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Wendy C. Birmingham
Brigham Young University - Provo

Adriane Ito de Queiroz Cavallini
Brigham Young University - Provo, adrianeq@gmail.com

Jordan Sgro

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Spousal influence: A study of women with eating and body image concerns

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Wendy C Birmingham ,
Adriane Q Cavallini and Jordan Sgro

Abstract

Eating disorder literature often overlooks those exhibiting eating and body image concerns without an eating disorder diagnosis. Supportive spouses may ameliorate negative body image and eating behavior, but spouses who exhibit both supportive and non-supportive behaviors concurrently (ambivalent) may send mixed messages. Eating disorder behaviors and spousal interactions were assessed in 61 women who demonstrated eating disordered behavior and body dissatisfaction but were not clinically diagnosed with an eating disorder. Spouses mostly provided messages of reassurance. However, some women were unable to overcome their internalized negative body image. Feelings of social comparison were seen with ambivalent spouses. Supportive relationships may be protective, but actual interventions may be needed to change negative body image.

Keywords

body image, eating disorders, marriage, relationships, spousal influence

Eating disorders (EDs) such as bulimia nervosa (BN), anorexia nervosa (AN), and binge-eating disorder (BED) are increasingly recognized as an important cause of morbidity and mortality, with ED having the highest mortality rate of any psychiatric disorder (Arcelus et al., 2011; Hoek, 2006; Suokas et al., 2013). EDs include, but are not limited to, extreme thinness, a pursuit of thinness, distorted body image, food restriction, and vomiting or laxative use (AN); eating large amounts of food followed by behavior which compensates for overeating such as vomiting, laxative use, or excessive exercising (BN); periods of binge-eating without purging, and eating even when full or not hungry (BED). The presence of eating disordered behavior or body shape/weight concerns that do not meet criteria for an ED diagnosis (Isomaa et al.,

2009; Saekow et al., 2015) have been associated with an increased risk of eventually meeting ED criteria (Jacobi et al., 2011; Killen et al., 1996; Patton et al., 1999; Taylor et al., 2003). Women are more often diagnosed with ED than men (Currin et al., 2005; Yu et al., 2018) and EDs are relatively more common in adolescents and young adults (Lewinsohn et al., 2000) with typical onset between 16 and 25 years (Currin et al., 2005). Body dissatisfaction and body shame are central to the development of eating pathology

Brigham Young University, USA

Corresponding author:

Wendy C Birmingham, Department of Psychology,
Brigham Young University, Provo, UT 84602, USA.
Email: wendy_birmingham@byu.edu

and have been identified as robust risk factors for ED among women (Rohde et al., 2015; Stice, 2002; Stice et al., 2017). A large proportion of women experience considerable dissatisfaction with their body size (Runfola et al., 2013; Slevec and Tiggemann, 2011; Smith et al., 2020; Tiggemann, 2004), and this dissatisfaction often continues across the lifespan (Ginsberg et al., 2016; Stice, 2002; Tiggemann and Lynch, 2001).

Social support can be a protective factor that may mitigate the effects of ED risk factors (i.e. body dissatisfaction, thin-ideal internalization, and perfectionism) on eating pathology (Schirk et al., 2015; Stice, 2002). Research on adolescent ED focuses on parental social support (Chng and Fassnacht, 2016; Hart and Chow, 2020; Hillard et al., 2016; Kirsch et al., 2016; Krug et al., 2016; Linville et al., 2011), but for adult women, an important source of social support may be their spouse. Research has consistently shown that marriage is beneficial for one's health and may protect individuals from various causes of morbidity and mortality (Robles et al., 2014). One way the "healthy marriage" effect may work is via the monitoring and influence spouses have on each other's health behavior (Homish and Leonard, 2008; Jackson et al., 2015; Umberson, 1992). Spouses can encourage healthier eating, exercising, and going to the doctor for regular check-ups and discourage risky behaviors (Falba and Sindelar, 2008; Homish and Leonard, 2008; Tucker and Anders, 2001), such as smoking or drinking (Falba and Sindelar, 2008).

But not all marriages are created equal, and not all influence from a spouse is positive. Research has shown that a spouse can impact a person's self-image and self-evaluation, particularly as it applies to weight, shape, and appearance satisfaction (Hoelter, 1984; Markey et al., 2004; Murray et al., 1995; Pole et al., 2004; Tantleff-Dunn, 2002) which may be particularly detrimental for women. Men place high importance on women's body size and shape when initiating a dating relationship (Singh and Young, 1995; Smith et al., 1990; Wagstaff et al., 2015). Fung (2013)

found that both US and Chinese men showed higher preference for women with lower than average body weight. Once in a relationship, women report being worried about partner criticism of their weight (Murray et al., 1995) and are more likely to alter their feelings about their bodies to reflect their partner's preferences (Tantleff-Dunn and Thompson, 1995). This worry about criticism is valid. Fung (2013) showed that 50 percent of the men in his study showed discrepancy between their preferred body weight and their girlfriend/wife's actual body weight, and 33 percent of participants preferred their girlfriend/wife lose weight. In a study of college students, Sheets and Ajmere (2005) found 30 percent of students in an exclusive relationship had been told to lose (women) or gain (men) weight, and Eisenberg et al. (2013) found that perceptions of encouragement to diet from a significant other was associated with disordered eating.

The quality of marital relationships can play a role in a spouse's influence. For example, unhealthy behaviors such as diet pill consumption and vomiting have been associated with poor relationship functioning (Juda et al., 2004; Kiriike et al., 1998; Markey et al., 2001). However, not all marriages are either purely positive or purely negative. While spouses can be sources of supportive influence (high positivity), they can also be sources of criticism and conflict (high negativity) which can exact a toll on both physiological health (Robles and Kiecolt-Glaser, 2003) and on daily-life activities (Newsom et al., 2008), such as eating behavior. Marriages can, and often do, contain both positive and negative aspects simultaneously (ambivalence). Social relationship ambivalence can be more detrimental to health and well-being (Birmingham et al., 2015, 2019) than even purely negative relationships (Birmingham et al., 2009; Holt-Lunstad et al., 2003; Uchino, 2009; Uchino et al., 2001). In fact, Holt-Lunstad et al. (2003) examined relationship positivity, negativity, and the interaction between positivity and negativity (ambivalence) and found interactions with ambivalent network ties

associated with the highest levels of systolic and diastolic ambulatory blood pressure. Ambivalent spouses may present mixed messages regarding weight expectations or eating behavior which could be particularly harmful for women with eating and body image concerns.

While the literature has examined the influence of a spouse for women with EDs, less is known regarding the influence of an ambivalent spouse. Furthermore, while relationship quality and marital functioning have been associated with disordered eating, the impact of an ambivalent spouse on disordered eating in women with eating and body image concerns has not been explored. This study was designed to address this gap in the literature. In this exploratory study, we examined supportive spouse behavior and ambivalent spouse behavior to determine the impact on women's body image and eating behavior in a sample of women with eating and body image concerns.

Method

Using a mixed method design, surveys were administered and one-on-one interviews were conducted with married women presenting with eating and body image concerns, examining relationship quality and partner impact on body dissatisfaction and eating behaviors. Quantitative data allowed for perceptions of spousal supportive or ambivalent behavior, and participant's body image, body satisfaction, and eating behaviors. Qualitative data provided increased depth and breadth of these perceptions, allowing for details not available through quantitative questionnaires.

Participants

The sample consisted of 62 female participants between the ages of 21 and 47 ($M=25.94$, $SD=7.3$) years, all legally married. Mean length of marriage was 4.8 ($SD=6.4$; range 1–25) years. Participants were 74.4 percent White, 11.3 percent Hispanic, 4.8 percent Native American, and 3.2 percent Pacific Islander and/or Asian. Most participants were educated, with

34 percent college graduates or/and graduate school experience, and 62.9 percent reporting at least partial college education. Participants' body mass index (BMI) ranged from 19 to 43 ($M=25.22$; $SD=5.9$), with nine participants in the obese range (i.e. exceeding 29.9). Participants had never been diagnosed with any ED.

Procedures

All procedures performed in this study were in accordance with the ethical standards of the institutional and/or National Research Committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. This study was approved by the University Institutional Review Board (#F15134). Participants were recruited through married campus housing and from the local community through social media (e.g. Facebook and Instagram). A lab email was provided on advertisements for interested individuals. Individuals who expressed interest were sent an online screener to determine eligibility. Potential participants were disqualified if reporting any history of an ED diagnosis. Those who remained were considered eligible if scoring a 1, 2, or 3 on the SCOFF (see information regarding SCOFF cutoff scoring in section "Measures") indicating body image and eating behavior concerns. Once eligibility was ascertained, participants gave informed consent online and were then directed to an online survey which collected demographics, health behaviors (e.g. exercise habits and typical hours of sleep per week), height and weight, body image, eating behaviors, and measures of relationship quality. Upon survey completion, participants were contacted to schedule a one-on-one interview with a study researcher. All interviews were digitally recorded.

Measures

SCOFF questionnaire screener. The Sick, Control, One, Fat, Food (SCOFF) questionnaire is a concise and easy to score, five-item instrument that is effective in detecting eating

disordered behavior and body image concerns (Morgan et al., 1999). The SCOFF has been designed to suggest a likely ED case rather than to diagnose. The maximum score is 5, and a score of 2 or higher indicates that further ED assessment has been traditionally indicated. Therefore, in this study, qualified participants received a score of a 1, 2, or 3, which allowed for exclusion of women who are very likely to have a full ED diagnosis (scores of 4 and 5) and women who are likely to have no eating or body image concerns (score of 0), while including those with possible ED symptomatology such as eating and body image concerns.

The Social Relationship Index. The Social Relationship Index (SRI; Campo et al., 2009) is a self-report version of the social support interview (Uchino et al., 1992), which assesses relationship ambivalence. Prior work has shown the SRI temporally stable with significant 2-week test-retest correlations of $r = .81$ ($p < .001$) for positivity and $r = .83$ ($p < .001$) for negativity (data reported in Uchino et al., 2001). For this study, the internal consistencies for the SRI positivity and negativity ratings were comparable to prior work (alphas of .74–.85). Participants rated their spouse's behavior when the participant needed support on a 6-point scale from "Not at all" to "Extremely" for the questions, "How positive is your spouse?" and "How upsetting is your spouse?" A spouse who was rated greater than "2" on positivity and only a "1" on negativity, was labeled "supportive." A spouse who was rated greater than a "2" on both positivity and negativity was labeled "ambivalent." These cutoffs are based on prior work and a broader framework (Uchino et al., 2001), as spouses are typically not rated as aversive (a 1 on positivity and greater than a 2 on negativity) or indifferent (both a 1 on positivity and a 1 on negativity). In addition, research indicates that for a stable and happy marriage much more positive interactions are needed to compensate for negative ones: one negative interaction is balanced by five positive interactions (Gottman,

1994a, 1994b). A measurement of ambivalent spouse interactions, therefore defines a relationship as ambivalent if a spouse is rated more than "not at all positive" and more than "not at all upsetting" in situations when support is needed (for more details see Campo et al., 2009).

Body Attitudes Survey. The Body Attitudes Survey is the authors' qualitative questionnaire ascertaining participants' attitude toward their own body parts, and abilities. Questions asked participants to describe their best physical feature and worst physical feature. Participants could freely respond to questions such as "To use my body athletically makes me feel . . ." and "When I see myself nude in the mirror, my reaction is . . .," and "If I am engaged in sexual relations, I feel _____ about my body." We currently have no psychometric data on this scale.

Change in Eating Disorder Symptoms scale. The Change in Eating Disorder Symptoms (CHEDS) scale is a 35-item (Spangler, 2010), multidimensional measure of ED symptomatology (i.e. body image and eating behavior), which includes measurements of eating concerns/preoccupation/restriction and body preoccupation/dissatisfaction. Reliability coefficients of the subscales range from .85 to .93; overall internal reliability coefficient alpha is .96. One-week test-retest reliability was $r = .90$, $p < .000$. Body-related body image preoccupation/body dissatisfaction scores range from 0 to 70, and eating concerns/preoccupation/restriction scores range from 0 to 64.

Qualitative interview. An interview guide was created based on specific items from the CHEDS measure (Spangler, 2010). Interview items also focused on perceptions of the spouse's influence on the participant's eating behavior, body image, and body satisfaction. Interview questions aimed at spousal influence included items such as "Can you tell me how your spouse responds to you when you are feeling unhappy with your appearance?"

Data analyses

Quantitative. Qualitative data was analyzed using SPSS (IBM SPSS Statistics, version 25). Individuals were categorized as ambivalent or supportive per SRI criteria, such that those who scored greater than a 1 on positivity and only a 1 on negativity were classified as supportive, while those who scored greater than a 1 on positivity and greater than a 2 on negativity were classified as ambivalent. All free-response responses on the Body Attitude Survey were quantitatively scored through coding by three independent coders and responses were categorized as positive or negative self-perceptions. Interrater reliability was .94.

Qualitative. A directed content analysis (Hsieh and Shannon, 2005) approach was used for qualitative data. Interview recordings were transcribed verbatim by one trained research assistant and verified by a second. Transcripts were coded using NVivo software (QSR International Pty Ltd., version 12) using predetermined categories, identifying participants' self-perceptions and spousal influence on body image and eating behavior.

Results

Quantitative

Marital relationship quality. Prior literature (Birmingham et al., 2015, 2019; Uchino et al., 2013, 2014) has found the rate of spousal ambivalent behavior at approximately 65–75 percent. It is interesting thus, that in contrast to prior work, only 40.3 percent of women in our study ($n=25$) reported spousal ambivalent behavior, with most women ($n=37$; 59.7%) reporting their spouse as supportive. One may assume that ambivalence would generally be found in the highest rates in marriages of longer duration; it may take multiple positive and negative interactions over the years to produce ambivalent behavior. Our sample was fairly young (mean age: 24.94 years) and young in marriage (mean length of marriage: 4.8 years), so the assumption might be that the high

number of supportive spouses would be related to age and length of marriage. However, ambivalent rates are found in younger marriages, and in younger individuals as well as in older marriages and older individuals (Birmingham et al., 2019). It is therefore somewhat surprising that our sample was fairly low in ambivalent spousal behavior. It may be that spouses are aware of their wives' concerns in body image and eating behavior and limit their support to positive interactions.

Body image. Participants reported and rated their best physical feature and their worst physical feature via open-ended questions from the Body Attitude Survey. Most (75.8%) reported their best physical feature as a non-weight related body part, such as their eyes, their smile, their hair, their teeth, or their lips. When asked to identify their worst physical feature, most reported a body part related to weight: 86 percent identified their stomach/tummy/belly/muffin top, or thighs/legs. When asked to provide a word or phrase describing their feelings about their body as a whole, slightly over half of participants (53.2%) used negative terms. Negative comments included terms such as “unsatisfied,” “upset,” “disappointed,” “I’m fat and I’m not enough pretty,” and “I hate it.” More positive comments included “confident,” “healthy,” “sexy,” and “satisfied.” Participants reported their feelings upon seeing themselves in the mirror naked, and 59 percent responded with negative terms such as “gross,” “appalled,” “I’m fat,” “I’m ugly,” “disgust,” “Do I really look like that?” and “to look away.” Those who responded with positive terms included such language as, “I’m satisfied,” “I think I’m hot,” and “wow!”

Participants showed moderate levels of body image preoccupation/dissatisfaction ($M=28.05$, $SD=17.95$) and low levels of eating concerns/preoccupation/restriction ($M=13.98$, $SD=10.96$). Linear regression was performed to ascertain the effects of relationship quality on body image preoccupation/dissatisfaction, and eating concerns/preoccupation/restriction. Relationship quality was significantly associated with body

image preoccupation/dissatisfaction ($B=9.93$, $SE=4.63$, $p=.036$), such that those who reported ambivalent spousal behavior demonstrated higher body dissatisfaction and preoccupation. Eating concerns/preoccupation/restriction were not significantly associated with relationship quality ($B=4.03$, $SE=2.83$, $p=.160$). Binomial logistic regression was performed to ascertain the effects of relationship quality on women's report of their best and worst physical feature (i.e. weight related or not). There was no significant association between relationship quality and reported body part ($\chi^2(1)=.026$, $p=.871$).

Qualitative

Data from the qualitative data crossed with relationship quality can be found in Table 1.

Body image. In order to develop a more complete picture of the influence of spouses on participants' body image and eating behaviors, we examined each participant's interview. We first looked at participant's perceptions of their body. As reflected in our quantitative data, many participants indicated dissatisfaction with their bodies. Relationship quality (i.e. supportive or ambivalent) and participant number are noted in the brackets following comments:

So I feel like, with as much exercise as I do, I still don't like my legs. I feel my legs are too big, and, when I do gain muscle, it's not where I want it. (117 supportive)

I am not skinny enough, if I am not thin enough, people won't want to date me or no one would want to be in a romantic relationship with me. (128 supportive)

. . . so when I look at myself in the, the mirror, I may see at first, oh my gosh, I'm flabby in some areas. (149 supportive)

. . . No matter what . . . , it's my self-loathing that puts me over the edge. (105 supportive)

I always tell my husband "if you don't make it seem like you like my body or that you like what

you see or what you look, I'm going to hate it even more." (102 ambivalent)

Spousal influence

As a main aim of this study was to determine the influence of supportive and ambivalent spousal behavior on participant's body image and eating behavior, we examined participant's reports of their spouse's language and behavior, either supportive or ambivalent.

Supportive

During the interviews, participants discussed at length the impact their spouses had on their body image, and most reported a strong positive and supportive influence. Prior literature indicates that unhealthy body image and eating behaviors are associated with poor relationship quality (Markey et al., 2001); we thus expected that participants who experienced body satisfaction would report supportive relationships and this was indeed found in our qualitative data:

I guess I'm a pretty confident person with my body. I mean, look at the survey thing, you'll probably see that I'm pretty confident. (133 supportive)

I've never really felt the need to lose a huge amount of weight, I've never felt like my body or my weight has really affected my self-esteem a whole lot. (158 supportive)

However, it is of interest that participants who reported dissatisfaction with their bodies also reported supportive relationships. In addition, contrary to expectations, some participants with supportive spouses still compared themselves to others and found themselves lacking:

I look at girls walking around campus and think, oh why can't I be as thin as them, why can't I be that skinny. (116 supportive)

Spouses often sought to reassure the participants of their attractiveness by telling

Table 1. Qualitative responses by relationship quality.

Variable	Supportive (n=37)		Ambivalent (n=25)	
	N	%	N	%
Body image				
Positive	19	51.4	10	40
Negative	18	48.6	15	60
Not mentioned	0	0	0	0
Spousal comments				
Body image				
Positive	37	100	25	100
Negative	7	11	12	19
Not mentioned	0	0	0	0
Eating behavior				
Positive	27	72.9	10	40
Negative	7	18.9	13	52
Not mentioned	3	8	2	8
Social comparisons				
Negative	2	5.4	13	52
Not mentioned	36	97.3	12	48
Negative image remains				
Mentioned	8	21.6	6	24
Not mentioned	29	78	19	76

participants they are beautiful, or by mentioning specific things they like about the participant’s body:

He says, “I think you are beautiful the way that you are, you are perfect for me, like it doesn’t matter . . .” When I say I feel I have gained too much weight, he says, “I think you are perfect . . .” (113 supportive)

He always tries to make me feel better, because he knows the insecurities that I have or the parts of my body that I don’t like, and he says, “Well, those are my favorite!” I’m like, “I don’t like my legs . . .” and he says, “I love your legs! They’re great!” (117 supportive)

These comments from supportive spouses helped participants feel better about their bodies. Participants noted that comments on their attractiveness not only calmed them but also when their spouse spoke of relationship characteristics that reminded participants of their

importance to their spouse, and of more central aspects of the relationship, participants were reassured:

Um, I think that for me it’s has been positive because I can see how much my husband

loves me and accepts me and values me and even with my body image, like, he loves that

just as much. So it has been a positive thing for me because I’m like oh, he loves me and

thinks that I am perfect and my body is perfect more than I think so about myself. So I

think it has been positive, at least for me. (128 supportive)

I’ve been 100 pounds lighter, 100 pounds heavier with my husband, thick and thin, and he loves me for me. I married my best friend and that’s our relationship. (105 supportive)

. . . and he'll compliment me on something that is related to my body and then totally unrelated to my body. And so it's actually like a system and its super helpful. (137 supportive)

Participants also reported that their spouse encourages them to find ways to overcome negative body image by participating in healthier behavior, including eating behavior:

. . . after he's established that like what I'm feeling is legitimate then he'll say, what do you want to do, do you think there is a way you can feel better about yourself? And so he moves it to me and so I can attempt to feel empowered by saying okay well maybe I should exercise more . . . And then after that he'll say, I think that's a great idea, is there any way I can help you? (137 supportive)

Participants also reported that they feel more comfortable eating around their spouse than around their friends and expressed the idea that they were comfortable with their spouse and felt no judgment:

So if I'm like with my friends, I'm being completely candid here, so if I'm with my friends, I'll try and be a little more, "oh a salad," or like, "I eat this way" but my husband, he's like, you know, he eats whatever the hell he wants to, so I do too! Because there's no judgement there. So it's very different depending on who I am with. (101 supportive)

Despite the positive spousal assurance of participants' attractiveness and desirability, participants still reported difficulty in changing the internal negative body image dialogue, and this was surprisingly found most often in women in supportive relationships:

My husband can say "oh you are the most beautiful girl in this world" but if I don't believe it, it's not going to matter. (111 supportive)

He'll say, "You don't see yourself how you actually are! I feel sad that you don't see how beautiful you are like I do." Or he'll say . . . "Why do you think this way? Why can't you just

see what's really there?" But it's hard for me to accept that. (120 supportive)

My own self-doubts sometimes are stronger than my husband telling me that he thinks I'm beautiful. So I act on my self-doubt rather than on his opinion of me. In my experience, my voice inside my head is stronger than his voice telling me that I'm beautiful. [Researcher: How does that make you feel?]. Pretty good. Unless the doubting voice in my head is louder. (135 supportive)

Ambivalent

Participants who reported ambivalent spouses spoke of positive messages from their spouse, but these were often interwoven with negative messages that could appear judgmental or dismissive of the participant's concerns:

I feel like I am constantly talking about like I'm fat, I'm this, I'm that or whatever and my husband just gets like—I can tell he gets annoyed. He's like "ok then do what you want to do, you're fine the way you are, go to the gym, don't eat, do eat . . ." He's always like I will love you when you're 900 pounds and I'm like sure . . . (102 ambivalent)

Depends on how many times it's happened in the past day or so. There's like the loving, "No, that's true. You're beautiful in all these ways." And then, sometimes, he'll be like, "You're ridiculous, come on, that's not true." More like, "Seriously, no." (160 ambivalent)

He would just tell me about like I'm getting a little fat or like a joke, even if he says a joke, it bothers, so . . . or he would tell me "yeah you should probably like avoid these foods" or like he lets me eat whatever I want but then he would complain. (162 ambivalent)

. . . [on being supportive] if I decide I want to do a diet or not, he will support doing it or not doing it or either way . . . And then, later in the diet, it's like "Well, shouldn't you be eating that?" or "Shouldn't you be doing this?" Or "Shouldn't you be doing that?" And then it's like, they're more nagging you to do it. (131 ambivalent)

Social comparisons were often mentioned, and a higher percentage of participants who felt judged were in relationships which were not uniformly supportive (ambivalent). While neither quantitative questionnaires nor qualitative questions included perceptions of social comparisons, this was a topic of concern in qualitative data with participants expressing feelings of judgment from social others in both body image and eating behavior:

I hate going to family reunions because I'm like, I wonder how much I've gained since last year. Who's going to notice? I wonder what they're thinking about me, I wonder what they're saying about me. (102 ambivalent)

And so I feel like sometimes people judge me if I eat more than like my husband per se, which has happened. (118 ambivalent)

And I'm super, I think I'm way—I always think—even when I'm walking down the grocery store I feel like people are judging me. Like, “Oh, I know she's probably looking at me like ‘Oh, that lady probably should have put on something else or whatever.’” So I feel like it's taking over sometimes, I feel like it's taking over my life. (102 ambivalent)

Well, her and my sister sit and make fun of how I eat because I guess—I didn't know—but I only eat . . . If there's a plate full of food, I only eat one and then I go to the next. And they think it's weird. And so, they bug me and so I don't eat much in front of them. (110 ambivalent)

Participants with ambivalent spouses also reported they would restrict or monitor their food intake around their spouse. Some commented that they tend to restrict their food intake when around their spouse for fear of being perceived negatively or judged:

. . . sometimes I don't feel like I'm going to shove my face if my husband is nearby. So for me I get self-conscious, if he's thinking “Really, did she need to eat all of that?” (102 ambivalent)

So, I dunno, I know he's not like, oh, I dunno, looking down on me. “She talks so much about

her body, like, why isn't she eating better? You know, if it really bugs her, you know, why doesn't she eat better?” (116 ambivalent)

Yeah I'll be like, “Listen, stop judging me.” I always tell him to stop judging me, “I know you're judging me because I feel like I'm eating too much.” Or he'll be like “oh I'm going here what do you want” or whatever and I'll tell him at the end of the text “don't judge me I know it's a lot” or something like that you know. So yeah I do, I don't feel like he would ever say anything, but sometimes I feel the judging eyes. (102 ambivalent)

Discussion

While prior research has examined spousal influence on eating behaviors and body image in women diagnosed with ED, no study that we are aware of has focused on relationship quality in terms of spousal supportive or ambivalent behavior in subclinical women's body image, body satisfaction, and eating behavior. This mixed method study examined quantitative assessments of body image and body dissatisfaction, and perceptions of spousal supportiveness or ambivalence, while qualitative interviews provided participant's thoughts, feelings, and deeper details, delivering a depth and breadth which could not be ascertained through questionnaires alone. This multifaceted study provides insight into the influence of ambivalent and supportive spouse's behaviors on women's perceptions of their body and eating decisions. Quantitative data indicated most participants found their relationships to be primarily supportive, rather than ambivalent. These levels of supportiveness in the relationship were also found in the qualitative analyses where most spousal influence was perceived and reported to be positive and helpful. However, participants reporting ambivalent spousal behavior were more likely to be influenced by the negativity in the spousal messages, despite the positivity the spouse also expressed.

Our data indicated that most participants perceived their bodies in negative rather than positive terms and were more likely to mention a body part related to body shape and weight

when reporting their worst feature. Most reported a body part not related to shape and weight when reporting their best feature. This reflects the body shape concern that the women in this study have, in contrast with neutrality or positivity toward body parts that are not centrally linked to body shape and weight. This finding is also particularly concerning as body dissatisfaction is central to the development of eating pathology, and is one of the strongest risk factors for ED (Rohde et al., 2015; Stice, 2002). In addition, body shape and weight concerns are characteristic of subclinical EDs that may eventually warrant treatment (Killen et al., 1996; Taylor et al., 2003).

In the interviews participants discussed their spouse's influence on their body image and most reported a positive influence, with spouses frequently giving positive feedback about the participant's body with the intention to reassure them of their importance, beauty, and attractiveness. Participants' comments about their body dissatisfaction and spousal attempts to reassure indicate that this support is ongoing, with spouses offering such support on a daily basis, or each time they notice the participant is struggling with their body image. Participants reported feeling more confident in their appearance through their spouse's comments and reported that the feedback received allowed them to see positive aspects of the marital relationship as well. These supportive comments about the body not only positively impacted participant's body image perception, but also the perception of the marital relationship in itself. This finding confirms previous research that spousal support is correlated with marital quality and satisfaction.

Sometimes the reassurance and encouragement revolved around supporting participants in developing a healthy lifestyle that includes exercise and healthy eating, and not necessarily changing the body to meet certain standards. The positive reassurances of the spouse stand in contrast to previous research indicating that most people in a relationship have been told by their partner that they should change their body or lose weight as noted by

Sheets and Ajmere (2005). It could be because all participants in our sample were in marital relationships rather than dating relationships, and that marital relationships carry different expectations. After all, one has committed themselves to this person for life and may thus feel a greater commitment and acceptance to their partner's body as well. Dating relationships, however, may include an expectation that the partner should change their body before the relationship becomes permanent.

While less participants reported ambivalent behavior from their spouse, those who did reported mixed messages. The negativity in these mixed messages seemed to be more salient than the positivity in the messages and participants seemed to believe the negative comments more than they believed the positive comments. Quantitative analysis showed ambivalent relationship quality associated with worse body satisfaction and higher body preoccupation. This correlates to our qualitative data where the negative aspects of comments from an ambivalent spouse seemed to outweigh the positive aspects in the comments which could lead to greater worry and less reassurance. It is also informative that those participants who reported spousal ambivalent behavior also reported feelings of social judgment or evaluation. Smith et al. (2012) found feelings of social evaluation linked to worse health outcomes such as increased blood pressure, but no link has yet been made between ambivalent partner behavior, social evaluation, and ED. It will therefore be important to examine this link in future studies.

It is important to note, however, that reassurances from the spouse did not permanently resolve the body image dissatisfaction of the participant. Participants reported their spouse as supportive and spoke of specific attempts of the spouse to reassure the participant of their importance to the relationship and their attractiveness, yet some participants still could not overcome their own self-doubts. Many participants were aware they were holding on to the negative perception of their own body, and expressed that this negative body image is

internal and independent from their spouse. However, the women in this sample may have been more impacted by their spouse's positive feedback about their bodies than they realized as none had received a full ED diagnosis. Positive feedback from a spouse may be a protective factor. Still, this positive influence and reassurance does not seem enough to allow participants to overcome their internalized body dissatisfaction and body image concern. It is therefore important to differentiate between protective factors and curative factors when it comes to negative body image. A supportive relationship may be acting as a protective factor and have an impact in preventing the participant from developing full ED syndrome, but to actually change negative body image into a healthy body image actual intervention seems to be needed. It is also expected that these two aspects (protective and curative) complement each other and may have a greater positive impact when used together. It is known that supportive relationships are vital to ED recovery (Linville et al., 2012, 2016; Tozzi et al., 2003), and given the newer developments of treatments of EDs aimed at couples in which one of the partners has an ED (Kirby et al., 2015), this research further supports the importance of both social support and the need of appropriate interventions to address negative body image and body dissatisfaction.

It is worth noting the limitations of our study. Our sample was predominantly White and educated, and our participants were fairly young. Most reported supportive relationships which are not consistent with the prior literature that shows ambivalence generally at higher levels. However, our study allowed for qualitative data collection from a large number of participants, and the interviews were detailed and specific. Our inclusion of both quantitative and qualitative data gives our findings depth and complexity. Our findings of ambivalent partner behavior associated with mixed messages in which the negativity in the message seems to outweigh the positivity of the messages are important in understanding spousal influence and warrant further examination. Furthermore, the greater

feelings of social evaluation in ambivalent relationships indicate the value in additional exploration of this phenomenon.

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ORCID iD

Wendy C Birmingham  <https://orcid.org/0000-0002-8908-206X>

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