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# The Association of Disordered Eating and Sexual Health With Relationship Satisfaction in Female Service Members/Veterans

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Low relationship satisfaction is associated with mental health disorders in service members/veterans (SM/Vs), yet eating disordered behavior (EDB) and sexual function and satisfaction in SM/Vs are understudied. Those with EDB may experience bodily discomfort that may be associated with low relationship satisfaction because of avoidance of physical contact and intimacy, suggesting that sexual satisfaction and function may modify the association of EDB and relationship satisfaction. As the majority of female SM/Vs are partnered, it is imperative to study the association of sexual function and satisfaction with EDB and relationship satisfaction. Partnered female SM/Vs ($N$ = 479) completed an online survey assessing demographic characteristics (e.g., relationship duration, deployment history), EDB, sexual satisfaction and function, and relationship satisfaction measures. Thirty-three percent, 20%, and 58% of the sample reported scores consistent with relational distress, probable eating disorder, and sexual dysfunction, respectively. After adjusting for covariates, EBD was negatively associated with relationship satisfaction with a small-to-medium effect size. Sexual satisfaction and function had a significant indirect effect on the association of EDB and relationship satisfaction, suggesting that sexual satisfaction and function accounted for some of the variance between these 2 variables. Screening for EDB, sexual satisfaction, and sexual function among partnered female SM/Vs may provide critical insight into mechanisms of relational distress.

*Keywords:* female service members/veterans, eating disordered behavior, sexual health, relationship satisfaction



Low romantic relationship satisfaction is associated with a host of mental health disorders in service members/veterans (SM/Vs; Renshaw, Rodrigues, & Jones, 2008; Taft, Watkins, Stafford, Street, & Monson, 2011). Although higher relationship satisfaction can buffer against mental health disorders, mental health disorders can erode relationship satisfaction over time (e.g., Campbell & Renshaw, 2013). To date, most studies of the association between individual mental health problems and romantic relationship satisfaction in SM/Vs have focused on posttraumatic stress disorder (PTSD), ignoring the potential negative effects of other mental health disorders, such as eating disorders. Moreover, little research has been done in this area specific to female SM/Vs, despite women being one of the largest growing demographics in the military (Patten & Parker, 2011), and the elevated risk of eating disordered behavior in these women (Maguen et al., 2012). The overarching goal of this study was to examine the association of eating disordered behaviors with romantic relationship satisfaction.

Eating disorders pose significant health concerns, including medical and mental health morbidity and early mortality (Arcelus, Mitchell, Wales, & Nielsen, 2011; Fichter & Quadflieg, 2016), and may be of particular interest in SM/Vs given job-related stressors that increase risk for disordered eating. Indeed, the military has strict weight and fitness standards that may predispose individuals to develop disordered eating behaviors, particularly in times of stress (for review, see Bartlett & Mitchell, 2015), including combat deployment (Jacobson et al., 2009). Research also shows that exposure to deployment-related trauma and military sexual trauma is associated with risk for eating disorder diagnoses (Blais et al., 2017; Jacobson et al., 2009). Such exposures make SM/Vs a unique sample in which to study eating disorders (Stander & Thomsen, 2016).

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Of the limited data on eating disorders in SM/Vs, a cross-sectional, retrospective study of national Department of Veteran Affairs (VA) data on 593,739 veterans demonstrated that 0.01% of women and <.001% of men veterans had an eating disorder diagnosis in their VA medical chart (Maguen et al., 2012). Another retrospective study in a representative sample of VA-enrolled veterans who were obese or overweight found that the majority of those individuals engaged in binge eating behaviors (Higgins et al., 2013). A recent literature review suggests that VA estimates of eating disorders may underrepresent the magnitude of this public health concern. Indeed, the review estimated that 5% to 8% of military women have an eating disorder diagnosis, which is similar to, or even higher than, rates observed in civilian samples (Bartlett & Mitchell, 2015). Given the medical and mental health complications associated with eating disorders, risk for eating disordered behavior within the military culture, and equal or higher risk of eating disorders among SM/Vs relative to civilians, additional research on eating disorders in military samples is needed. Finally, as the majority of female SM/Vs are married (Patten & Parker, 2011), it is critical to understand how eating disorders relate to their interpersonal functioning.

To date, there are no theoretical models that explain the potential association of eating disorders with romantic relationships in military SM/Vs, but family systems theory and civilian studies provide some contextual understanding of this association. According to family systems theory, individual behavior and distress impacts couples' relationship functioning, and couples' relationship functioning impacts individual behavior and distress (e.g., Minuchin, 1974). Within the context of eating disorders, individuals with eating disorders may engage in behaviors that are detrimental to the couple, and couple-related issues may worsen eating disorder symptoms (Kirby, Runfola, Fischer, Baucom, & Bulik, 2017). Indeed, studies show that overweight individuals who engage in overeating experience higher emotional suppression (Butler, Young, & Randall, 2010), and those with binge eating disorder engage in more negative interactions with their partners relative to those without binge eating disorder (Whisman, Dementyeva, Baucom, & Bulik, 2012). Further, individuals with eating disorders evidenced heightened social isolation and reduced reliance on their non-affected partners when dealing with daily stressors (Schmit & Bell, 2017). Partners, too, engaged in behaviors that were unhelpful to the relationship and their partner. For example, partners experienced heightened levels of worry in the relationship (Schmit & Bell, 2017) and reported difficulties dealing with the challenges secondary to eating disorders (e.g., heightened levels of secrecy; Huke & Slade, 2006).

Within military samples, difficulties relying on one's partner or engaging in social isolation are compelling explanations with which to understand the potential association of eating disorders and relationship dissatisfaction given the emotional distancing and numbing observed in other disorders and corresponding relationship problems. For example, eating disorders are highly comorbid with PTSD (Maguen et al., 2012) and therefore might share similar pathways to intimate relationship strain. For example, previous research shows that emotional numbing and distancing are related to poorer relationship satisfaction (e.g, Blais, Renshaw, & Jakupcak, 2014; LeBlanc et al., 2016). Eating disorders, too, may be related to poorer relationship satisfaction because of emotional and physical avoidance or discomfort related to body image concerns that decrease a female SM/V's willingness to engage physically and emotionally with her partner. Although not yet studied in veteran samples, studies in civilian samples show that individuals with eating disorders report body dissatisfaction and discomfort being seen by others (Griffiths et al., 2016). To reduce distress resulting from body dissatisfaction, female SM/Vs may conceal their body and limit physical contact with their partners, resulting in less sexual contact and intimacy. This decreased intimacy and contact may result in poorer relationship satisfaction over time.

Body concealment, limited physical contact, and overall decreased intimacy may be associated with lower sexual satisfaction (e.g., sense of compatibility with partner, satisfaction with sexual communication with partner) and function (e.g., ability to become lubricated when sexually aroused, reaching orgasm during sexual experiences with one's partner, lack of pain during intercourse). As such, lower sexual satisfaction and function may be mechanisms through which eating disorders relate to poorer relationship satisfaction. Indeed, Barlow's (1986) theory of sexual dysfunction suggested that problematic sexual function may lead people to cognitively attend to nonerotic stimuli during sexual encounters as a way to disengage with the anxiety and stress accompanying the sexual activity. Nonerotic stimuli can include body-related issues, which are paramount in those with eating disorders. Over time, this cognitive avoidance can result in decreased arousal and stress, therefore reinforcing avoidance of intimacy and increasing sexual problems (e.g., Wiegel, Scepkowski, & Barlow, 2007). Research has shown that those diagnosed with eating disorders or who report higher eating disordered behavior reported lower sexual desire (Gonidakis, Kravvariti, & Varsou, 2015; Pinheiro et al., 2010), lower sexual satisfaction (Gonidakis et al., 2015; Wiederman, Pryor, & Morgan, 1996), higher pain, problems with lubrication, and difficulties reaching orgasm (Gonidakis et al., 2015); greater fears of intimacy (Newton, Boblin, Brown, & Ciliska, 2006) or lower intimacy (Van den Broucke, Vandereycken, & Vertommen, 1995), fears of being judged as physically unattractive (Cash, Thériault, & Annis, 2004), and higher self-consciousness during sexual activity (Schembri & Evans, 2008) relative to their female counterparts without eating disorders or those with lower eating disordered behavior. As more than half of all SM/Vs are partnered (Patten & Parker, 2011), and research shows higher sexual satisfaction is associated with higher relationship satisfaction (Byers, 2005), a better understanding of sexual satisfaction and function in SM/Vs a timely issue.

Taken together, it is possible that lower sexual satisfaction and function have indirect effects on the association of eating disordered behaviors and relationship satisfaction. We are not aware of any other studies on eating disordered behavior, relationship satisfaction, and sexual satisfaction and function in current or former service members. Consequently, the association of these issues remains unclear. The purpose of the current study was to determine (a) whether higher eating disordered behavior was associated with lower relationship satisfaction, and (b) whether lower sexual satisfaction and function accounted for some of the variance in the association of eating disordered behavior and relationship satisfaction. In all analyses, we covaried for relationship duration, age, and deployment history. We covaried for age given that older age is associated with risk for sexual dysfunction in women (Dennerstein & Hayes, 2005). We also covaried for deployment history, as research in veterans shows that deployments can negatively impact

relationship satisfaction and function (e.g., Balderrama-Durbin et al., 2015; Cigrang et al., 2014).

## Method

### Participants

Participants were 479 females who self-reported current or past military service and reported being in a romantic relationship at the time of the study. Age and duration of their current relationship are shown in Table 1. The majority of the sample identified as White ($n$ = 370; 77.2%), married ($n$ = 363; 75.8%), and reported service in the Army ($n$ = 254; 53.1%). Half ($n$ = 247; 51.6%) reported a history of deployment. Of those 247, the majority reported one deployment ($n$ = 167; 67.6%, range = 1–4). The majority of the sample reported being discharged from the military ($n$ = 364; 76.0%).

### Procedure

Data analyzed for this study were extracted from a larger "parent" study on military sexual trauma, intimate relationship satisfaction, and sexual functioning in 832 partnered women SM/Vs. Participants were included in the current study if they completed all measures relevant to the current investigation and reported being in a romantic relationship at the time of participation. Of the 832, 15 (1.8%) had missing data on our dependent variable, relationship satisfaction, and 301 (36.2%) had missing data on our independent variable, eating disordered behavior. Sixty (7.2%) had missing data on measures of sexual satisfaction and function, and 32 (3.8%) had missing data on covariates, resulting in a final sample of 479 (57.6%). We used Pearson correlations, analyses of variance, and chi-square statistics to explore potential demographic differences between the parent sample and the sample used in the current study with regard to race, education, military service branch (Army vs. other), age, marital status (married vs. partnered), history of deployment, and relationship duration. Those in the current sample reported significantly longer relationship durations ($M$ = 77.5 months, $SD$ = 70.9) relative to those in the parent sample ($M$ = 68.3 months, $SD$ = 60.0), $t(773) = -1.9$, $p = .05$. No other significant differences were observed ($p$s $> .05$).

Facebook advertisements and e-mail listservs were used to recruit female SM/Vs. Advertisements were targeted to partnered (key terms: engaged, in a domestic partnership, in a relationship, or married) English-speaking female SM/Vs. All measures were administered through Qualtrics (Qualtrics, Provo, UT). Screening items confirmed service in the U.S. military, female sex, and partnered status. Individuals who did not meet screening criteria could not advance in the survey and were therefore not included in analyses. All measures were completed in the same order, as there was no a priori reason to suspect an order effect. Participants who completed the study were directed to a separate Qualtrics platform to enter identifying information to facilitate payment. Compensation for participation was $15. This was study approved by the Institutional Review Board of Utah State University.

### Measures

Participants completed a demographic inventory assessing age, race, relationship status, relationship duration, education, branch of service, discharge status, and number of deployments.

Relationship satisfaction, our outcome variable, was assessed using the Couples Satisfaction Index–4 (CSI-4; Funk & Rogge, 2007), a four-item measure assessing overall relationship satisfaction. A sample item is "Please indicate the degree of happiness, all things considered, of your relationship." Items are scored using a Likert scale with varying anchors that range from 0 to 5 or 0 to 6. Items were summed for a total score, which ranges from 0 to 21. Higher scores indicate greater relationship satisfaction. Scores less than 13.5 are indicative of distressed relationships (Funk & Rogge, 2007). Psychometric properties in the norm sample showed adequate convergent validity with other measures of relationship satisfaction (Funk & Rogge, 2007). Cronbach's alpha in the current sample was adequate at .93.

Eating disordered behavior, our independent variable, was assessed using the Eating Disorders Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994), a 31-item self-report measure assessing eating disordered behavior, including restricting food intake, fear of losing control when eating, or bodily shape or weight concerns, using a Likert scale with varying anchors ranging from 0 to 6. A sample item is "On how many of the past 28 days have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?" Only 22 items are used to calculate a global eating disordered behavior score. Scores range from 0 to 6, with higher scores indicating greater eating disordered behavior. The suggested mean to identify a probable eating disorder is >4.02 (Aardoom, Dingemans, Slof Op't Landt, & Van Furth, 2012). Norms in a nondiagnostic community sample showed

Table 1
*Means, Standard Deviations, Percent Exceeding Clinical Cutoffs, and Bivariate Associations of Couples' Relationship Satisfaction, Disordered Eating Behavior, Sexual Satisfaction and Function, and Covariates*

| Study variables | $M$ ($SD$) | Observed score range | $n$ (%) exceeding clinical cutoff | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|---|---|
| 1. Couples' Relationship satisfaction[a] | 14.77 (4.88) | 0–21 | 157 (32.8) | — | | | | |
| 2. Eating disordered behavior[b] | 2.41 (1.62) | 0–6 | 94 (19.6) | −.20*** | — | | | |
| 3. Sexual satisfaction[a] | 84.55 (23.60) | 24.50–120 | — | .67*** | −.25*** | — | | |
| 4. Sexual function[a] | 22.32 (9.87) | 2–36 | 276 (57.6) | .47*** | −.17** | .63*** | — | |
| 5. Relationship duration (months) | 77.38 (70.69) | 3–432 | — | −.20*** | .03 | −.21*** | −.22*** | |
| 6. Age (years) | 31.91 (7.47) | 19–62 | — | −.18*** | .05 | −.18*** | −.17*** | .64*** |

[a] Higher scores represent better functioning. [b] Higher scores represent worse functioning.
** $p \leq .01$. *** $p \leq .001$.

an average score of 1.55 (*SD* = 1.21; Fairburn & Beglin, 1994). Cronbach's alpha for the current sample was .96.

Sexual satisfaction was measured using the Sexual Satisfaction Scale for Women (SSS-W; Meston & Trapnell, 2005), a 30-item self-report measure assessing overall sexual satisfaction including contentment, communication, compatibility with partner, relational concerns, and personal concerns. Items are scored using a Likert scale with varying anchors that range from 1 to 5. A sample item is "My partner and I do not discuss sex openly enough with each other, or do not discuss sex often enough." Total scores range from 30 to 150, with lower scores indicating worse sexual satisfaction. No cutoff score is suggested to identify those with problematic levels of sexual satisfaction. Cronbach's alpha for the full scale in the current sample was .94.

Sexual functioning was measured with the Female Sexual Function Index (FSFI; Rosen et al., 2000), a 19-item self-report measure assessing sexual function, including desire, arousal, lubrication, orgasm, satisfaction, and pain. Items are rated using a Likert scale ranging from 0 to 5 or 1 to 5, with total scores ranging from 2 to 36. A sample item is "Over the past four weeks, how often did you feel sexually aroused during sexual activity or intercourse?" Lower scores indicate worse sexual function, and scores less than 26.55 suggest probable issues with sexual function (Wiegel, Meston, & Rosen, 2005). Cronbach's alpha for the full scale in the current sample was .96.

## Analytic Plan

Demographics were calculated using descriptives. The associations among relationship satisfaction, eating disordered behavior, sexual satisfaction, sexual function, age, duration of relationship, and number of deployments were initially investigated at the bivariate level. A linear regression analysis was conducted to determine the association of eating disordered behavior with relationship satisfaction after accounting for covariates. To determine whether sexual satisfaction or function accounted for some of the variance in the association of eating disordered behavior and relationship satisfaction, we used PROCESS macro syntax with 5,000 bootstrap samples for bias corrected bootstrap confidence intervals (Hayes, 2016).

# Results

Means, standard deviations, and intercorrelations of primary study variables and continuous covariates can be found in Table 1. The average score on the CSI-4 was above the suggested clinical cutoff of 13.5 to identify relationally distressed individuals (Funk & Rogge, 2007); however, approximately one third of all participants fell into the distressed range category. The average score on the EDE-Q was below the suggested clinical cutoff of 4.02 (Aardoom et al., 2012), but approximately one fifth of participants met or exceeded the clinical cutoff. The average score on the FSFI fell below the clinical cutoff, suggesting that this sample is experiencing appreciable levels of sexual dysfunction. Of those, 57.6% ($n$ = 276) evidenced scores suggestive of sexual dysfunction (Rosen et al., 2000).

At the bivariate level, relationship satisfaction was negatively associated with eating disorder behavior with a small-to-medium effect size, and positively related to sexual functioning and satisfaction with large effect sizes. Eating disordered behavior was negatively associated with sexual function and satisfaction with small-to-medium effect sizes. Sexual function and satisfaction were positively associated with a large effect size. Age and relationship duration, which served as covariates in the current study, were negatively associated with relationship satisfaction, sexual function, and satisfaction with small-to-medium effect sizes. Age was positively related to relationship duration with a large effect size (see Table 1). Number of deployments (ordinal) was significantly associated with older age (odds ratio = 1.05, 95% confidence interval [CI] [1.03, 1.08]) but was unrelated to relationship satisfaction, eating disordered behavior, sexual function, sexual satisfaction, or duration of relationships ($p$s $> .05$).

## Relationship Satisfaction and Eating Disordered Behavior

When relationship satisfaction was regressed onto eating disordered behavior, age, number of deployments, and relationship duration, the overall regression was significant, $F(4, 474) = 10.45$, $p \leq .001$. Higher eating disordered behavior and shorter relationship duration were associated with lower relationship satisfaction with small-to-medium effect sizes (see Table 2).

## The Indirect Effect of Sexual Function on the Association of Eating Disordered Behavior and Relationship Satisfaction

When relationship satisfaction was regressed onto eating disordered behavior, age, number of deployments, relationship dura-

Table 2
*Regression of Couples' Relationship Satisfaction on Eating Disordered Behaviors, Sexual Function, Sexual Satisfaction, and Covariates*

| Study variables | Indirect effect: None Unstandardized *B* (*SE*) | Indirect effect: Sexual function Unstandardized *B* (*SE*) | Indirect Effect: Sexual satisfaction Unstandardized *B* (*SE*) |
|---|---|---|---|
| Sexual satisfaction[a] | — | — | .13 (.01)*** |
| Sexual function[a] | — | .21 (.02)*** | — |
| Eating disordered behavior[b] | −.55 (.13)*** | −.35 (.12)** | −.07 (.11) |
| Relationship duration | −.01 (.004)** | −.001 (.004) | −.002 (.003) |
| Age | −.04 (.04) | −.03 (.04) | −.02 (.03) |
| Number of deployments | −.32 (.25) | .18 (.23) | −.23 (.19) |

*Note.* *SE* = Standard error.
[a] Higher scores represent better functioning. [b] Higher scores represent worse functioning.
** $p \leq .01$. *** $p \leq .001$.

tion, and sexual function, the overall regression was significant, $F(5, 473) = 31.46$, $p \leq .001$. Higher eating disordered behavior was associated with lower relationship satisfaction and higher sexual function was associated with higher relationship satisfaction (see Table 2). The indirect effect of sexual function on eating disordered behavior and relationship satisfaction was significant (indirect effect = −.20, 95% CI [−.33, −.09]; see Table 2).[1]

## The Indirect Effect of Sexual Satisfaction on the Association of Eating Disordered Behavior and Relationship Satisfaction

When relationship satisfaction was regressed onto eating disordered behavior, age, number of deployments, relationship duration, and sexual satisfaction, the overall regression was significant, $F(5, 473) = 79.05$, $p \leq .001$. Higher sexual satisfaction was associated with higher relationship satisfaction, but eating disordered behavior was no longer significantly associated with relationship satisfaction (see Table 2). The indirect effect of sexual satisfaction on eating disordered behavior and relationship satisfaction was significant (indirect effect = −.48, 95% CI [−.67, −.30]; see Table 2).[2]

## Discussion

This is the first study, to our knowledge, to examine the association of eating disordered behavior, sexual satisfaction and function, and relationship satisfaction in partnered female SM/Vs. Results demonstrated that higher eating disordered behavior was negatively associated with relationship satisfaction above and beyond demographic and military characteristics. Moreover, sexual satisfaction and function accounted for some of the variance in the association of eating disordered behavior and relationship satisfaction.

The significant indirect effect of sexual satisfaction and function on the association of eating disordered behavior and relationship satisfaction suggests that the link between eating disordered behavior and relationship satisfaction may be more fully explained by the female's perception and experience of physical intimacy in her romantic relationship. Clinically, such results suggest that targeted screening for sexual satisfaction and function among partnered female SM/Vs, particularly those evidencing eating disordered behavior, may be of great utility when trying to understand lower relationship quality. Given that these results are preliminary, additional research is needed to replicate our findings. Moreover, the study of sexual function and satisfaction concerns among partnered female SM/Vs would be further strengthened by investigations that explore which components of sexual function and satisfaction contribute to poor relationship functioning among SM/Vs who are experiencing clinical levels of disordered eating behaviors and sexual problems. Indeed, sexual function and sexual satisfaction are multifaceted issues. The lack of differentiation between the subscales of sexual function and satisfaction in the association of eating disordered behavior and relationship satisfaction observed in the current study may be an artifact of our relatively healthy sample. That is, specific components of sexual function and satisfaction may have a unique association with eating disordered behavior and relationship satisfaction only among those experiencing clinical levels of distress.

Family systems theory provides a compelling model with which to understand the association of eating disorders and strain in relationships. Indeed, research shows that greater distancing from romantic partners is related to an increase in eating disordered behavior (Butler et al., 2010; Schmit & Bell, 2017). In the current sample, this distancing may manifest itself in lower sexual satisfaction and function, which may subsequently lead to lower relationship satisfaction over time. Helping SM/Vs understand how their eating behavior and sexual health not only impacts their individual functioning but also relates to their interpersonal relationships may be helpful, particularly for females who disengage from their partner when feeling distressed. Our data are cross-sectional, so this observation is purely speculative, and future research should examine the temporal order of eating disordered behavior, sexual satisfaction and function, and relationship satisfaction. Notwithstanding, helping SM/Vs see the connection between their individual behaviors and experiences and their interpersonal functioning, regardless of the causal ordering of events, could be paramount in reducing distress experienced by partnered female SM/Vs.

Nearly one third of our sample reported levels of relationship satisfaction that fell into the distressed range. Those individuals may benefit from not only psychoeducation regarding the reciprocal influence of individual- and interpersonal-related influences on relationships but also more formalized interventions such as a couples' therapy. Most interventions for relational distress offered to SM/Vs are specific to veterans with PTSD (e.g. Monson & Fredman, 2012), veterans with comorbid PTSD and substance use (e.g. Schumm, Monson, O'Farrell, Gustin, & Chard, 2015), or not specific to any mental health disorder (e.g. Christensen, Jacobson, & Babcock, 1995). Our findings suggest that providing evidenced-based interventions to treat sexual dissatisfaction and function may be particularly helpful. Interventions for distressed couples who are affected by eating disorders, such as United Couples in the treatment of Anorexia Nervosa (UCAN; Bulik, Baucom, Kirby, & Pisetsky, 2011) may be helpful and provide information that can be used in interventions developed specifically for military service members. Indeed, couples-based prevention programs that aimed to reduce the risk of disordered eating was effective in minimizing the impact of pressures to be thin and altering unhealthy body weight ideals in partnered women (Ramirez, Perez, & Taylor, 2012).

Limitations of the current study include the use of a nonrepresentative convenience sample of female SM/Vs. All variables were based on self-report and data were cross-sectional. It is possible that low relationship satisfaction leads to heightened eating disor-

[1] Post hoc analyses examining the indirect effects of desire, arousal, lubrication, orgasm, satisfaction, and pain on the association of eating disordered behavior and relationship satisfaction revealed that all indirect effects, with the exception of pain (indirect effect: –.03, 95% confidence interval [–.10, .02]), were significant, suggesting that specific components of sexual function did not yield novel or divergent information from the full scale score.

[2] Post hoc analyses examining the indirect effects of contentment, communication, compatibility with partner, relational concerns, and personal concerns on the association of eating disordered behavior and relationship satisfaction revealed that all indirect effects were significant, suggesting that specific components of sexual satisfaction did not yield novel or divergent information from the full scale score.

dered behavior. Given the cross-sectional nature of our data, we were unable to statistically test whether one pathway (i.e., higher eating disordered relates to lower relationship quality) was superior to another (i.e., lower relationship quality relates to higher eating disordered behavior). Future studies should distinguish between different eating disorder diagnoses in studies of sexual health, as there is some evidence that those with anorexia nervosa report greater sexual function concerns relative to those with bulimia nervosa or no eating disorder diagnoses (Gonidakis et al., 2015). Our sample was relatively healthy, and it is possible that alternate findings would have been detected in a clinical sample of female SM/Vs with eating disorder diagnoses or female SM/Vs currently being seen in family therapy clinics for relationship problems serious enough to warrant professional help. Little research has been conducted on the age of onset of new eating disorder diagnoses in military samples. Some evidence suggests that job-related stressors, such as deployment, may increase risk for an eating disorder diagnosis (Jacobson et al., 2009), but this research is not definitive. Gathering additional information on age of onset could further our understanding of risk factors, which may aid the development or augmentation of interventions to reduce eating disordered behavior and increase relationship satisfaction. No information on sexual orientation or gender identity was collected, which prevented an exploration of potential differences between hetero- and nonheterosexual relationships or comparisons among gender identities. Little information was collected on demographics of partners, including sex, history of mental health issues, or military service, all of which might contribute to perceptions of relationship quality.

In conclusion, the current study is the first to examine the association of eating disordered behavior, sexual satisfaction, and function with relationship satisfaction in female partnered SM/Vs. Results demonstrated that higher eating disordered behavior was associated with poorer relationship satisfaction, and one pathway to explain this association was through lower sexual satisfaction and function. Our findings suggest that targeted screening for eating disordered behavior and sexual satisfaction and function may yield important information about possible mechanisms of distress among female SM/Vs reporting relationship distress.

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