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Body talk, weight status, and pathological eating behavior in romantic relationships☆

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ABSTRACT

This study examined whether engagement in body talk would interact with weight status (body mass index; BMI) to predict pathological eating behaviors among romantically involved adults. Adults ($N = 137$, females = 86.86%, average age = 23.50) involved in a romantic relationship were recruited to complete an online survey about their body image, dietary behaviors, and engagement in body talk. Results indicated that engagement in negative body talk was directly related to higher pathological eating (i.e., drive for thinness, dieting, and bulimia symptoms). Positive body talk, on the other hand, had a significant interaction effect with BMI to predict pathological eating. For individuals with a high BMI, high engagement in positive body talk was associated with increased drive for thinness, dieting, and bulimia symptoms. However, for those with a low BMI, high engagement in positive body talk was protective against pathological eating. These findings suggest that while negative body talk is harmful in general, positive body talk is uniquely problematic for individuals of a higher weight status.

1. Introduction

Body dissatisfaction is prevalent among adults, with 66% of women and 52% of men reporting dissatisfaction with their current body weight (Garner, 1997). Not surprisingly, overweight and obese individuals report higher body dissatisfaction than individuals of normal weight (Stice & Shaw, 2002). Individuals' discontent with their appearance and body tend to manifest in social interactions. *Body talk*, also known as appearance conversation, refers to the social discussion of individuals' perceptions of their own bodies, which may take self-deprecating (negative) or self-accepting (positive) forms (Rudiger & Winstead, 2013). Numerous studies have demonstrated correlations between engagement in negative body talk and body dissatisfaction (Arroyo & Harwood, 2012; Salk & Engeln-Maddox, 2011) as well as pathological eating behaviors (Clarke, Murnen, & Smolak, 2010). Little research attention, however, has been given to self-accepting or self-affirming body talk. Furthermore, most existing research on body talk focuses on social interaction among peers (e.g., Arroyo, Segrin, Harwood, & Bonito, 2016; Clarke et al., 2010; Tucker, Martz, Curtin, & Bazzini, 2007), despite romantic relationships being the most important sources of intimacy and support (Carbery & Buhrmester, 1998). Hence, the purposes of this study were to examine (a) the direct associations among weight status, positive and negative body talk in romantic relationships, and eating pathology and (b) how positive or negative body talk may be a risk factor that elevates (moderates) the negative consequences of high weight status on eating pathology.

1.1. Weight status

Weight status appears to be an important predictor of negative body image and eating behavior. Previous research has consistently found that individuals of a higher weight status (e.g., high BMI) suffer from more body image disturbance and eating pathology than individuals of a healthy weight (Stice & Shaw, 2002). In general, Western society is uncomfortable with "fat," and individuals with higher weight status do not appear immune to this phenomenon (Crandall, 1994). Individuals with overweight status display the same level of anti-fat attitudes as others, suggesting limited, if any, in-group support for overweight individuals regarding their weight (Crandall, 1994). As might be expected,

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individuals who are overweight and obese engage in dieting behavior at a higher rate than normal weight individuals (French & Jeffery, 1994). Unhealthy dieting behaviors can have a number of negative outcomes, including weight-preoccupation, binge eating, development of eating disorders, and the risk of negative health outcomes of "weight-cycling" if and when dieting is not successful (Brownell & Rodin, 1994; Liechty & Lee, 2013).

1.2. Body talk

Body talk, as conceptualized in this study, refers to both negative body talk (e.g., fat talk) and positive body talk. Negative body talk is a social ritual among adolescent girls and young women in which negative remarks are made to others about one's own body. These negative remarks can include comments about one's shape, weight, or level of physical fitness (Nichter & Vuckovic, 1994; Shannon & Mills, 2015). Examples of negative body talk statements may include disclosures such as "I'm so fat" or "My thighs are too flabby." As expected, negative body talk is a highly normative experience for females, with 93% of college women stating that they engage in appearance-related conversation with peers (Salk & Engeln-Maddox, 2011). Women exposed to a confederate who speaks negatively about her body are more likely to engage in body talk themselves; they also rate higher levels of body dissatisfaction after listening to the confederate (Salk & Engeln-Maddox, 2012).

Negative body talk is associated with disordered eating for both women and men (Tzoneva, Forney, & Keel, 2015). Specifically, men who were presented with confederates engaging in a fat-talk or muscle-talk conversation had increased body dissatisfaction and decreased self-esteem compared to those who were presented with confederates engaging in a neutral conversation (Engeln, Sladek, & Waldron, 2013). This experimental research illustrates the negative consequences of body talk on both men and women, drawing attention to the risk of negative body talk on the general population.

Although much of the current research is correlational, body talk is generally associated with a number of poor outcomes including body dissatisfaction, eating disorders, the objectification of women in society, and high social comparison (Shannon & Mills, 2015). For instance, it was found that both men and women may experience the negative consequences of body talk on dieting, drive for thinness, bulimia, and body dissatisfaction. (Arroyo & Harwood, 2012; Tzoneva et al., 2015). Among men, body talk is associated with pathological eating behavior and drive for muscularity (Engeln et al., 2013). Among women, body talk is related to depression, body image distortions, higher rates of unhealthy binge/purge behaviors, and lower rates of exercising (Arroyo et al., 2016; Rudiger & Winstead, 2013).

The literature on body talk has focused primarily on fat talk or other negative disclosures (e.g., body dissatisfaction, self-degradation), and positive body talk deserves more research attention (Rudiger & Winstead, 2013), especially its relation to body image disturbance and eating pathology. The research on this topic is somewhat mixed. Rudiger and Winstead (2013) found that engagement in self-accepting and positive body talk was related to positive outcomes like a lower body dissatisfaction and increased self-esteem; however, it did not serve as a protective factor against unhealthy dieting, bulimia, oral control, or depression. In a study of the effects of listening to body talk, Corning, Bucchianeri, and Pick (2014) found that exposure to body talk statements was associated with greater body dissatisfaction among listeners, regardless of the positive or negative nature of the statements. This suggests that the consequences of listening to positive body talk may be as detrimental as negative body talk.

Another important limitation of existing research on body talk and eating pathology is that most studies have examined peer or friend relationships (see review Shannon & Mills, 2015). Research shows that romantic partners are the most important source of social support and intimacy in adulthood (Carbery & Buhrmester, 1998). Some research indicates that weight related discussion does occur within these relationships (Berge, Pratt, & Miller, 2016; Dailey, Richards, & Romo, 2010; Eisenberg, Berge, Fulkerson, & Neumark-Sztainer, 2011) and that romantic partners do influence one another's body image and health status (Markey, Markey, & Gray, 2007). However, this body of research focuses primarily on the partner's comments on and responses to one's weight and appearance (e.g., criticism), rather than the mutual disclosure and validation of negative and positive aspects of body image. Given that body talk can be conceptualized as a form of social support (Nichter, 2000), it is important to investigate the body talk dynamics in romantic relationships. Because romantic relationships are salient to young adults (Carbery & Buhrmester, 1998), we argue that the associations between body talk that occur in romantic relationships should be related to individuals' pathological eating behaviors.

1.3. Potential interactions

Research indicates that individuals with a higher weight status engage in a higher frequency of body talk than their thinner peers (Engeln & Salk, 2014). Similarly, individuals of a higher weight status feel more pressure to engage in negative body talk (Martz, Petroff, Curtin, & Bazzini, 2009). Little is known, however, about whether body talk would moderate the associations between weight status and pathological eating. Since body talk has been correlated with poor body image, body dissatisfaction, and dysfunctional eating behaviors (Engeln et al., 2013; Tzoneva et al., 2015), it may be more detrimental to the overweight population that is already at increased risk for these problems. In this study, we speculated that body talk would moderate the relationship between weight status and pathological eating, such that individuals of overweight status who engage in more fat talk would report higher pathological eating. We further speculated that positive body talk would moderate the relationship between weight status and pathological eating. The evidence behind positive body talk is mixed, suggesting that speaking positively about one's body is associated with increased self-esteem (Rudiger & Winstead, 2013) but listening to others engage in positive body talk is associated with body dissatisfaction (Corning et al., 2014). Because of this, it is difficult to hypothesize the exact nature of the moderating effect of positive body talk between weight status and pathological eating. It is possible that positive body talk could act as a buffer against disordered eating among those of high weight status, increasing well-being by being "body positive." On the other hand, it is also possible that positive body talk could be a detriment to eating behaviors, especially as weight status increases. This is because it draws attention to the individual's body and the process of pointing out positive body features may still bring attention to negative body features.

1.4. The current study

This study examined the associations among weight status, positive or negative body talk, and pathological eating behaviors (i.e., drive for thinness, dieting, and bulimia/food preoccupation). In addition, this study examined whether the associations between weight status and pathological eating were moderated by engagement in body talk. Based on our review of past literature, we hypothesized that:

(a) Weight status, negative body talk, and positive body talk would be related to more pathological eating (i.e., drive for thinness, dieting, bulimia/food preoccupation), and
(b) body talk would moderate the associations between weight status and pathological eating.

Specifically, we hypothesized that increased negative body talk (fat talk) would moderate the relationship between weight status and pathological eating behaviors, resulting in increased dysfunctional eating. Regarding positive body talk, we hypothesized a similar interaction effect, with positive body talk moderating the direct association between weight status and pathological eating behaviors. However, given the inconsistencies in the literature, directionality is more difficult to predict.

2. Methods

2.1. Procedure

The current data came from a larger, two-phase study on eating behaviors among adults in romantic relationships. The first phase included a number of questionnaires about body image, eating behaviors, and relationship variables. The second phase was a three-day diary portion about perceptions and views of one's body. In order to increase the current study's external validity, participants were recruited from a local college as well as through online advertisements. For the college sample, participants were recruited through the psychology department's SONA system and completed the survey online. These college participants earned course credits for their participation. For the community sample, participants were recruited through webpages (e.g., Facebook, Craigslist) and invited to complete the same survey online. One of the participants was randomly selected to receive a $50 grocery card.

2.2. Participants

Participants were 137 adults in romantic relationships from the community and university settings (86.86% female). The majority of participants were Caucasian (73%) with 16% Black, 5% Asian, 2% Hispanic, and 4% mixed or other. The participants' mean age was 23.50 years ($SD = 6.93$). Participants' body mass index (BMI; kg/m^2) was calculated from their self–reported height and weight; the mean BMI was 26.45 ($SD = 6.24$). Overall, according to BMI classification of body weight, 3.65% of participants were underweight, 49.63% normal weight, 24.82% were overweight, and 21.90% were obese.

Participants' average relationship length with their current partner was 41.9 months ($SD = 51.4$, median = 24, range = 1 to 307) and 42.3% of participants were cohabitating with their partner. Only 12.4% of participants were married to their partner. The statistics above represent their report of total relationship length, including time dating before marriage. Most participants reported that their current relationship was heterosexual (92.0%, $n = 126$). An additional 7.3% ($n = 10$) were involved in a relationship with a same-sex partner and 0.7% ($n = 1$) reported their partner's identification as genderqueer. Overall, participants rated their relationship closeness quite high, with a mean of 4.19 ($SD = 0.73$) on a 1 to 5 scale.

2.3. Measures

2.3.1. Drive for thinness

Drive for thinness was assessed using the drive for thinness subscale of the Eating Disorder Inventory (Garner, Olmstead, & Polivy, 1983). The subscale includes 7 items measuring preoccupation with thinness, such as "I eat sweets and carbohydrates without feeling nervous" and "If I gain a pound, I worry that I will keep gaining." Participants rated their agreement with each item on a six point Likert scale from 1 (*Always*) to 6 (*Never*). Items were averaged to form an overall drive for thinness score, with higher scores reflecting higher levels of concern for thinness. For this study, the reliability of the scale was good ($\alpha = 0.70$).

2.3.2. Dieting and bulimia

Dieting and bulimia were assessed used the 26-item Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982) of current pathological eating behaviors. This measure includes three subscales: 1) dieting, 2) bulimia/food preoccupation and 3) oral control. The dieting subscale includes 13 items (e.g., "Think about burning up calories when I exercise"). The bulimia and food preoccupation subscale includes six items (e.g., "Have gone on eating binges where I feel I may not be able to stop" and "Give too much time and thought to food"). The oral control subscale includes seven items (e.g., "Avoid eating food when I'm hungry"). Participants used a six point Likert scale from 1 (*Never*) to 6 (*Always*) to rate the frequency of experiencing the thoughts or behaviors described. Although the items were rated with a 6-point scale, the responses were then converted and scored as a 0 to 3 scale (see Garner et al., 1982). A higher score on the scale indicates greater symptomology. For this study, the reliability of the dieting and bulimia subscales were good ($\alpha = 0.81$, $\alpha = 0.74$). For the oral control subscale, the Cronbach's alpha was slightly below an adequate level ($\alpha = 0.65$). Due to this low internal consistency reliability and because the oral control subscale has been found to have low reliability and problematic psychometric properties (Mazzeo & Espelage, 2002), it was removed from analysis. Past studies have also omitted the oral control subscale (Mazzeo, Mitchell, & Williams, 2008; Sim & Zeman, 2006; Tylka & Wilcox, 2006).

2.3.3. Body talk

Engagement in body talk was assessed using Rudiger and Winstead's Body Talk measure (2013). This scale includes nine items, which consist of two subscales: 1) positive body talk (six items) and 2) negative body talk (three items). An example of a positive body talk item is, "How often do you say self-accepting things about your physical appearance in front of your partner?" An example of a negative item is, "How often does your partner say negative things about his or her physical appearance in front of you?" The items are rated on a five point Likert scale ranging from 1 (*Never*) to 5 (*Very Frequently*). The items from each subscale were averaged to create two overall positive and negative body talk scores, with higher scores representing more engagement in that type of body talk with the partner. The reliability of both the positive ($\alpha = 0.91$) and negative ($\alpha = 0.70$) subscales in this study was good.

2.4. Planned analysis

Descriptive statistics were conducted to examine the associations between demographic variables and key study variables. In order to examine whether body talk (negative or positive) interacted with weight status to predict pathological eating behaviors (i.e., drive for thinness, dieting, and bulimia/food preoccupation), a series of multiple regression analyses were conducted. A total of six regression models were estimated to predict drive for thinness,

dieting, and bulimia/food preoccupation, respectively, controlling for age, gender, and partner's gender. It is important to account for these control variables, given the previous research demonstrating the role of gender, partner's gender, and age differences in body image concerns and investment (Martz et al., 2009; Muth & Cash, 1997; Peplau et al., 2009). The first three multiple regression models included (1) participants' age, gender, and their partner's gender as control variables, and (2) BMI, negative body talk, and interaction between BMI and negative body talk as key predictors. The remaining three multiple regression models included (1) participants' age, gender, and their partner's gender as control variables, and (2) BMI, positive body talk, and interaction between BMI and positive body talk as key predictors. We standardized the predictor variables and gender was coded as 0 = Male, 1 = Female. When a significant interaction effect was detected, simple slopes were displayed and tested based on one standard deviation above and below the mean for the predictor and moderator (Aiken & West, 1991).

3. Results

3.1. Preliminary analyses

Means, standard deviations and correlations among the study variables are presented in Table 1. Independent t-tests were conducted and found that women experienced higher levels of drive for thinness compared to men, thus gender was included in subsequent analyses as a control variable. No other significant gender differences were found. Correlations showed that weight status was associated with drive for thinness, dieting, and bulimia. In addition, it was found that negative body talk was also associated with drive for thinness, dieting, and bulimia. Surprisingly, positive body talk was not associated with any other study variables.

3.2. Primary analyses

3.2.1. Negative body talk

Using a series of multiple regression analyses, we examined whether negative body talk interacted with BMI to predict pathological eating behaviors: (1) drive for thinness, (2) dieting, (3) bulimia/food preoccupation (Table 2). The overall model fit for drive for thinness was significant F (6,129) = 7.85, $p < 0.001$, $R^2 = 0.27$. Inspection of the beta weights showed that individuals with higher BMI and those who engaged in more negative body talk reported higher drive for thinness. Contrary to our hypothesis, the interaction between BMI and negative body talk on drive for thinness was not significant.

The overall model fit for dieting was significant, with F (6,129) = 10.25, $p < 0.001$, $R^2 = 0.32$. Inspection of the beta weights showed that individuals with higher BMI and those who engaged in more negative body talk reported more dieting behavior. The interaction between BMI and negative body talk on dieting, however, was not significant.

The overall model fit for bulimia/food preoccupation was significant, with F(6,129) = 5.50, $p < 0.001$, $R^2 = 0.20$. Inspection of the beta weights showed that individuals with higher BMI and those who engaged in more negative body talk reported more bulimia/food preoccupation. The interaction between BMI and negative body talk on bulimia/food preoccupation, however, was not significant.

Table 1
Means, standard deviations, and correlations between the key study variables.

	1	2	3	4	5	6
1. BMI	–					
2. Dieting	0.38*	–				
3. Bulimia	0.26*	0.62*	–			
4. Negative Body Talk	0.14	0.37*	0.29*	–		
5. Positive Body Talk	−0.08	−0.08	0.02	−0.12	–	
6. Drive for Thinness	0.36*	0.75*	0.50*	0.29*	−0.14	–
M (Males)	26.22	0.32	0.15	2.31	2.64	2.46
SD	4.98	0.36	0.21	0.79	0.88	0.93
M (Females)	26.48	0.49	0.24	2.38	2.27	3.27
SD	6.42	0.47	0.45	0.85	0.87	1.23

Note. *$p < 0.05$.

3.2.2. Positive body talk

Table 3 presents a series of multiple regression models that estimated whether positive body talk interacted with BMI to predict drive for thinness, dieting, and bulimia/food preoccupation, respectively. The overall model fit for drive for thinness was significant, with F (6,130) = 6.66, $p < 0.001$, $R^2 = 0.24$. The findings showed that BMI was predictive of drive for thinness. Positive body talk was not uniquely predictive of drive for thinness, but the interaction between positive body talk and BMI was significant. As displayed in Fig. 1, we found that the effect of BMI on drive for thinness was stronger for individuals who engaged in more positive body talk with their partner ($B = 0.76$, $SE = 0.17$, $p < 0.001$), compared to those who engaged in less positive body talk with their partner ($B = 0.22$, $SE = 0.13$, $p = 0.09$).

The overall model fit for dieting was significant, with F (6,130) = 5.96, $p < 0.001$, $R^2 = 0.22$. The findings showed that BMI was predictive of dieting. Positive body talk was not uniquely predictive of dieting, but the interaction between positive body talk and BMI was significant. As displayed in Fig. 2, we found that the effect of BMI on dieting behaviors was stronger for individuals who engaged in more positive body talk with their partner ($B = 0.30$, $SE = 0.07$, $p < 0.001$), compared to those who engaged in less positive body talk with their partner ($B = 0.12$, $SE = 0.05$, $p = 0.02$).

The overall model fit for bulimia/food preoccupation was significant, with F (6,130) = 3.07, $p = 01$, $R^2 = 0.12$. In this model, participants' gender was predictive of bulimia/food preoccupation, with females endorsing more symptoms than males. BMI was also found to be predictive of bulimia/food preoccupation. Positive body talk was not uniquely predictive of bulimia/food preoccupation, but the interaction between positive body talk and BMI was significant. As displayed in Fig. 3, we found that the effect of BMI on bulimia/food preoccupation was stronger for individuals who engaged in less positive body talk with their partner ($B = 0.21$, $SE = 0.06$, $p = 0.001$), compared to those who engaged in more positive body talk with their partner ($B = 0.04$, $SE = 0.05$, $p = 0.43$).

4. Discussion

The negative effects of body talk on an individual's body satisfaction and eating behavior have been well established in the literature (Shannon & Mills, 2015); research on positive body talk, however, has been largely ignored (see exception, Rudiger & Winstead, 2013). Furthermore, as most existing research on body talk has been within the context of friendships or peer relationships, the current study serves as an important advance in investigating the role of both positive and negative body talk in romantic relationships in relation to eating behavior. This study focused on drive for thinness, dieting, and bulimia as specific outcome variables. These outcomes are highly correlated with one another, however they represent distinct body image investment and behavioral outcomes. The overall findings revealed that negative body talk was associated with pathological eating behaviors regardless of weight status, while positive body talk was uniquely

Table 2
Findings from regression analyses for negative body talk.

	Drive for Thinness		Dieting		Bulimia	
	B (SE)	*p*	*B (SE)*	*p*	*B (SE)*	*p*
Intercept	2.94		0.56		−0.02	
Age	−0.01 (0.01)	0.61	−0.01 (0.01)	0.16	0.00 (0.01)	0.84
Gender	0.49 (0.39)	0.21	0.09 (0.14)	0.55	0.23 (0.14)	0.11
Partner's Gender	−0.33 (0.36)	0.36	−0.05 (0.13)	0.70	0.18 (0.13)	0.18
Negative body Talk	0.38 (0.10)	<0.001	0.17 (0.04)*	<0.001	0.15 (0.04)	<0.001
BMI	0.37 (0.10)	<0.001	0.15 (0.04)*	<0.001	0.09 (0.04)	0.01
Negative Body Talk * BMI	0.04 (0.08)	0.59	0.05 (0.03)	0.14	−0.05 (0.03)	0.10
Multiple R^2	0.27	<0.001	0.32	<0.001	0.20	<0.001

Note. *$p < 0.05$; for gender variables, 0 = males and 1 = females.

Table 3
Findings from regression analyses for positive body talk.

	Drive for Thinness		Dieting		Bulimia	
	B (SE)	*p*	*B (SE)*	*p*	*B (SE)*	*p*
Intercept	3.03		0.58		−0.10	
Age	−0.01 (0.01)	0.34	−0.01 (0.01)	0.09	0.00 (0.01)	0.73
Gender	0.60 (0.40)	0.13	0.14 (0.15)	0.37	0.30 (0.15)	0.05
Partner's Gender	−0.22 (0.37)	0.55	−0.00 (0.14)	0.99	0.24 (0.14)	0.08
Positive body Talk	−0.12 (0.10)	0.22	0.02 (0.04)	0.59	0.02 (0.04)	0.52
BMI	0.49 (0.10)	<0.001	0.21 (0.04)	<0.001	0.12 (0.04)	0.001
Positive Body Talk * BMI	0.27 (0.11)	0.02	0.09 (0.04)	0.04	−0.09 (0.04)	0.44
Multiple R^2	0.24	<0.001	0.22	<0.001	0.12	0.01

Note. *$p < 0.05$; for gender variables, 0 = males and 1 = females.

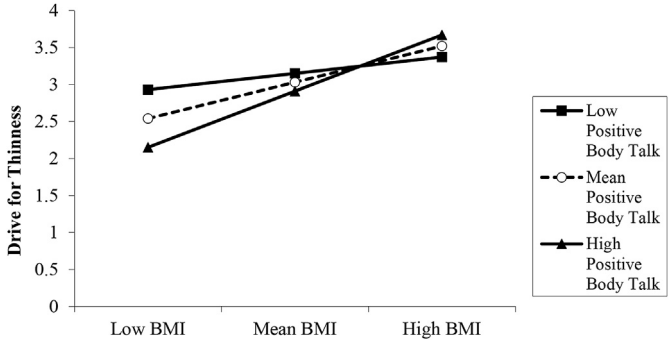

Fig. 1. Interaction effect of BMI and positive body talk for predicting drive for thinness.

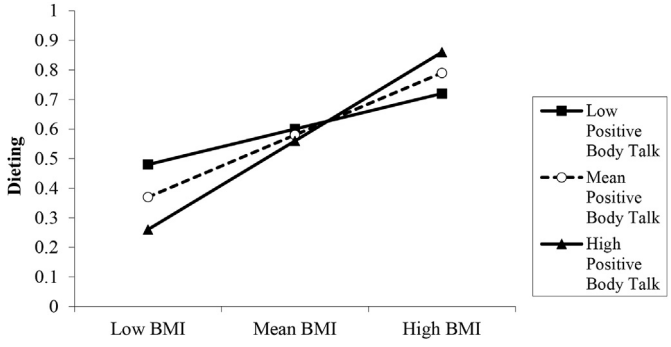

Fig. 2. Interaction effect of BMI and positive body talk for predicting dieting behaviors.

detrimental to individuals of a high weight status. Since findings were fairly consistent across all three outcomes for both positive and negative body talk, it appears that both negative body talk and the interaction of BMI and positive body talk may be related to a general motivation to modify one's body in some way.

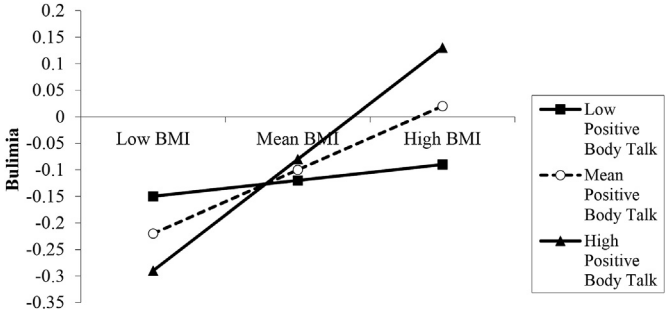

Fig. 3. Interaction effect of BMI and positive body talk for predicting bulimia.

4.1. Negative body talk

As hypothesized, negative body talk with a romantic partner was related to self-endorsement of drive for thinness, dieting, and bulimic behaviors. This is consistent with past research indicating that fat talk has a negative impact on body image (e.g. Arroyo & Harwood, 2012; Engeln et al., 2013; Tzoneva et al., 2015). Body talk could serve several functions in romantic relationships. At a basic level, negative body talk could be a behavioral expression of weight concern, which is a significant predictor of binging and purging behavior (Field et al., 2008). It is possible that when individuals engage in fat talk and draw attention to monitoring their own body, it may serve as a reminder that they are displeased with their weight or shape, increasing dysfunctional eating behaviors. Particularly, women are susceptible to engaging in body comparison with their partner; women who perceive themselves as larger than their partner report higher levels of body dissatisfaction than women who are thinner than their partner (Markey & Markey,

2014). It is likely that individuals who engage in negative body talk are comparing their body shape to their partner's body, thus increasing their desire to adhere to the societal standard of beauty through dieting. Indeed, research indicates that social comparison could be the mechanism by which body talk is harmful (Arroyo, 2014; Corning & Gondoli, 2012). In addition, body talk may serve as an attempt to regulate the eating behaviors of the individual's partner. Research suggests that this display of dissatisfaction with the partner's body is associated with lower body esteem and increased "healthy dieting" for the partner being regulated; one could speculate that partner dissatisfaction disclosed in a fat talk interaction could be related to one's unhealthy dieting or bulimia (Markey & Markey, 2006).

Inconsistent with our hypothesis, negative body talk did not moderate the relationship between BMI and drive for thinness, dieting, or bulimia. Thus, engagement in fat talk did not moderate the effect of BMI on pathological eating. Instead, negative body talk was independently related to pathological eating. Together, these findings suggest that participating in such negative body conversation may be detrimental to one's well-being (e.g., increased eating pathology) regardless of one's weight status.

4.2. Positive body talk

Contrary to our hypothesis, positive body talk was not directly associated with negative outcomes. Consistent with Rudiger and Winstead (2013), our results did not support any direct relationship between positive body talk and the pathological eating of drive for thinness, dieting, and bulimia. However, our findings were somewhat inconsistent with past research that suggests that positive body talk, or at least hearing the positive body talk of others, is associated with increased body dissatisfaction among women (Corning et al., 2014). One possible explanation for this inconsistency could be that positive body talk moderates the existing association between a third variable, such as weight status, and body image disturbances.

Indeed, we found that weight status interacted with positive body talk to predict the negative outcomes of drive for thinness, dieting, and bulimia. Although one of our competing hypotheses was that positive body talk may buffer against the negative impacts of higher weight status on eating pathology, this idea was not supported. Instead, we found that as individuals' BMI increased, their pathological eating also increased when they engaged in more positive body talk with their partner. The association between BMI and pathological eating was weaker, however, when individuals engaged in less positive body talk with their partner. While high engagement in positive body talk was protective for individuals with a lower weight status, such a protective effect was not true for individuals with a higher weight status (Figs. 1–3). This interaction pattern was consistent across drive for thinness, dieting, and bulimia.

There are several reasons why this relationship may occur. First, it is possible that speaking positively about oneself also draws attention to negative features. Research indicates that heavier individuals tend to experience lower body esteem (Stice & Shaw, 2002). Thus, attending to one's own body features during positive body talk may also cause an overweight or obese individual to think about their negative body qualities, even if these are not spoken aloud. This may be less of a problem for individuals of a healthy weight status, which would account for the interaction effect. Alternatively, engaging in positive body talk with a partner may lead to social comparison, a potentially negative cognition if one's partner has a more "ideal" body. Social comparison may act as a mechanism behind engaging in fat talk (Arroyo, 2014; Corning & Gondoli, 2012); so, it seems reasonable that social comparison would be at work in positive body talk conversations as well. Engaging in a conversation with one's romantic partner about positive body characteristics may invite opportunities for social comparison. If an overweight individual perceives his or her partner to have a more desirable body weight or shape, social comparison with the partyer may be detrimental to the individual's own feelings of body satisfaction. Additionally, due to the individual self-report nature of this study, we do not know how the participant's romantic partner typically responds to positive body disclosures. One's own body satisfaction, perception of partner's satisfaction with one's body, and the partner's actual satisfaction are all highly correlated with BMI, at least for women (Markey & Markey, 2006). For individuals of a high weight status, it is possible that their partners are not satisfied with their weight and therefore do not give as many statements of praise about the participants' bodies. A lack of positive response or encouragement to diet could increase the individual drive for thinness or dysfunctional eating. Finally, for overweight or obese individuals, speaking positively about their bodies may be difficult to do. If these overweight or obese individuals do not like their bodies, engaging in and matching the positive body talk of a conversation partner may cause a sense of cognitive dissonance in the speaker, triggering negative thoughts or desire to modify eating as a way to reduce the dissonance.

Although we found that engaging in more positive body talk may put individuals with higher BMI at more risk for pathological eating, it is possible that positive body talk could increase relationship intimacy, raising the feeling of closeness. Previous research has demonstrated that mutual disclosure and support are crucial for building relationship intimacy (Reis & Shaver, 1988). Within romantic relationships, body talk may serve as an opportunity for partners to validate each other and affirm that they still find one another attractive. Further research, however, is necessary to test these hypotheses.

4.3. Limitations and future directions

It is important to note several limitations of this study. First, this study consisted primarily of young, Caucasian females. While this population is known to be highly susceptible to fat talk conversations (e.g., Engeln & Salk, 2014), it limits the generalizability of findings. Future research is necessary to evaluate if these findings, particularly the interaction effect between positive body talk and BMI, hold under different conditions, such as among older adults or a more ethnically diverse sample. Furthermore, while the findings regarding negative body talk in romantic relationships were consistent with past research in peer and family relationships, further study could reveal if the interaction between positive body talk and BMI is unique to romantic relationships or is more generalizable.

In addition, this study utilized online self-report measures and was conducted with only one partner of a romantic couple regarding their engagement in body talk within that relationship. Because of this, the study is at risk for the same issues facing other self-report studies, such as common method bias and accuracy of reporting. Additionally, the study did not capture several partner characteristics that could impact findings, such as partner response to body talk and partner weight status. In order to remedy self-report biases, future research should consider adopting observational methods for capturing body talk (Romo & Mireles-Rios, 2016) in romantic relationships. Given the dyadic nature of body talk, future work may consider examining both members simultaneously when studying the effects of body talk on body image and eating outcomes (Arroyo & Andersen, 2016).

Last but not least, the data in this study are correlational and we

are unable to infer causation between variables. For instance, although negative body talk was related to increased eating pathology, it is possible that people who engaged in unhealthy eating behaviors were more likely to engage in negative body talk. Longitudinal research, therefore, is important for detangling the reciprocal associations between body talk and eating behaviors, especially in relation to individuals' weight status.

4.4. Conclusion and implications

The current study examined the relationship among weight status, body talk and pathological eating within the context of a romantic relationship. The study showed that negative body talk was directly associated with desire for thinness, dieting, and bulimia/food preoccupation. However, positive body talk was related to these negative outcomes only for individuals of a high weight status. These findings may have important implications for fat talk interventions. Consistent with past research, this study found that negative body talk, or "fat talk," was associated with negative outcomes for individuals of all sizes. Formal interventions and social media initiatives to prevent fat talk have focused primarily on decreasing engagement in self-degrading body talk and increasing commitment to accepting one's own figure (Garnett et al., 2014; Richardson & Paxton, 2009). However, the interaction effects between positive body talk and weight status in this study suggest that substituting positive body talk for negative body talk may provide no relief for individuals of a higher weight status. In the popular culture, body positivity and the anti-fat shaming movement are growing, with public figures standing up for their natural bodies by refusing to have their images photo shopped in magazines, claiming that "big is beautiful" (Dockterman & McCluskey, 2015). These actions have been supported by studies that find that weight related discrimination is associated with negative psychological outcomes and even weight gain (Jackson, Beeken, & Wardle, 2014). However, our findings suggest that such positive body talk may not be advantageous for overweight and obese individuals, even within their closest relationships; in fact, in this study, positive body talk was associated with eating pathology (i.e., drive for thinness, dieting, and bulimia) for individuals of a higher weight status. While public figures may see positive social results from taking a stand towards body positivity, it does not appear that positive body talk is generally beneficial for the psychological health of individuals with a high weight status. Instead, it may be better for these interventions to focus on reducing body related talk in general, especially for higher weight status individuals.

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