

THESIS

COUPLE CONFLICT AND PHYSICAL HEALTH: THE MODERATING ROLE OF DYADIC
PROCESSES IN ROMANTIC RELATIONSHIPS

Submitted by

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ABSTRACT

COUPLE CONFLICT AND PHYSICAL HEALTH: THE MODERATING ROLE OF DYADIC PROCESSES IN ROMANTIC RELATIONSHIPS

A growing body of research suggests that there may be specific interpersonal behaviors that couples can engage in to protect themselves from the well-known negative effects that couple conflict has on physical health in romantic relationships. The current study therefore explored a moderation model of three interpersonal variables (secure attachment, dyadic coping and mindful partnering) on the relationship between couple conflict and physical health. 620 participants from a large Western United States University subject pool and Mechanical Turks completed self-report measures of couple conflict, physical health, attachment, dyadic coping and mindful partnering.

Results from multiple regression moderation analyses indicated that secure attachment and mindful partnering moderated the association between couple conflict and physical health in romantic relationships. Though dyadic coping trended towards moderation of couple conflict and physical health at the bivariate level, it was not indicated to be a moderator at the multivariate level. Clinical implications, limitations, and areas for future research are also discussed in the paper.

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LITERATURE REVIEW

For many adults, romantic relationships constitute their most significant and enduring social relationship (Røsand et al., 2012). Compared to single individuals, those in healthy romantic relationships demonstrate a decrease in risk taking behavior, experience fewer mental health related issues and are less likely to have physical health issues (Braithwaite et al., 2010). Emotionally, romantic relationships are linked to increased relationship satisfaction, happiness and feeling loved or expressing love towards another (Kogan et al., 2010). Although healthy romantic relationships are associated with several benefits, not all relationships are healthy.

Romantic relationships are often experienced as healthy or pleasurable, yet many romantic relationships include unhealthy experiences that are associated with negative interpersonal processes (Fortenberry, 2003). Negative interpersonal processes are understood as co-created negative experiences to which both partners contribute, and may include ineffective communication, unhealthy dependency between partners and relationship dissatisfaction (Beck & Clark, 2010; La Guardia & Patrick, 2008). For example, when couples believe that only their partner must listen to and help resolve all problems to the point where they each exhaust themselves to be present for one another, they have co-created an unhealthy dependency. Negative interpersonal processes can negatively impact the physical and mental well-being of couples (Kiecolt-Glaser & Newton, 2001). One negative interpersonal process that will be examined in this study is couple conflict.

Couple Conflict

Conflict within romantic relationships can be defined as the “presence of disagreement or difference between partners” (Cahn, 1992, p. 2). Couple conflict is considered inevitable as it is

not realistic for two individuals to hold the same set of needs, expectations or opinions at every given moment (Shulman, 2003). Given that conflict is considered normative in romantic relationships (Markman et al., 2004), it can be helpful to examine various ways in which couples experience conflict. Overt forms of conflict can take place in the form of disagreements, verbal aggression or physical violence; while covert conflict shows up as avoidance of issues, spiteful interactions and negative body language (Whitton et al., 2018).

Conflict can allow partners to express differences with the intention of creating desired change to meet both their own and their partner's needs (Salvatore et al., 2011). Having these needs met is vital to the healthy evolution of romantic relationships (Salvatore et al., 2011). However, not all conflict leads to positive outcomes. Couples in functional, high-quality, stable and regulated relationships demonstrate very different ways of handling conflict than dysfunctional 'non-regulated' relationships (Holman & Jarvis, 2003). When regulated couples disagree, they tend to have at least five positive interactions for every one negative interaction (5:1 ratio) and view their differences openly and cooperatively in a validating manner (Holman & Jarvis, 2003). For example, a couple that disagrees about spending habits may resolve their conflict by voicing affection for one's partner, respecting their difference of opinion and eventually engage in compromise.

In contrast, when non-regulated couples engage in conflict, the 5:1 ratio is less common and they display specific behaviors and communication that signal current and/or future negative interpersonal functioning, collectively known as conflict danger signs (Markman et al., 2010; Stanley et al., 1999). Two well-established sets of conflict danger signs include Gottman's (1993) Four Horsemen (contempt, criticism, defensiveness, and stonewalling), as well as Markman and colleague's (2010) Destructive Patterns (escalation, invalidation, negative

interpretation, and withdrawal). In the financial scenario above, non-regulated couples might attack one another's spending choices or escalate the conflict by bringing in unresolved past issues to the current disagreement. Unregulated and ongoing conflict in romantic relationships is negatively associated with relationship quality, relationship satisfaction and mental and physical health outcomes (Fincham, 2003; Gordon & Chen, 2016; Umberson et al., 2006; Whitton et al., 2018). Among the many negative outcomes for high levels of couple conflict in romantic relationships, the association between couple conflict and physical health is strongly established in research. Though there are many different forms of conflict, for the purpose of the scope of this study, we will be focusing on conflict via communication. It can be helpful to review the association between conflict and physical health before identifying gaps in the literature.

Couple Conflict and Physical Health

Numerous studies have documented a strong link between couple conflict and physical health outcomes (Balzarotti et al., 2017; Rodriguez & Margolin, 2013; Whitton et al., 2018). It is important to understand the intra-personal and inter-personal processes that impact this association. From an *intra-personal* perspective, long-term conflict can send the body into overproduction or underproduction of the stress hormone cortisol (Repetti et al., 2011). Cortisol, released in the blood stream when an individual perceives stress, is typically regulated by the hypothalamic–pituitary–adrenal (HPA) axis (Taylor et al., 2011). The HPA axis controls functionality of our central nervous and endocrine systems responsible for helping individuals recover from a stressor. Unfortunately, if these systems are exposed to stimuli that are continuously perceived as threatening, such as couple conflict, the HPA axis can become dysregulated (Taylor et al., 2011). When dysregulation occurs, individuals in the partnership can experience distress in the form of burnout (Taylor et al., 2011). Burnout can be understood as a

prolonged response to chronic emotional and interpersonal stressors that are identifiable when an individual presents with emotional exhaustion, depersonalization and a heightened sense of reduced personal accomplishment (Dam et al., 2019). Such distress caused by the inability to appropriately regulate affect is often associated with poorer physical and mental health (Balzarotti et al., 2017; Pietromonaco & Beck, 2019). More specifically, intense or prolonged conflict with a partner can negatively impact cardiovascular, endocrine and immune functioning (Lee et al., 2018; Roberson et al., 2018; Wright & Loving, 2011). While high levels of conflict in a romantic relationship can impact physical health, one's ability to regulate emotions within the conflict process may play a mitigating role.

When the human brain perceives threat, it sends a message through the limbic system for the individual to react using one of three responses: fight, flight or freeze (Schmidt et al., 2008). Unable to differentiate between life-threatening and emotionally threatening situations, when one partner expresses sadness, anger or disappointment for example, the brain perceives that a threat is present (Fishbane, 2013). Partners can learn to monitor, evaluate and modify their own perceptions of threat and subsequent emotional reactions through emotion regulation (Thompson, 1991). Emotion regulation is largely determined by several extrinsic and intrinsic processes (Thompson, 1991). For example, the ways in which parents (external) talk to children about processing their emotions from an early age can play a significant role their ability to regulate emotions. Similarly, factors such as language and cognitive skill (internal) can influence how an individual perceives, communicates and comprehends emotion within their interpersonal relationships.

From an *inter-personal* perspective, romantic partners have the unique ability to co-regulate one another's emotional responses (Timmons et al., 2015). When one partner is

experiencing heightened emotions, the other partner often experiences similar emotions in a process called physiological linkage (Timmons et al., 2015). For example, when one partner receives good news and walks around the house humming and smiling, offering impromptu hugs and pours their partner a mug of coffee, this may make the other partner feel relaxed, calm and safe. In contrast, when a partner is angry and stomps around the house slamming doors, it may make their partner's shoulders tense and heart rate increase. Both of these are examples of unintentional physiological linkage; however, partners can learn to do this intentionally as well. For example, in recognizing that one's partner is agitated, an individual may lighten their tone, offer soothing and validating support, and provide reframes to help lower their partner's heart rate and agitation.

Often times when engaging in couple conflict, couples are unaware of how linked they are physiologically. Physiological linkage explains why couples that experience high levels of relational distress can simultaneously experience more negative physiological outcomes (Fishbane, 2013). Kenny and colleagues (2006) highlighted that because of the high levels of interdependency found in romantic relationships, intrapersonal and interpersonal processes both need to be examined in dyadic studies. Although the relationship between couple conflict and physical health has been well documented, there is limited understanding about the relational processes that moderate the impact that couple conflict has on physical health in romantic relationships.

MODERATING VARIABLES

In the couples' therapy literature, there has been a shift in focus from intra-personal to inter-personal behaviors that impact romantic relationships. As described above, relational processes are co-created interactions between partners that can determine the well-being and relational functioning of couples (La Guardia & Patrick, 2008). Until now, relational processes such as healthy communication and relationship satisfaction have been shown to improve physical health among couples experiencing high levels of conflict (Prigerson et al., 1999; Roberson et al., 2018). In contrast, hostile interactions between partners during marital conflict have been associated with elevated cardiovascular activity and dysregulation of immune functioning (Robles & Kiecolt-Glaser, 2003). It can be extrapolated that the ways in which couples engage on an inter-personal level through relational processes can directly impact how couple conflict is associated with physical health.

The exploration of relational processes that may moderate the association between couple conflict and physical health using this dyadic lens remains limited. The current study will therefore address this gap in the literature by focusing on three relational processes that may moderate the ways in which couple conflict is associated with physical health. More specifically, this study will examine the moderators of attachment, dyadic coping and mindfulness from a systemic perspective. These relational process moderators will be examined to identify which provides the strongest buffer effect for the relationship between couple conflict and physical health.

Attachment

Attachment theory highlights the role that primary attachment figures play in the formation of one's internal working models, or the mental representations with which individuals see themselves and others (Fuenfhausen & Cashwell, 2013). Attachment systems are formed early in life and are largely shaped by the interactions we have with our primary caretakers (Bartholomew & Schoppe-Sullivan, 2016). The original conceptualization of attachment (Bowlby, 1973) was based on the ways in which infants respond to perceived availability and threat in an infant-caregiver relationship. Infants who experienced a stable and available relationship with their primary caregiver may move into adult relationships with similar expectations. An individual's attachment style plays a major role in their ability to have their needs met (Sroufe & Waters, 1977). Based on these early experiences, some adults may experience hesitancy and anxiety about their relationship's dependability due to inconsistency or unavailability in their youth (Hazan & Shaver, 1987). More specifically, memories of the perceived availability of one's primary caregivers can shape current perceptions of relational challenges or threats in one's adult romantic relationships (Overall & Simpson, 2015).

Adult attachment systems can be conceptualized as the degree to which individuals experience comfort or discomfort with closeness and dependency in their adult romantic relationships (Hazan & Shaver, 1987). Based on this conceptualization, adult attachment systems are broadly categorized as secure or insecure (with insecure subcategories of anxious and avoidant attachment). Securely attached individuals (SAI) typically respond to distressing situations by reconciling differences with their partner using honest and vulnerable conversation and assume positive expectations of their partners responsiveness to their needs (Mikulincer, 1998). SAI acknowledge negative emotions and are able to regulate them constructively with the

help of their partners (Laurent, 2008). SAI also tend to resolve their conflicts faster, with less distress and can better focus their attention on factors unrelated to their attachment (Mikulincer & Shaver, 2003). In contrast, if attachment figures were perceived as unresponsive or unavailable, individuals tend to develop insecure attachment to cope with the insecurity (Butzer & Campbell, 2008).

In contrast to securely attached strategies, individuals may develop more insecure attachment styles based on early experiences. These early experiences may have been characterized by inconsistency or unavailability of caregivers. Adults with a more typical anxious attachment style may respond to feelings of insecurity with high anxiety and low avoidance behaviors (Stefanou & McCabe, 2012). For example, if an individual chooses to spend time with friends instead of their romantic partner, the anxiously attached partner may feel rejected and may worry this action is a sign their partner does not value the relationship. Anxiously attached adults often experience a heightened fear of abandonment that can shape their behavior (high levels of emotional expressiveness, worry, impulsiveness) in maintaining even unhealthy romantic relationships (Armbruster & Witherington, 2016; Mikulincer & Shaver, 2005).

Avoidantly attached adults on the other hand, often exhibit low relational anxiety and high avoidance/distancing behaviors (Stefanou & McCabe, 2012) such as dissociating, ignoring or avoiding confrontation altogether, in order to cope with the insecurities that stem from fear of closeness or over-dependence in their romantic relationships (Lazarus & Folkman, 1984; Mikulincer & Shaver, 2005). For example, an avoidantly attached adult may exhibit emotional distance behaviors when their significant other suggests they move in together due to fear that they will be hurt if they become too close or reliant on their partner. When viewed as an intra-

person system, attachment styles were found to be stable into adulthood, affecting the way adults perceived themselves and their partners, romantic relationships and their responses to stress (Hazen & Shaver, 1987). At its core however, attachment theory is a relational theory and needs to be conceptualized from a dyadic lens (Mikulincer & Shaver, 2007).

Attachment from a Dyadic Lens

Feelings and behaviors related to romantic relationships are influenced by not only our own attachment styles, but also by the bidirectional context of how partners interact with one another. Interdependence is a key feature of romantic relationships that emphasizes compromise, support and sacrifice and is largely governed by how individuals have experienced these factors in their infant caregiver relationship (Overall & Simpson, 2015). Because partners mutually affect one another, they serve as secondary attachment figures in romantic relationships (Winterheld & Simpson, 2007). Contrary to historical conceptualizations that viewed attachment systems as stable over the life-course (Hazen & Shaver, 1987), a dyadic lens allows researchers to conceptualize secure interactions as co-created environments that can protect romantic relationships from the damaging effects of past insecurity (Overall & Simpson, 2015). Viewing secure attachment as a set of behaviors that each partner can engage in to actively co-create a more secure interaction suggests that couples have more control over their romantic relationship attachment style than previously conceptualized. For example, an individual may feel jealousy about their partner's close co-worker. This individual may openly share the insecurity and seek reassurance from their partner. In response, the partner may provide clarity, validate the jealousy and use reassuring words that can provide security. This can also mean that irrespective of the type of attachment formed between infant and caregiver, a secure attachment can be co-created

between romantic partners. One of the tools couples can use to form more secure bonds is couples' therapy.

Psychotherapy approaches have been developed with the notion that attachment can be rewired at the dyadic level. Emotionally Focused Therapy (EFT), is one among a few brief attachment-focused couple therapies that aims to help couples improve their relationship functioning by co-creating more secure attachment bonds (Johnson, 2004). Therapists encourage couples to both share here-and-now emotional experiences that are often blocked from expression by conflict and help couples learn to listen and respond in emotionally attuned ways (Wiebe & Johnson, 2016). Gradually, EFT interventions, can help distressed couples co-create the elements of secure attachment: emotional accessibility, responsiveness and engagement (Burgess Moser et al., 2012). Among many of the relational benefits described earlier, securely attached relationships are associated with greater relationship satisfaction, lesser depressive and PTSD symptoms and better physical health (Burgess Moser et al., 2012; Maunder & Hunter, 2008).

Attachment and Physical Health

In the presence of perceived threat, the ways in which adults regulate their emotions is closely linked to their attachment system (Pietromonaco & Beck, 2019), that in turn has long-term implications for physical health (Pietromonaco et al., 2015). When feeling distressed, secure partners turn towards one another for closeness and support to help them co-regulate and return to a calmer state (Fishbane, 2013). Puig and colleagues (2013) explain that when one partner is distressed, the other partner's availability and responsiveness or lack of both, can influence the distressed partner's physiological stress response, serving as a protective or risk factor (respectively) of physical health (Pietromonaco et al., 2015). For example, after a rough

day at work, one might seek their partner out to cuddle and feel cared for. If the partner instead tells them to stop over-reacting and walks away, it can trigger the release of cortisol in the stress response described above. Repeated exposure to such attachment insecurities can therefore predict poorer physical health outcomes (Puig et al., 2013). Given how prevalent stress is in romantic relationships, the ways in which couples cope with stress is another relational process worth examining.

Dyadic Coping

It has been well-documented that experiencing stress is inevitable in all relationships, and perhaps more pronounced in romantic relationships given the inherent intimacy and interdependence (Cahn, 1992; Randall & Bodenmann, 2017). Historically, the process of coping with stress has been viewed through an individual or intra-person lens (Bodenmann et al., 2016). Lazarus and Folkman's (1984) transactional theory of stress and coping highlights that how an individual reacts to a stressor is dependent on their appraisal of the situation and the resources they possess in order to cope (Bodenmann et al., 2016). In other words, the experience of stress was conceptualized as an interaction between an individual and their environment (Lazarus & Folkman, 1984), and the supportive role a partner may play in reducing the effects of stress (Falconier & Kuhn, 2019). This conceptualization, although still relevant, is only one side of the stress and coping coin.

Coping with Stress from a Dyadic Lens

The shift from an intra-personal to inter-personal systemic view of coping with stress has been marked with the recognition that stressors can affect both partners directly and indirectly (Falconier & Kuhn, 2019). The ways in which romantic partners respond to both their own stress reaction and their partner's experience of stress is known as dyadic coping (Falconier & Kuhn,

2019). Dyadic coping is often used in romantic relationships to stabilize one's partner in the face of distress (Bodenmann, 1997). In addition, Dyadic coping may be used to calm one's self indirectly by calming a partner or may be used by both partners simultaneously (Bodenmann, 1997). To begin the process of dyadic coping, one partner must communicate the stress they are experiencing in order for the other partner to respond (Leuchtman, 2018). The ways in which a romantic partner responds to the communicated stress initiates the type of dyadic coping that a couple may exhibit (Mohr et al., 2013). Dyadic coping is commonly thought to include three components: dyadic coping behaviors chosen once the stress has been communicated, the components of processing required to cope, and the recipient/s of the stress.

First, Bodenmann and colleagues (2016) examined the dyadic coping behaviors chosen once partners have shared that a stressor is present. Positive dyadic coping characterizes couple behavior as supportive and empathic when helping behaviors, emotion-focused and problem-focused strategies are employed in romantic relationships. For example, if one partner is fired from a job, the other partner may help them cope by being actively involved in the job search process creating an 'us against the problem' feeling. In contrast, negative dyadic coping is characterized by superficial, ambivalent and hostile behaviors in response to stress like sarcasm or dismissal of the partner's stressful experience. Next, Bodenmann and colleagues (2019) extrapolated that dyadic coping encapsulates four different process within itself: cognitive (evaluations of coping resources, active delegation and goal setting), emotional (co-regulation), physiological (recognizing stress impacts on the endocrine system) and behavioral (joint problem solving, supportive behaviors like hugging, engaging in active listening).

Finally, dyadic coping includes the component of who experiences the stressor in the dyad. Common dyadic coping refers to coping in a situation where both partners in the romantic

relationship are faced with an external stressor, like financial problems for example (Hilpert et al., 2016). When only one partner experiences a stressor, like the loss of a close friend, the relationship can still experience dyadic stress through a spill-over effect. The example described above is referred to as supportive dyadic coping (Hilpert et al., 2016). Both financial problems and the loss of a friend are external sources of stress. In the short term, when faced with within-relationship or internal stressors, such as couple conflict, partners are more likely to rely on individual coping strategies (Falconier & Kuhn, 2019). However, when stress effects are prolonged, individuals often seek out social resources and engage in dyadic coping for support (Bodenmann, 2005). What is less understood is how couples who actively engage in dyadic coping strategies respond when facing couple conflict, and subsequently, the impact that these dyadic coping strategies have on their physical health.

Dyadic Coping and Physical Health

As stated above, stress that enters romantic relationships can affect both partners directly and indirectly (Falconier & Kuhn, 2019). The mechanisms by which couples cope with this stress can have direct implications on physical health (Bodenmann, 2005). Couples that engage in positive dyadic coping strategies typically help their partner cope with stress by taking over more responsibility, helping one another put their problems in perspective and helping one another actively relax (Bodenmann, 1997). For example, when one partner is diagnosed with cancer, the other partner may take over more of the child-care responsibilities so as to alleviate the cumulative stress the partner with cancer may have previously faced without this additional help. This example of supportive dyadic coping is aimed at restoring a state of homeostasis at the couple level, which is linked to reduced distress that can have direct implications on physical health (Meier et al., 2011). Researchers have also demonstrated that dyadic coping is indirectly

related to better physical health outcomes because partners who engage in dyadic coping often encourage one another to cope in healthy ways, such as engaging in exercise when stressed or sick (Badr & Acitelli, 2017). To date, several studies have captured these positive associations between dyadic coping and physical health when one partner is diagnosed with serious physical health challenges (Pereira et al., 2012; Rottmann et al., 2015; Traa et al., 2015).

In conclusion, dyadic coping researchers have illuminated a myriad of mechanisms by which physical health is affected when couples face external stressors. However, external stress can spill over into romantic relationships causing internal stressors, like couple conflict (Merz et al., 2014). Identified as a gap in the literature, the current study aims to examine dyadic coping as a potential moderator of the association between couple conflict (internal stressor) and physical health and compare this buffering impact with other related yet distinct relational processes like mindfulness.

Mindful Partnering

Mindfulness is a state of awareness that occurs by intentionally paying attention to an experience in the present without judgement or evaluation (Demarzo et al., 2014). Mindfulness allows an individual to become alert to the occurrences of the here-and-now (Bishop et al., 2004). Intrapersonal mindfulness can be conceptualized in two ways. Trait mindfulness refers to the tendency for an individual to be more mindful in daily life and is viewed more as a combination of genetics and life experiences that form a personal characteristic (Demarzo et al., 2014). State mindfulness, on the other hand, refers to behavioral mindfulness that can be altered depending on the context in which an individual finds themselves in (Tanay & Bernstein, 2013).

Individuals who practice mindfulness everyday often demonstrate an open, accepting and present focus of attention on their daily life experiences, situations and activities (Thompson &

Waltz, 2007). Although inherent in most human beings, some experience and practice mindfulness more than others (Brown & Ryan, 2003). The capacity to be mindful can be developed through active practices such as mindfulness training or meditation (Jordan et al., 2014). The level of awareness that these mindful practices can contribute to a person's life suggest that an individual can develop heightened insight into their own psychological (thoughts and feelings) and physiological (breathing, eating and drinking) functioning (Beshara et al., 2013). This can have strong implications for the psychological and physiological well-being of individuals who practice mindfulness.

Mindfulness and Physical Health

In western psychology, mindfulness was conceptualized from the mindfulness-based stress reduction (MBSR) program (Kabat-Zinn, 1990) originally based on philosophies from Buddhist mindful practices (Dorjee, 2010), and later adapted into what is now referred to as mindfulness-based interventions (MBIs; Baer, 2003). There are two core aspects to mindfulness in MBSR: self-regulation of attention when exposed to unwanted thoughts and sensations and change in one's attitude that is marked by curiosity and acceptance rather than avoidance (Dorjee, 2010). MBIs and programs have been shown to improve depression, quality of life, anxiety, interpersonal romantic relationship safety, relationship quality and satisfaction and physical health (Grossman et al., 2004; Jones et al., 2011; Karremans et al., 2017).

Meditation practices and MBIs were developed with the intention of incorporating self-discovery and personal growth from mindful practices, along with the focused ability to treat mental and physical symptoms that individuals present (Carlson, 2012; Karremans et al., 2017). MBIs have demonstrated the ability to directly and indirectly buffer an individual's response to stress (Demarzo et al., 2014) by having a positive influence on two biomarkers of stress

regulation, namely, sleep and cortisol secretion (Brand et al., 2012). In addition, MBIs have successfully reduced emotional reactivity in many individuals and demonstrated success in treating chronic inflammatory conditions (Creswell et al., 2012; Malarkey et al., 2013; Rosenkranz et al., 2013). Given that individuals are social beings and function within multiple social contexts, researchers began exploring how mindfulness can impact relationships (Laurent et al., 2016; Karremans et al., 2017).

In the context of romantic relationships, Karremans and colleagues (2017) examined how intrapersonal mindfulness influenced how each partner viewed conflict behavior. A mindful individual may notice the bodily sensations and feelings that arise during couple conflict or the resentment that surfaces after a conflict occurs. The ability to be aware of and notice these sensations and emotions without evaluating or judging them within oneself and a partner can then allow a person to consciously alter responses towards their partner. More specifically, intrapersonal mindfulness can buffer or moderate the impact of couple conflict on the neuroendocrine stress response (Laurent et al., 2016). The mindful practices that were found to buffer cortisol reactivity included mindful attitudes, decentering, and engaging in mindfulness during the actual conflict episodes (Laurent et al., 2016). While the associations between intrapersonal mindfulness and physical health are well-documented in the literature, far less is known about interpersonal mindfulness.

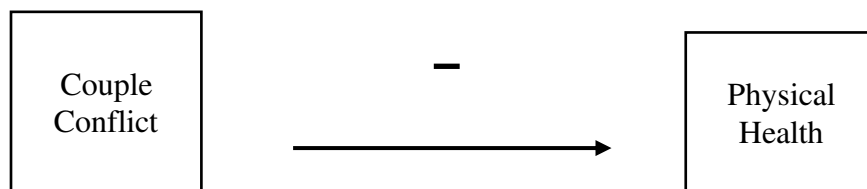
Mindfulness from a Dyadic Lens

More recently, mindfulness researchers have argued that human beings struggle within a social context, thereby highlighting the need for a biopsychosocial perspective to mindfulness rather than solely an intrapersonal one (Barker, 2014). A vast majority of the research examining mindfulness until now has been intra-personal, leaving gaps in how interpersonal mindfulness is

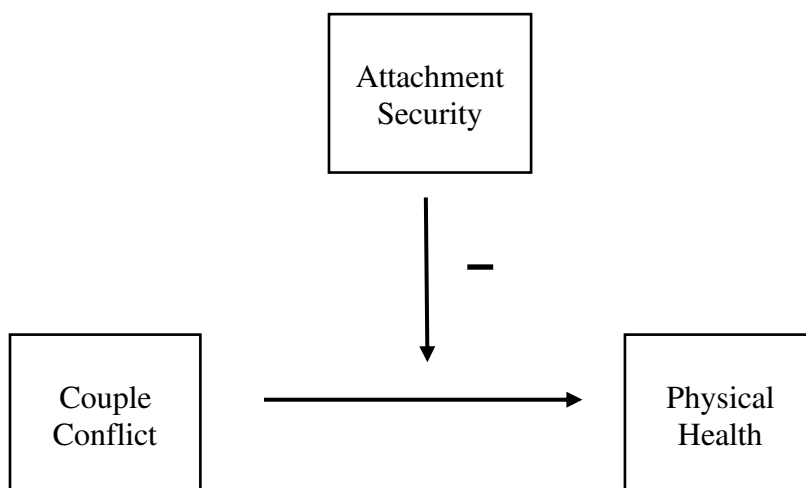
understood within a relational context. Limited past literature has positively linked interpersonal mindfulness with friendship quality (Pratscher et al., 2018), parent happiness and mental health (Lo et al., 2018) and more recently, with relationship and psychological well-being (Kimmes et al., 2020). These findings suggest that in addition to intrapersonal mindfulness, there are interpersonal elements to mindfulness that impact relationship quality. Specifically, interpersonal mindfulness may include mindful awareness in attention and action toward one's romantic partner, nonreactivity in conflict, emotional awareness of one's partner, intentional acceptance of and compassion towards one's partner and self-compassion in the romantic relationship (Seiter et al., in press). This five-part interpersonal relational process is a relatively new construct that is referred to as *mindful partnering* (Seiter et al., in press). Given the vast literature supporting the association between intrapersonal mindfulness and physical health, the current study predicts that mindful partnering, a form of interpersonal mindfulness, will moderate the relationship between couple conflict and physical health.

CURRENT STUDY

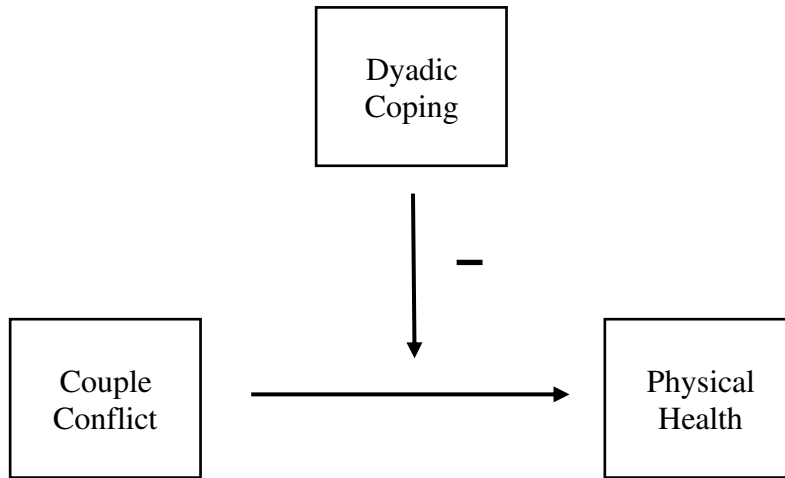
Relational processes are co-created interactions between romantic partners that can affect the relational well-being and functioning of couples, however additional research is needed to better understand these associations. Three relatively new relational process constructs were selected to better understand their influences on the association between couple conflict and physical health outcomes. Grounded in the outlined review of literature in this paper, it was hypothesized that couple conflict will be negatively associated with physical health as a main effect (hypothesis 1; Figure 1). The next three hypotheses examined moderating effects; specifically, all three moderators were hypothesized to weaken the main effect relationship. The effects of couple conflict on the couples' physical health will be moderated by attachment security (hypothesis 2; Figure 2). Similarly, the effects of couple conflict on the couples' physical health will be moderated by dyadic coping (hypothesis 3; Figure 3). And lastly, the effects of couple conflict on the couples' physical health will be moderated by mindful partnering (hypothesis 4; Figure 4).



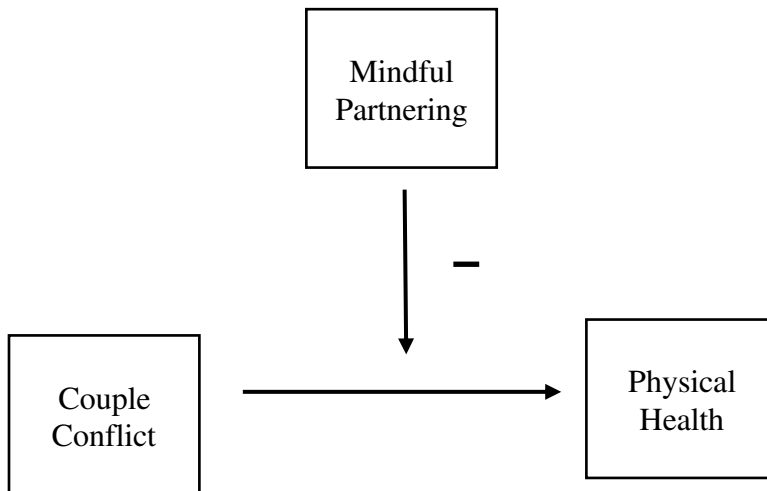
(Figure 1.)



(Figure 2.)



(Figure 3.)



(Figure 4.)

METHOD

Participants

Participants were recruited from a large Western United States University subject pool and Mechanical Turks (MTurks). MTurks is an online data collection platform this is utilized by social scientists to conveniently gather large and representative samples on-demand (Paolacci et al., 2010). Recruitment efforts resulted in 620 individuals who participated in the study. Individuals reported having experienced an average of 2.3 romantic relationships ($SD= 1.89$). Participants were young adults on average ($M=19.81$, $SD= 2.13$) with the following gender distribution: 66% female, 24% male, 9% gender queer/fluid/questioning and 1% unreported. 88.2% of participants identified as heterosexual, 8.2% identified as bisexual, 2% of data was missing, 4.9% identified as gay, and 0.4% identified as other. With respect to race/ethnicity, the sample was 69.2% White, 13.2% Hispanic, 7.5% Mixed Race, 3.5% Black/African American, 2.7% Asian, 0.8% Pacific Islander, 0.8% Indian or 0.4% Native American. Eligibility included that students must be enrolled in a course with access to the Research Pool or individuals with access to the Mechanical Turk data platform. Participants in the research pool were awarded 3 points of extra credit that they could apply to their courses, and participants in the MTurks sample were paid \$10 for their time. Participants also must have been at least 18 years old at the time of participation. Exclusion criteria included the inability to access a computer long enough to complete the questionnaires, and individuals not currently in a romantic relationship.

Procedure

Data were collected from two sources. The first procedure involved collecting data from an undergraduate research study pool housed in a larger western United States University. As is typical of subject pool data collection, students could select a study to participate in out of the

many study options that were available to them. Students received credit for participation and could also chose to complete another study or withdraw their participation at any time. Study participation involved clicking on the participation link within the subject pool, providing informed consent, and completing the questionnaires online.

The second procedure for collecting data and recruiting individuals made use of Amazon Mechanical Turk (Mturks). Individuals could log into Mturks from any location of their choosing, provide informed consent and proceed to complete the questionnaires. This study has been approved by the University Institutional Review Board.

Measures

Participants reported on demographic information including individuals' age, ethnicity, sexual orientation and duration of relationship. In addition, participants completed five self-report questionnaires (see Table 2).

Conflict Tactics Scale

The Revised Conflict Tactics Scale (CTS2) is a self-report questionnaire that was adapted from the original Conflict Tactics Scale (Straus et al., 1996). The CTS2 measures the prevalence and severity of couple conflict in relation to both perpetuation and victimization (Jose et al., 2012; Straus & Douglas, 2004). The scale has 78 items that assess couple conflict and intimate partner violence and are spread across five subscales: negotiation, psychological aggression, physical assault, sexual coercion, and injury. The current study made use of this scale by having participants only mark their responses for the psychological aggression scale as the current focus on the study is not intimate partner violence which is strongly represented by the remaining scales. Respondents participated by selecting their response on a Likert scale that has a range

from 0 to 7 including, 0 (*Never*), 4 (*3-5 times*) and 7 (*More than 20 times*). Internal consistency for the CTS2 psychological aggression subscale was $\alpha = .71$.

Medical Outcomes Study Short Form-36 Health Survey

The Short Form 36 (SF-36) is a brief yet comprehensive self-report measure of functional health and well-being (Heyde, 2007). The SF-36 questionnaire consists of 8 scales that yield two summary measures. Four of the scales pertaining to physical health include physical functioning, role-physical, bodily pain, and general health. The remaining four scales pertain to mental health and include vitality, social functioning, role-emotional, and mental health. Thirty-five of the items contribute to the scales while one unscaled item asks participants to reflect about health change over the past year. Both Likert scale options and yes/no options are used to assess functional health. Higher scores are indicative of better health status. The SF-36 has been found to be reliable, valid and responsive as a helpful aid to a range of medical diagnoses (Jenkinson et al., 1994). Cronbach's alpha was acceptable demonstrating good internal consistency with $\alpha = .77$

Experiences in Close Relationship Scale-Short Form

Adult attachment has been operationalized using the Experiences in Close Relationship Scale (ECR)-Short Form (ECR-S, 12-item) measure that was adapted from the original 36-item ECR (Brennan et al., 1998). Given the equivalence in psychometric properties such as reliability, factor structure and validity, the short form scale is encouraged over the original to avoid issues of participant fatigue (Wei et al., 2007). The ECR-S evaluates how people generally experience relationships and can be used even when an individual is not currently in a romantic relationship. The 12-item scale has 6 items for each of the constructs being measured (attachment anxiety and avoidance).

Sample items that are incorporated in the scale include, “It helps to turn to my romantic partner in times of need,” “I try to avoid getting too close to my partner,” and “I get nervous when partners get too close to me.” The items are all rated on a 7-point scale to which participants can indicate their responses. The Likert scale has a range from 1 to 7 including, 1 (*Definitely not like me*), 4 (*Neutral*) and 7 (*Definitely like me*). Higher scores represent greater insecure attachment. Cronbach alphas for the current study were .88 for secure attachment and .79 for insecure attachment.

The Dyadic Coping Inventory

The Dyadic Coping Inventory (DCI) (Bodenmann, 1997; Ledermann et al., 2010) was used to assess dyadic coping. The DCI is a 37-item measure. The subscales of this measure include stress communication, dyadic coping (supportive, negative, delegated and common) and two single items related to the satisfaction and efficiency of dyadic coping. The DCI evaluates the extent to which individuals and their partners engage in a variety of coping behaviors. The items are all rated on a 5-point scale ranging from 1(*very rarely*) to 5(*very often*). Higher scored values indicate more of the respective behavior for each of the scales within the DCI. Cronbach’s alpha was $\alpha = .71$

Mindful Partnering Measure

The Mindful Partnering Measure (MPM) (Seiter, 2021) was developed to measure the extent to which an individual is able to demonstrate five aspects of mindful partnering within their romantic relationships. The five aspects of mindful partnering include, (1) mindful awareness in attention and action toward partner (MPM- mindful awareness), (2) emotional awareness of ones’ partner in the relationship (MPM- emotional awareness), (3) nonreactivity during couple conflict (MPM- nonreactivity), (4) intentional acceptance and compassion for

ones' partner (MPM- acceptance/compassion), and (5) self-compassion in the romantic relationship (MPM- self-compassion).

Adapted from a measure of mindful parenting known as the expanded version of the Interpersonal Mindfulness in Parenting scale, all items from the 31-item IMP were modified by a previous study (IMP scale, Coatsworth et al., 2015; Lippold et al., 2019) to adequately be used in romantic relationships rather than parenting relationships by replacing the word “child” with “partner”. Participants were asked to rate each statement in terms of how true the statement typically is in their romantic relationship on a scale from 1(*never true*) to 5(*always true*). Higher scores reflect greater levels of mindful partnering in one's relationship. Cronbach's alpha for the current study was .72 overall.

Data Analytic Plan

A multiple regression analyses was used to test the main effects. In order to test for moderation effects for hypotheses 2 through 4, multiple regression was used wherein three interaction terms were entered. For hypothesis 2, the interaction term was couple conflict and attachment security. For hypothesis 3, the interaction term was couple conflict and dyadic coping. For hypothesis 4, the interaction term was couple conflict and mindful partnering. Control variables for the study included number and duration of romantic relationships. All of the analyses for the current study were conducted using the Statistical Package for the Social Sciences (SPSS).

RESULTS

To examine the hypotheses proposed in this paper, we conducted four separate linear regressions. For each of these analyses number of romantic relationships was entered as a control variable. To conduct the test of moderation the variables were centered around the mean and then converted into an interaction term (between predictor and moderator). This resulted in the following interaction terms in the regression models: conflict-attachment, conflict-dyadic-coping, and conflict-mindful-partnering. The outcome variable was physical health.

Descriptive statistics are outlined below, with bivariate correlations in Table 1, means and standard deviations for the variables in Table 2, and regression analyses in Table 3. Results revealed support for the hypothesized main effect, wherein couple conflict was negatively associated with physical health, $B = -.38, p < .001$. Results also supported the second hypothesis, wherein higher ratings of secure attachment moderated the relationship between couple conflict and physical health, $B = .41, p < .001$. The third hypothesis was not supported, with dyadic coping not reaching statistical significance in moderating the relationship between couple conflict and physical health, $B = .14, p = .07$. Importantly, the relationship between dyadic coping and physical health was significant in the bivariate correlation and trended towards significance in the test of moderation. Results supported the fourth hypothesis, wherein mindful partnering moderated the relationship between couple conflict and physical health, $B = .51, p < .001$.

Table 1. Correlations Among Variables

	1	2	3	4	5
1. Conflict	1.00				
2. Physical Health	-.54**	1.00			
3. Secure Attachment	-.49**	.33**	1.00		
4. Dyadic Coping	-.19*	.21*	.16	1.00	
5. Mindful Partnering	-.65**	-.36**	.21	.43**	1.00

Note: Conflict refers to the Conflict Tactics Scale

Physical Health refers to the Medical Outcomes Study Short Form-36 Health Survey

Secure attachment refers to the Experiences in Close Relationship Scale-Short Form

Dyadic Coping refers to the Dyadic Coping Inventory

Mindful Partnering refers to the Mindful Partnering Measure

Table 2. Descriptive Information for Variables

<i>Variable</i>	<i>M</i>	<i>SD</i>	<i>Range</i>
Couple Conflict	2.32	.60	1.00-3.00
Physical Health	2.41	1.00	1.00-6.65
Secure Attachment	2.25	.61	1.00-4.45
Dyadic Coping	4.44	1.84	1.00-7.00
Mindful Partnering	2.02	.55	1.00-4.00

Note: Conflict refers to the Conflict Tactics Scale

Physical Health refers to the Medical Outcomes Study Short Form-36 Health Survey

Secure attachment refers to the Experiences in Close Relationship Scale-Short Form

Dyadic Coping refers to the Dyadic Coping Inventory

Mindful Partnering refers to the Mindful Partnering Measure

Table 3. Summary of Regression Analysis

Model	Variable	<i>B</i>	<i>SE</i>
1	conflict	.42	.17
2	conflictXattach	.21	.19
3	conflictXdc	.09	.10
4	conflictXmp	.30	.16

Note: dependent variable: physical health

DISCUSSION

The purpose of this study was to investigate whether secure attachment, dyadic coping and mindful partnering moderate the relationship between couple conflict and physical health in romantic relationships. Although past research has demonstrated that couple conflict is strongly associated with physical health (Balzarotti et al., 2017; Rodriguez & Margolin, 2013; Whitton et al., 2018), and that variables such as attachment or dyadic coping have been studied as moderators in past research designs, this study is the first of its kind for many reasons. To our knowledge, this is the first study to view all three moderating variables from an interpersonal lens. Until now, many studies have conceptualized attachment, coping with stress and mindfulness as an *intra*-personal variable. More recently, there has been a shift in focus from *intra*-personal to *inter*-personal behaviors that impact romantic relationships. Couples were initially viewed as two independent individuals coming together. From this limited lens, it was not possible to see how interconnected couples have been on both neurobiological and physiological levels (Fishbane, 2013).

An *inter*-personal lens has allowed researchers to conceptualize these three constructs as co-created interactions that potentially have important relationships with physical health in romantic relationships. Attachment systems for example, were once thought to be conceptualized during infancy, stable throughout the life-course and determining of the type of relationship security and related health outcomes two partners could have (Hazen & Shaver, 1987). Secure interactions are now recognized as forms of interaction that can actively be fostered by couples, despite one or both partners potentially having had insecure childhood attachments (Overall & Simpson, 2015). Similarly, *intra*-personally, individuals have been thought to cope with their

own stress alone, based on the appraisal of the resources available to them (Lazarus & Folkman, 1984). Within couple dyads however, researchers learned that stress affects both partners directly and indirectly providing an *inter*-personal system called dyadic coping, by which couples can communicate their stress and cope with it together (Falconier & Kuhn, 2019). Researchers have shown that this expanded lens allows romantic partners to more effectively cope with the stress that accompanies long-term stressors like physical illnesses or the loss of a job, that could otherwise lead to burnout if they were each coping alone. Lastly, the mindfulness literature has strongly focused on the many physical and mental health benefits that come from intentionally paying attention to experiences in the present, without judgement or evaluation, *intra*-personally (Demarzo et al., 2014). When *intra*-personal mindful practices were re-structured through an *inter*-personal lens, it allowed for relationships like friendships and co-parents to reap similar health benefits through the increased acceptance, compassion and non-reactivity during conflict practices being newly introduced (Lo et al., 2018; Pratscher et al., 2018). The current study hypothesized that similar protective advantages could come from introducing this inter-personal lens to romantic relationships through the process of mindful partnering.

As hypothesized, we found a strong negative association between couple conflict and physical health. This main effect was expected given the vast literature specifying that stressful conflict in romantic relationships is associated with poor physical health (Balzarotti et al., 2017; Whitton et al., 2018). This association is often found because couple conflict can send the body into over or under production of cortisol, which can over time dysregulate the HPA axis that is responsible for regulation of several physical systems in the body (Repetti et al., 2011; Taylor et al., 2011). When the HPA axis is dysregulated, individuals and their partners can experience burnout in the form of emotional and physical exhaustion and increased depersonalization (Dam

et al., 2019). Prolonged couple conflict has therefore been associated with poorer cardiovascular, endocrine and immune functioning (Lee et al., 2018; Roberson et al., 2018; Wright & Loving, 2011). For example, when partners have a long-standing argument over keeping the house clean, the conflict they engage in on a weekly basis can trigger the physiological stress response within both of their bodies. Over time, they may report weakness, expressions of burnout and symptoms of illness. Depending on how long the conflict continues unchecked, it is possible that the partners may experience a decline in self-reported physical health or measurable physiological shifts in their physical health that can require medical attention.

Our results revealed that secure attachment moderates couple conflict and physical health. In line with more recent attachment literature, secure attachment between romantic partners can protect partners from insecurities that may have been formed with primary caregivers (Overall & Simpson, 2015). For example, when one partner reaches out for a hug of support during a distressing time and the other reciprocates this gesture, the availability and responsiveness displayed are markers of secure attachment that allow partners to co-regulate and return to a calmer more regulated physical state (Fishbane, 2013). In contrast, if the partner ignored the request for connection or responded with rejection, the feeling of insecurity could trigger the human stress response for the one who reached out, through the release of cortisol (Taylor et al., 2011). Repeated over time, insecure attachments can predict poorer physical health outcomes as the surplus of cortisol production can dysregulate HPA functioning (Puig et al., 2013; Taylor et al., 2011). Secure attachment therefore stands in as a protective moderating factor on the association between couple conflict and physical health.

From a clinical lens, this finding suggests that therapists can introduce this empirical information into sessions with couples, with the intention of highlighting the many advantages

that forming a secure attachment can have. At its core, secure attachment is made up of elements such as emotional accessibility, responsiveness and engagement (Burgess Moser et al., 2012). Therapists can help couples by highlighting the many ways in which these elements can be rebuilt into their daily interactions; more specifically, these elements can be introduced to couples during a conflict episode. For example, couples can learn how to appear more accessible to their partner by facing them with open body language, engaging in eye contact and increasing the use of other non-verbal cues, such as nodding, that indicate interest. Co-creating a safe environment during conflict is a crucial piece to how secure attachment acts a moderator during couple conflict. Feelings of safety are explicitly created by helping partners use sentences that allow for acceptance and unconditionality during arguments that can look like, “Though I am still upset, I can understand why you felt the need to act that way,” or “Yes, this fight is really bad, but I am definitely not leaving you.” Partners typically report greater security in their relationships when they sense consistency their emotional needs being met, along with validation of past times where these needs were not met.

Contrary to the predictions made in past research (Pereira et al., 2012; Rottmann et al., 2015; Traa et al., 2015), dyadic coping did not significantly moderate the association between couple conflict and physical health. Though the results indicated that dyadic coping was significant in the bivariate correlation, it is not entirely clear why dyadic coping was not found to be a significant moderator despite data trending towards this outcome. There are two possible explanations that are worth exploring in future research projects. First, it is possible that many people may not be clear as to what dyadic coping is or how it is different from two individuals coping separately. Though the Dyadic Coping Inventory provides clear examples of what dyadic coping can look like in romantic relationships, if the participants were unaware of the

mechanisms by which dyadic coping differentiates from individual coping, it is possible that this bias could have unintentionally shown up in the self-report responses. For example, in response to one of the dyadic coping inventory statements '*when my partner feels he/she has too much to do, I help him/her out,*' a respondent may focus on the task they have taken over while responding to the questionnaire rather than the joint coping strategy of viewing both their own and their partner's experience of stress as a unit.

Secondly, a potential gender bias in the study is worth discussing (Females N = 409, Males N = 149, Queer = 59). Past literature suggests that for women particularly, dyadic coping is strongly related to relationship satisfaction and their overall well-being (Kiecolt-Glaser & Newton, 2001). Applying these findings to the current study, it is possible that relationship quality played a role in how women perceived and responded to the questions related to dyadic coping. In the event that several women were experiencing poorer relationship satisfaction, their reports of dyadic coping would have been low. Despite not finding dyadic coping to be a statistically significant moderator for couple conflict and physical health, we need to be careful not to disregard the variable as unimportant. Backed by empirical research, dyadic coping has significant associations with physical health (Badr & Acitelli, 2017; Bodenmann, 2005). It is possible that additional factors like the one's discussed above, or others may explain the null finding in the current study.

Mindful partnering was found to be a significant moderator of the association between couple conflict and physical health. More specifically, just as *intra*-personal mindfulness has been found to significantly moderate this association in past research (Carlson, 2012; Karremans et al., 2017), a type of *inter*-personal mindfulness (mindful partnering) seems to be a moderator as well. Interpersonal mindfulness includes the practice of mindful awareness in attention and

action towards one's romantic partner. More specifically, it can show up as non-reactivity in conflict, emotional awareness of one's partner, as well as intentional acceptance and compassion towards one's partner (Seiter et al., in press). Individuals may notice bodily sensations and feelings that arise during or after an episode of couple conflict. Those who practice mindfulness are often able to notice when their body is getting aroused during conflict and engage in mindful skills, like deep breathing, that eventually helps them bring their body to a state of homeostasis (Karremans et al., 2017; Laurent et al., 2016). These individuals may be able to buffer cortisol reactivity by acting mindfully during the actual conflict, which in turn provides them the opportunity to alter how they respond towards their partner (Laurent et al., 2016). In short, it seems that mindful partnering buffers or protects couples from the association between conflict and physical health.

Mindful practices are increasingly being introduced in therapeutic settings for their significant associations with positive physical health outcomes. The findings of the current study can enhance this niche area by providing more empirically backed research supporting the specific ways in which couples can be mindful together in order to lessen the association that their conflict may have with their physical health. Some techniques that therapists can introduce include enhancing partners' attention towards one another, helping couples practice non-reactivity during conflict and helping couples practice partner and self-compassion activities to intentionally increase couples' mindful partnering practices in romantic relationships.

Lastly, although attachment systems, dyadic coping and mindful partnering are similar concepts in some ways (inter-personal variables that are associated with physical health), it is important to address the reasons that could have led to moderation effect differences. Secure attachment and mindful partnering were found to be moderators; dyadic coping was not. It is

possible that the reason for this distinction lies in how these variables relate to couple conflict. On one hand, couples may engage in dyadic coping when it comes to stressors like the loss of a job or physical illness. However, dyadic coping may not theoretically relate to couple conflict. Secure attachment and mindful partnering involve skills that actively work to make couple conflict less impactful on physical health. Dyadic coping on the other hand, involves the skill of understanding and coping with one's own stress and their partners. For example, a couple may be able to dyadically cope with the external stressor of being laid off, by working together to adapt their budget or having the other partner take on more job shifts. However, it may not protect them from becoming physiologically aroused during conflict. Given the vast literature associating couple conflict and physical health, dyadic coping may therefore not buffer or moderate this relationship.

In addition, unlike dyadic coping, secure attachment and mindful partnering are interpersonal skills that are activated *during* an actual conflict event. For example, while arguing, one partner may say, "this fight has gotten really bad, you're not leaving me, are you?" The reassurance or security provided by their partner acts as a protective buffer that in turn calms their neuroendocrine system. Similarly, when two partners are in a heated fight, one might say to the other, "I'm noticing we're really escalated. Let's both breathe together for a moment." This example provides an understanding of how *during* conflict, mindful partnering skills such as compassion for oneself and partner, attunement into their physical and emotional state, and action towards de-escalation, can help couples physiologically calm down.

Limitations and Future Directions

While the findings from this study are an important step towards determining the effects of dyadic processes such as attachment, dyadic coping and mindful partnering on physical

health, additional research is necessary to broaden and confirm these findings. Data were obtained exclusively from a cross sectional research design using convenience sampling self-report measures. Although self-report measures can be considered good indicators of how an individual may be doing quantitatively with unique value in knowing someone's subjective evaluation of something going on in their lives, they are also known to be vulnerable to bias (Kikken & Shook, 2012). In addition to these limitations, online surveys pose sampling issues like self-selection bias and only target populations that have internet access. In order to off-set these limitations, future studies can look into longitudinal research designs that measure physiological responses of couples together rather than individuals in romantic relationships.

Another noteworthy limitation is the lack of diversity within the demographics of the study. There were 69.2% of those in the study that identified as White, with a small percentage of mixed race, Asians, African Americans and other minority race representations. There are several studies that indicate differences in how individuals from non-white-majority locations perceive and respond to several of the factors in the current study including attachment, conflict and perceptions of physical health (Henderson & Ainsworth, 2003; Johnson et al., 2018). For example, researchers have learned that east Asians report the highest percentage of anxious attachment in romantic relationships than any other ethnic group (Schmitt et al., 2004). In addition, the culture around arranged marriages, collectivistic outlooks, and stigma around dating culture can all impact the results of the study. Future studies would need to address these limitations by seeking out a more diverse sample to learn whether the findings transcend across these groups. In addition, it may be fruitful to alter the research design into a longitudinal one in future research projects. It is possible that the data at various time points will more closely allow researchers to note if these moderation effects can stand the test of time. Such findings may not

only aid couples in building skills to help them potentially maintain the longevity of a healthy relationship, but also help protect them from the health concerns that accompany couple conflict. Additionally, partners seeking therapy for couple conflict may benefit from learning whether the inter-personal skills of fostering secure attachment and mindful partnering also moderate the relationship between conflict and their measured *physiological* health.

Conclusion

The current study examined relational constructs using a novel interpersonal lens to determine their moderating potential on the well-established relationship between couple conflict and physical health in romantic relationships. The results of the study provide initial evidence for the significant moderating effects of secure attachment and mindful partnering. The relationship between dyadic coping and physical health was significant in the bivariate correlation and although not statistically significant for moderation, it demonstrated a trend towards it at the multivariate level. As such, this study may have clinical implications by providing therapists with empirically backed information to share with clients about the skills they can build (secure attachment and mindful partnering) to reduce the associations between couple conflict and physical health in their romantic relationships.

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