors concluded that romantic partners could be an "untapped resource" for interventions targeting individual "healthy" dieting engagement (Markey et al., 2008, p. 431). Similarly, Novak and Webster (2011) conducted a daily diary study with married adults who were about to begin a weight loss attempt. One aim of their study was to understand the best type(s) of social support for spouses to use when encouraging their partners to diet and lose weight, and the effects different types of social control have on well-being (measured using positive affect and relationship satisfaction). They found that spouses used three types of social control to influence participant's eating behaviour: instrumental (e.g., "Cooked less food."), reinforcing (e.g., "Celebrated your progress with you."), and monitoring social control (e.g., "Told you that other people thought you needed to lose weight."). Based on the pattern of results the authors inferred that the use of instrumental

[8] Markey et al. (2008) note that they are investigating how people can help increase their partner's "healthy" dieting behaviours. They use the Healthy Dieting Behavior subscale of the Weight Control Behavior Scale (WCBS; French, Perry, Leon, & Fulkerson, 1995) to measure these behaviours. This subscale contains 11 items: "kilocalorie reduction, increased exercise, increased fruit and vegetable intake, eliminating snacks, decreasing fat intake, eliminating sweets, reducing the amount of food consumed, changing the type of food eaten, eating less meat, eating less high-carbohydrate food, and eating low-kilocalorie foods." (French, Perry, Leon, & Fulkerson, 1995, p. 549). Although other researchers have made this distinction between "healthy" and "unhealthy" dieting behaviours, I do not make this distinction, and place quotation marks around healthy/unhealthy, because—as outlined in previous sections—I believe that all dieting behaviours and the pursuit of weight loss are unhealthy and damaging to peoples mental and physical health.

and reinforcing social control by romantic partners predicted greater dieting adherence and better well-being for individuals; whereas, the use of monitoring social control by partners was negatively associated with dieting adherence and well-being. They also found that BMI moderated some study effects such that instrumental social control was associated with less negative affect for fatter participants only; whereas, monitoring social control was associated with less negative affect for thinner participants only. The authors concluded that spouses should avoid using monitoring social control strategies when trying to help their partners adhere to their diet and lose weight because these strategies could be "counterproductive and potentially harmful", especially for fatter individuals (p. 240).

Coupled with the known harms of dieting for individual health, my results suggest that the kinds of dieting interventions that I have just described are no longer an appropriate line of inquiry as dieting is associated with poorer individual and interpersonal functioning. Evidently people are able to influence their partner's dieting behaviours; however, dieting engagement also likely leads to discord in their relationship and is ultimately harmful to people's well-being.

Healthcare practices. Furthermore, my findings contribute to the growing body of evidence concerning the harms of dieting and should help convince medical professionals about the dangers of dieting for individual and interpersonal well-being. Medical professionals should not be promoting dieting as an effective means to lose weight or improve health, and instead should be advising people about the risks of dieting for themselves and their romantic relationships. Because the medical community is still supportive of dieting, people are likely going to continue to view it positively and continue to engage in it. Upholding the validity of dieting as a way to achieve health is also upholding weight stigma, which is damaging to people's health. Controlling for their actual body size, people who experience weight stigma

have higher mortality rates, higher morbidity rates for chronic diseases, and a higher risk of "obesity" (Tomiyama et al., 2018). Therefore, medical professionals prescribing dieting as a way to lose weight or improve health are actually achieving the opposite of their aims. Researchers and medical professionals should be intent on finding and providing the best care possible, and also have an ethical obligation to protect people from undue harm. Moreover, in order to maintain the respect and confidence of the public, researchers and medical professionals should be supporting and providing evidence-based science and care, which in this case point to the dangers of dieting. Rather than advising patients to diet to lose weight, health care providers could adopt a weight-neutral HAES approach and focus their efforts on improving individual health and well-being independent of weight loss. Thus, they might encourage patients to respect and care for their bodies via eating intuitively and engaging in physical activities that feel good and that they enjoy doing. Treatment goals and outcome measures should also be tailored to the individual rather than imposing weight loss as a universal goal and indication of treatment progress. Medical professionals should not give unsolicited advice about weight loss or dieting. If patients specifically request help with dieting, medical providers could ask the patient why they want to diet or what they are hoping to get from dieting. Likely people will cite weight loss and/or health goals for why they want to diet (Clarke, 2002; Grogan, 2017). Medical professionals could respond by educating individuals on how these goals are likely to go unmet (i.e., dieting is associated with weight gain and worse physical and mental health outcomes) and encourage weight-neutral health goals. Medical professionals might also refer patients to an intuitive eating dietician or HAES informed therapist to receive additional help developing a healthier relationship with food, eating, and their bodies.

Improving close relationships. It is possible that my research can be utilized to develop psychological interventions to improve people's well-being as well as the quality of intimate bonds. Given the significance of intimate relationships in determining people's well-being, identifying the factors that contribute to the quality of intimate bonds can be helpful in furthering our understanding of relationship dynamics and in determining areas for potential prevention and intervention efforts. Knowing how dieting and body image are associated with romantic relationship quality can help us discern how these individual factors interfere with dyadic couple well-being, how they might be affecting current interventions, and if they are viable targets for future interventions. Understanding the different risks and protective factors that influence the quality of intimate bonds has the potential to prevent the deterioration of relationships and improve the quality of relationships. In turn, having high quality intimate relationships benefits people's general well-being (Robles, Slatcher, Trombello, & McGinn, 2014). Interventions could help people understand how their individual behaviour is influencing their relationship and possibly keep them from engaging in behaviours that are damaging to their relationship such as dieting.

For example, a potential intervention might follow a similar format as the couple-based intervention for anorexia nervosa: Uniting Couples in the treatment of Anorexia Nervosa (UCAN; Bulik, Baucom, Kirby, & Pisetsky, 2011; Kirby et al., 2015). In UCAN therapists provide psychoeducation about anorexia nervosa and teach the couple communication skills to help the couple understand and effectively communicate about their experiences with eating disorders symptoms, their relationship, and related issues such as body image and physical intimacy. Therapists aid couples in creating effective strategies for addressing eating disorder symptoms and any other relevant concerns as a team. Preliminary findings suggest that involving

romantic partners in the treatment of eating disorders can have a number of benefits. Compared to people in other clinical interventions, people in UCAN are less likely to drop out of treatment, gain more weight during treatment, have lower eating disorder symptoms at the end of treatment, and indicate improved relationship functioning over the course of treatment (Bulik & Baucom, 2012 as cited in Kirby et al., 2015). Given the severity of clinical eating disorders, UCAN was designed to be delivered to couples in-person by a therapist as part of a multidisciplinary team including a dietician and a physician. In comparison, a couples intervention for dieting might utilize an online format which is more economical and enables a wider reach by eliminating a number of barriers to treatment such as the financial cost of hiring child care and the inconvenience of attending physical therapy sessions (Kanter & Schramm, 2018). Online interventions are more accommodating to couples busy schedules because they allow couples the flexibility of completing therapeutic work at the times that are most convenient to them (Kanter & Schramm, 2018). The proposed intervention would also differ from UCAN in that the focus would be on dieting rather than anorexia nervosa. Thus, the psychoeducation component might include information regarding what dieting is, why people diet, the harms of dieting, how dieting symptoms can influence relationships, a weight neutral approach to health (e.g., HAES), what the alternative to dieting is (i.e., intuitive eating), and what the process of disengaging from dieting will likely be like including the challenges that they are likely to face. Couples would discuss how dieting symptoms and body dissatisfaction have affected them and work as a team to create a plan for addressing these concerns and fostering a healthy food and body environment. Partners would help each other let go of external rules for eating and start learning how to trust their own bodies. For example, partners might agree to no longer buy diet foods, to explore food together that was previously “forbidden” to them on their diet, or to eat meals

together and try to hold each other accountable for not restricting their food intake. Additionally, I would include a self-compassion training component. Self-compassion has three core elements: self-kindness, a feeling of being part of a common humanity, and mindfulness (Neff & Beretvas, 2013, p. 79; Neff, 2003). Participants who listened to 20-minute self-compassion meditations once a day for three weeks had lower body dissatisfaction, body shame, and contingent self-worth based on appearance, and had higher body appreciation compared to a waitlist control group (Albertson, Neff, & Dill-Shackleford, 2015). Self-compassion is also associated with romantic relationship quality (Jacobson, Wilson, Kurz, & Kellum, 2018; Neff & Beretvas, 2013). People who are self-compassionate perform more positive relationship behaviours and less negative relationship behaviours, and experience higher quality relationships (Jacobson et al., 2018; Neff & Beretvas, 2013). Thus, self-compassion training could be a beneficial addition to an intervention for decreasing dieting and improving relationship functioning in romantic couples. By improving individual symptoms and dynamics within the relationship, I believe that an intervention of this type could help reduce maladaptive eating symptoms and body image concerns, and improve relationship functioning.

Strengths & Limitations

This study was a novel first step in advancing our understanding of how dieting may influence romantic relationship functioning. There is limited research examining dieting and romantic relationships, and no previous research examining negative associations between dieting and romantic relationship quality. This study will help guide avenues for future research to explore. The use of dyadic data allowed for the exploration of how dieting is associated with outcomes for romantic partners. Although the findings of my study are encouraging, there are a number of limitations that should be addressed in future research.

Firstly, the study used data from a single time point. Thus, the findings need to be replicated using longitudinal data to confirm the directionality of the associations. Secondly, because I used archival data, I was not able to select the specific measures used in the study. As a result, I was only able to test whether participants' perceptions of their own body predicted their perceptions of their romantic partner's physical attractiveness, rather than their partner's body specifically. Moreover, the measure used to assess physical attractiveness only contained two items. Additionally, there were some questions that were asked to participants but not their romantic partners which limited the research questions that could be evaluated. In future research, I would ensure that all raters are asked the same set of questions and that raters are asked to evaluate their romantic partner's bodies and overall attractiveness using more comprehensive measures. This would allow me to explore how different individual variables effect dyadic functioning. For example, does one person's dieting engagement influence their partner's body dissatisfaction? Or, does it change the results if both partners are engaging in similar levels of dieting? I would also control for potentially confounding variables by including additional measures that assess length of dieting engagement, thin ideal internalization, fat bias, and exercise behaviour. Finally, my data could not fully rule out an alternative model, in which people who diet more severely date less attractive people. As such, future work should also include attractiveness ratings from objective observers from outside of the relationship to definitively rule this possibility out.

Future Research

This study provided a first look into how dieting is associated with romantic relationship quality. As mentioned in previous sections, this work needs to be replicated with longitudinal data, a larger sample size, and in different populations (e.g., older, fatter, community samples,

etc.). Future work should also include additional variables to help answer remaining questions and experimental research designs should be used to help validate these effects. More specific ways that future research should expand on this study, and things that were not mentioned in previous sections, are detailed below.

Body mass index. Participants with lower BMIs experienced higher levels of relationship conflict. Past studies have found no association, or inconsistent associations, between BMI and relationship quality (Sobal, Rauschenbach, & Frongillo, 2009). However, there does appear to be an association between weight loss and relationship quality. People who participate in weight loss programs, and women who lose a significant amount of weight, experience increased relationship conflict (Felitti, 1993; Sobal, Rauschenbach, Frongillo, 2009). Thus, it could be that the amount of weight loss mediates this effect such that people who are at lower BMIs as a result of significant weight loss experience heightened conflict; whereas, people who naturally fall at lower BMIs do not experience higher levels of relational conflict. However, this finding was unanticipated and the preceding interpretation is post-hoc speculation. Weight fluctuations were not assessed in the current study and this hypothesis cannot be tested with this dataset; therefore, future work should seek to replicate and understand the mechanism(s) behind this effect.

Additionally, fatter participants thought their partners were more worthy, compared to thinner participants. Although researchers have explored the association between BMI and romantic relationship quality, they have not explicitly investigated how BMI is associated with people's perceptions of their romantic partner's worth. This finding was unanticipated and past studies are unavailable to aid in the understanding of this effect. However, it is possible that unmeasured variables could explain this finding. For example, it is possible that thinner participants might have higher expectations and standards—or a higher *comparison level*

(Thibaut & Kelley, 1959)—for their romantic partners due to their appearance aligning more closely with societal beauty ideals. That is, thinner people might feel that their appearance affords them a higher social currency which might cause them to have higher expectations for romantic partners, and as a result make them more critical of their partner's worthiness. However, this is conjecture and investigating the mechanism behind this effect is beyond the scope of this study. Future research should work towards replicating and understanding this association.

Self-esteem. Future research should confirm that the mechanism(s) behind the effect of body dissatisfaction on evaluations of romantic partner physical attractiveness are indeed the same as what has been theorized for global self-esteem. The similarities and differences between the influences of global self-esteem and body dissatisfaction should also be explored in future research to better identify and tease apart what effect these two variables have on people's relationships and well-being. Researchers should utilize experimental manipulations of rejection threats and interdependence conflicts to explore why this effect occurs and how it can be distinguished from global self-esteem. Future research should also explore the possibility that the self-protective partner-derogation dieters engage in extends beyond physical attractiveness, as well as the effects of other domains of self-esteem on romantic relationships.

Attachment style. Future research should explore whether attachment style can speak to the processes I studied. Some readers may perceive similarities between some of the arguments I have made concerning self-esteem and close-relationship processes and attachment theory. Attachment theory proposes that people have an innate need and ability to form intimate bonds with others, but that people adopt different attachment patterns as a result of early life experiences that they use as "working models" for later relationships (Bowlby 1973, 1980, 1982;

Hazan & Shaver, 1994). The two dimensional model of adult attachment proposes that there are two underlying dimensions of attachment—the self/anxiety and other/avoidance dimension—that range from positive to negative and intersect to form four different attachment patterns (Bartholomew, 1990). The other/avoidance dimension represents people's sense that close others will be available and supportive to them and determines whether people seek out or avoid intimacy (Griffin & Bartholomew, 1994). The self/anxiety dimension represents people's sense of self-worth and is characterized by either a confidence in close relationships or anxiety in close relationships (Griffin & Bartholomew, 1994). Thus, there are similarities between the self-dimension of attachment and the concept of global self-esteem.

Despite these similarities, there are important differences that led me to focus on global self-esteem rather than attachment patterns. First, global self-esteem is stable over time and across relationships (Trzesniewski, Donnellan, & Robins, 2003), whereas, attachment anxiety is not (Baldwin & Fehr, 1995). Second, global self-esteem is dimensional and includes a body evaluation component (Crocker & Wolfe, 2001; Franzoi & Shields, 1984), whereas, attachment theory does not have these theoretical components. Finally, global self-esteem includes evidence of partner derogation and projecting insecurities onto romantic partners (e.g., Murray et al., 1998), whereas, there is less evidence of this in attachment theory. People with an insecure attachment pattern might engage in less relationship promoting behaviours when faced with an interdependence conflict (e.g., Simpson, Rholes, & Phillips, 1996), but there is no evidence that they project their insecurities onto their romantic partners. As a result, my study focused on global self-esteem rather than attachment patterns. However, future researchers should explore the possibility that attachment also influences these processes and tease apart the roles played by self-esteem and attachment pattern.

Mood and self-regulation. An alternative interpretation of my findings is that the changes in mood and self-regulation observed in dieters explain my study effects. Dieting is associated with heightened rates of depression, anxiety, irritability, emotion dysregulation, and poor impulse control (Ackard et al., 2002; French, Story, et al., 1995; Polivy, 1996; Stice et al., 2000), which could influence romantic relationship quality (e.g., Mazzuca, Kafetsios, Livi, Presaghi, 2018; Rehman, Gollan, & Mortimer, 2008). In my study I observed a direct link between an individual's level of dieting engagement and their reports of conflict in their relationship. It is possible that this link is the result of the side effects to mood and regulatory processes that can result from dieting. Future work should include measures of mood and self-regulation processes to explore the predictive effect of these on relationship quality and rule out this alternative.

Dieting and body image. Dieting severity predicted higher body dissatisfaction and the variables could not change places in the study model. However, the study was conducted using correlational data, so the directionality of this association could not be conclusively determined. These findings need to be replicated with longitudinal data that assess dieting and body dissatisfaction at multiple timepoints to examine their simultaneous effects over time. I expect that dieting and body dissatisfaction likely have a maladaptive recursive relationship, whereby the presence of one increases the presence of the other. Body dissatisfaction is likely the first to appear and subsequently causes the onset of dieting. However, after onset, dieting engagement likely exacerbates body dissatisfaction because dieters are preoccupied with their bodies and food, eating, and body relevant cues are more salient to dieters making them more aware of their body concerns (e.g., Cooper & Fairburn, 1992; Green & Rogers, 1993; Jiang & Vartanian, 2012).

Generalizability to other relationships. The data from this study did not allow me to examine whether these effects show up in other close relationships or whether these findings are specific to romantic relationships. Future research should explore whether the same effects occur in other close relationships such as friendships, and whether they extend to other types of relationships such as acquaintances and strangers. It is possible that when people are more critical of their own bodies they are more critical of other bodies more generally; however, there might be something specific to romantic partners that makes people may project their vulnerabilities and insecurities onto them but not onto others. It would also be interesting to see whether a similar effect occurs for single people seeking relationships. That is, does dieting engagement also influence relationship initiation? If dieters are more critical of other people's bodies in general, it is likely that they will experience difficulties during relationship initiation.

Conclusion

This study provided an initial look into how dieting is associated with romantic relationship quality. People who dieted more severely were more critical of their own bodies, and as a result were more critical of their romantic partner's attractiveness, which ultimately interfered with the well-being of their relationship. Disseminating the information about the costs of dieting for themselves as well as their relationships might help deter people from engaging in dieting, or encourage them to stop dieting, and ultimately improve relationship functioning. This research could also be beneficial to the design and delivery of interventions targeting the reduction of dieting and body dissatisfaction. Medical professionals should be deterred from promoting dieting as healthy, and researchers should focus future efforts on decreasing dieting engagement rather than increasing it. Future research should replicate these findings using longitudinal and experimental data, and should expand on these findings by including more

variables and having both partners complete the same set of questionnaires. Researchers should also explore whether these effects occur with friends, strangers, and at different stages of relationships.

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Appendix

Questionnaire Items

Demographics

1. Gender ____
2. Age ____
3. What is your height? ____ feet and ____ inches
4. What is your weight? ____ pounds
5. What is your ethnicity? ____

Dieting

1. Since the term began, I have worried about my diet and/or weight.

   [dropdown menu]

   1 – never

   2 – rarely

   3 – sometimes

   4 – often

   5 – always

2. Since the term began, I have felt guilty after eating.

   [dropdown menu]

   1 – never

   2 – rarely

   3 – sometimes

   4 – often

   5 – always

3. Since the term began, I have refrained from eating when I was hungry.

   [dropdown menu]

   1 – never

   2 – rarely

   3 – sometimes

   4 – often

   5 – always

4. Since the term began, I have punished myself for eating more than I should have.

   [dropdown menu]

   1 – never

   2 – rarely

   3 – sometimes

   4 – often

   5 – always

5. Since the term began…

   [dropdown menu]

   1 – I never weighed myself

   2 – I weighed myself once

   3 – I weighed myself several times

   4 – I weighed myself several times each week

   5 – I weighed myself every day

   6 – I weighed myself more than once a day

6. Since the term began…

[dropdown menu]

1 – I never considered vomiting to lose weight

2 – I felt tempted to vomit to lose weight

3 – I vomited once to lose weight

4 – I vomited several times to lose weight

5 – I vomited several times each week to lose weight

6 – I vomited every day to lose weight

7. Since the term began…

[dropdown menu]

1 – I never considered bingeing (eating an excessive amount)

2 – I felt tempted to binge

3 – I binged once

4 – I binged several times

5 – I binged several times each week

6 – I binged every day

Body Dissatisfaction

1. Do you notice other people's body shapes and feel that your own shape compares unfavourably?

[dropdown menu]

1 – never

2 – rarely

3 – sometimes

4 – often

5 – always

2. Does being naked, such as when taking a bath, make you feel fat?

   [dropdown menu]

   1 – never

   2 – rarely

   3 – sometimes

   4 – often

   5 – always

3. Does eating sweets, cakes, or other high calorie food make you feel fat?

   [dropdown menu]

   1 – never

   2 – rarely

   3 – sometimes

   4 – often

   5 – always

4. Do you feel ashamed of your body?

   [dropdown menu]

   1 – never

   2 – rarely

   3 – sometimes

   4 – often

   5 – always

5. Are you particularly self-conscious about your shape when you are with other people?

[dropdown menu]

1 – never

2 – rarely

3 – sometimes

4 – often

5 – always

6. Do you find yourself brooding about your shape?

[dropdown menu]

1 – never

2 – rarely

3 – sometimes

4 – often

5 – always

7. In general, I am satisfied with my weight. (Reverse coded)

[dropdown menu]

1 – strongly disagree

2 – disagree

3 – slightly disagree

4 – neutral

5 – slightly agree

6 – agree

7 – strongly agree

8. If your weight is not what you would ideally like it to be, does it bother you that you do not weigh what you ideally desire?

    [dropdown menu]

    1 – It does not bother me at all

    2 – It bothers me a little

    3 – It bothers me somewhat

    4 – It bothers me quite a bit

    5 – It bothers me a lot

Physical Attractiveness

Now we are interested in knowing how you would rate **you/your current romantic partner** on a number of characteristics, relative to other people. On the chart below, in the column **marked self-rating/partner-rating**, we would like you to rate yourself/your partner on each characteristic using the following scale:

0 – 50 – 100

"**0**" means you think you/your partner is **lower than the rest of the population** on that trait.

"50" means you think you/your partner is **average than the rest of the population** on that trait.

"100" means you think you/your partner is **higher than the rest of the population** on that trait.

1. Physically attractive ____
2. Sexy ____

Self-Esteem

1. I feel that I am a person of worth, at least on an equal basis with others.

    [dropdown menu]

    1 – very strongly disagree

    2 – disagree

    3 – moderately disagree

4 – slightly disagree

5 – neutral

6 – slightly agree

7 – moderately agree

8 – agree

9 – very strongly agree

2. I feel that I have a number of good qualities.

   [dropdown menu]

   1 – very strongly disagree

   2 – disagree

   3 – moderately disagree

   4 – slightly disagree

   5 – neutral

   6 – slightly agree

   7 – moderately agree

   8 – agree

   9 – very strongly agree

3. All in all I am inclined to feel that I am a failure. (Reverse coded)

   [dropdown menu]

   1 – very strongly disagree

   2 – disagree

   3 – moderately disagree

   4 – slightly disagree

5 – neutral

6 – slightly agree

7 – moderately agree

8 – agree

9 – very strongly agree

4. I am able to do things as well as most other people.

   [dropdown menu]

   1 – very strongly disagree

   2 – disagree

   3 – moderately disagree

   4 – slightly disagree

   5 – neutral

   6 – slightly agree

   7 – moderately agree

   8 – agree

   9 – very strongly agree

5. I feel that I do not have much to be proud of. (Reverse coded)

   [dropdown menu]

   1 – very strongly disagree

   2 – disagree

   3 – moderately disagree

   4 – slightly disagree

   5 – neutral

6 – slightly agree

7 – moderately agree

8 – agree

9 – very strongly agree

6. I take a positive attitude toward myself.

[dropdown menu]

1 – very strongly disagree

2 – disagree

3 – moderately disagree

4 – slightly disagree

5 – neutral

6 – slightly agree

7 – moderately agree

8 – agree

9 – very strongly agree

7. On the whole I am satisfied with myself.

[dropdown menu]

1 – very strongly disagree

2 – disagree

3 – moderately disagree

4 – slightly disagree

5 – neutral

6 – slightly agree

7 – moderately agree

8 – agree

9 – very strongly agree

8. I wish I could have more respect for myself. (Reverse coded)

[dropdown menu]

1 – very strongly disagree

2 – disagree

3 – moderately disagree

4 – slightly disagree

5 – neutral

6 – slightly agree

7 – moderately agree

8 – agree

9 – very strongly agree

9. I certainly feel useless at times. (Reverse coded)

[dropdown menu]

1 – very strongly disagree

2 – disagree

3 – moderately disagree

4 – slightly disagree

5 – neutral

6 – slightly agree

7 – moderately agree

8 – agree

9 – very strongly agree

10. At times, I think that I am no good at all. (Reverse coded)

[dropdown menu]

1 – very strongly disagree

2 – disagree

3 – moderately disagree

4 – slightly disagree

5 – neutral

6 – slightly agree

7 – moderately agree

8 – agree

9 – very strongly agree

Ratings of Romantic Partner's Worth

1. I feel that my partner is a person of worth, at least on an equal basis with others.

[dropdown menu]

1 – strongly disagree

2 – moderately disagree

3 – slightly disagree

4 – neutral

5 – slightly agree

6 – moderately agree

7 – strongly agree

2. I feel that my partner has a number of good qualities.

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – moderately agree

   7 – strongly agree

3. I certainly feel that my partner is useless at times. (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – moderately agree

   7 – strongly agree

4. At times, I think that my partner is no good at all. (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

4 – neutral

5 – slightly agree

6 – moderately agree

7 – strongly agree

Relationship Quality

Commitment. Composite score created by averaging the standardized relationship satisfaction, commitment, alternatives, and investment items.

Satisfaction.

1. I am extremely happy with our relationship.

   [dropdown menu]

   1 – not true

   2 – 2

   3 – 3

   4 – 4

   5 – somewhat true

   6 – 6

   7 – 7

   8 – 8

   9 – very true

2. I have a very strong relationship with my partner.

   [dropdown menu]

   1 – not true

   2 – 2

3 – 3

4 – 4

5 – somewhat true

6 – 6

7 – 7

8 – 8

9 – very true

3. I do not feel that our relationship is successful. (Reverse coded)

   [dropdown menu]

   1 – not true

   2 – 2

   3 – 3

   4 – 4

   5 – somewhat true

   6 – 6

   7 – 7

   8 – 8

   9 – very true

4. My relationship with my partner is very rewarding (i.e., gratifying, fulfilling).

   [dropdown menu]

   1 – not true

   2 – 2

   3 – 3

4 – 4

5 – somewhat true

6 – 6

7 – 7

8 – 8

9 – very true

Commitment.

1. Will the two of you remain together and get married?

   [dropdown menu]

   1 – 0%, absolutely certain that the relationship will end before this time

   2 – 10% certain that we will still remain together

   3 – 20%

   4 – 30% certain that we will still remain together

   5 – 40% certain that we will still remain together

   6 – 50% equal probability that we will be together or separate

   7 – 60% certain that we will still remain together

   8 – 70% certain that we will still remain together

   9 – 80% certain that we will still remain together

   10 – 90% certain that we will still remain together

   11 – 100%, absolutely certain that we will still remain together

2. Will the two of you remain together for a lifetime?

   [dropdown menu]

   1 – 0%, absolutely certain that the relationship will end before this time

2 – 10% certain that we will still remain together

3 – 20%

4 – 30% certain that we will still remain together

5 – 40% certain that we will still remain together

6 – 50% equal probability that we will be together or separate

7 – 60% certain that we will still remain together

8 – 70% certain that we will still remain together

9 – 80% certain that we will still remain together

10 – 90% certain that we will still remain together

11 – 100%, absolutely certain that we will still remain together

Alternatives.

1. The people other than my partner who I might become involved with are very appealing. (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – agree

   7 – strongly agree

2. If I were not in this relationship, I would be satisfied being alone or spending time with friends. (Reverse coded)

[dropdown menu]

1 – strongly disagree

2 – disagree

3 – slightly disagree

4 – neutral

5 – slightly agree

6 – agree

7 – strongly agree

3. It would take me a fairly long time to find another dating relationship as good as my current one.

[dropdown menu]

1 – strongly disagree

2 – disagree

3 – slightly disagree

4 – neutral

5 – slightly agree

6 – agree

7 – strongly agree

4. It would be somewhat difficult for me to find another dating partner who meets my needs the way my current partner does.

[dropdown menu]

1 – strongly disagree

2 – disagree

3 – slightly disagree

4 – neutral

5 – slightly agree

6 – agree

7 – strongly agree

5. I flirt with people of the opposite sex without mentioning my partner. (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – agree

   7 – strongly agree

6. I'm very aware that there are plenty more "fish in the sea". (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – agree

   7 – strongly agree

Investment.

1. I have put a great deal into my relationship that I would lose if this relationship were to end.

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – moderately agree

   7 – strongly agree

2. Many aspects of my life have become linked to my partner (recreational activities, etc.) and I would lose all of this if we were to break up.

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – moderately agree

   7 – strongly agree

3. Compared to other people I know, I have invested a great deal in my relationship with my partner.

[dropdown menu]

1 – strongly disagree

2 – moderately disagree

3 – slightly disagree

4 – neutral

5 – slightly agree

6 – moderately agree

7 – strongly agree

Conflict.

1. My partner and I frequently argue with each other. (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – moderately agree

   7 – strongly agree

2. My partner often criticizes me about my behavior or attitudes. (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

4 – neutral

5 – slightly agree

6 – moderately agree

7 – strongly agree

3. I often criticize my partner about his/her behavior or attitudes. (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – moderately agree

   7 – strongly agree

4. When my partner and I have a disagreement if often escalates into a 'full blown' fight. (Reverse coded)

   [dropdown menu]

   1 – strongly disagree

   2 – moderately disagree

   3 – slightly disagree

   4 – neutral

   5 – slightly agree

   6 – moderately agree

   7 – strongly agree