Self-Competence and the Prediction of Bulimic Symptoms in Older Women

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Previous research in undergraduate women has demonstrated that an individual's level of self-competence was a stronger predictor of bulimic symptom change than their level of self-liking (Bardone, Perez, Abramson, & Joiner, 2003). The authors examined whether self-competence would similarly predict bulimic symptom change in a sample of older women. In April 2000, a large group of adults attending mood disorder conferences completed questionnaires about eating disorder symptoms and self-esteem. Approximately 2.5 years later, 150 women, 45 years of age and older, were contacted for a follow-up study. Eighty-eight women completed follow-up eating disorder and self-esteem measures. Consistent with prior research, self-competence emerged as a stronger predictor of bulimic symptom change than self-liking, such that lower self-competence was associated with an increase in bulimic symptoms. The results indicate that self-competence may serve as a useful prognostic indicator and therapeutic target for older women seeking treatment for eating disorders.

RESEARCH IN THE AREA of eating disorders suggests that self-esteem is an important variable to consider with regard to the etiology and treatment of bulimia nervosa. This reflects the fact that self-esteem has repeatedly emerged as a correlate of bulimic symptoms, such as disordered eating attitudes and behavior (Bulik, Wade, & Kendler, 2000; Button, Sonuga-Barke, & Thompson, 1996; Fisher, Pastore, Schneider, Pegler, & Napolitano, 1994; Tomori & Rus-Makovec, 2000). Multiple cognitive-behavioral models indicate self-esteem as a factor in the onset of bulimia (Byrne & McLean, 2002; Fairburn & Wilson, 1993; Johnson, Connors, & Tobin, 1987; Mizes, 1988; Stice, 1994; Vohs, Bardone, Joiner, Abramson, & Heatherton, 1999). For example, Fairburn and Wilson (1993) proposed that societal pressures to be thin have a greater effect on individuals with low self-esteem than on individuals with high self-esteem. Accordingly, individuals with low self-esteem are more likely to turn to dieting to fit societal standards of slimness, thus increasing their risk for the development of bulimic symptoms. In another study, Vohs et al. found that women with high levels of perfectionism, and who perceived themselves as overweight, were particularly likely to develop bulimic symptoms over time if they also had low self-esteem. They conjectured that women with low self-esteem were more susceptible to self-sabotaging bulimic behavior (i.e., binge eating) because of their negative expectations for themselves. Finally, one prospective study found low self-esteem to be predictive of disordered eating symptoms in adolescent girls over a 4-year period (Button et al., 1996). Across studies, low self-esteem has been linked to the development of bulimic symptoms, while high self-esteem appears to serve as a buffer from bulimic symptom development.

These findings have led to the evaluation of self-esteem as a prognostic indicator within the context of treatment for bulimia nervosa. For example, Fairburn, Kirk, O'Connor, Anastasiades, and Cooper (1987) found that self-esteem was the only variable in their study that predicted treatment outcome for bulimic women, where women with lower levels of self-esteem were significantly less likely to have positive treatment outcome than women with higher levels of self-esteem. Additional studies have found that bulimic women with the lowest levels of self-esteem do least well in cognitive-behavioral, interpersonal, and behavioral therapy as compared to women with moderate or high levels of self-esteem (Fairburn et al., 1995; Schneider, O'Leary, & Agras, 1987). Collectively, these empirical studies suggest that self-esteem may serve as an important prognostic indicator for the course of bulimic symptoms.

Self-esteem has typically been regarded as a uni-

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dimensional construct reflecting an individual's overall view of herself. In fact, the Rosenberg Self-Esteem Scale, which has been consistently used since its development in 1965, was designed to tap a unitary construct. However, theorists (Franks & Marolla, 1976) formally challenged this notion of self-esteem, proposing that self-esteem is experienced bidimensionally. Tafarodi and Swann (1995, 2001) provided empirical support for two dimensions that comprise global self-esteem: self-liking (sense of self-worth) and self-competence (sense of personal efficacy). Self-liking is an individual's judgment about themselves based upon how they feel others view them (cf. "looking glass self"; Cooley, 1902). People with high levels of self-liking tend to be self-accepting and feel comfortable in social settings. In contrast, people who have low levels of self-liking tend to be self-critical and have difficulty in social contexts. On the other hand, self-competence focuses on an individual's beliefs about their abilities to control and manipulate their environment. Thus, people who are high in self-competence tend to feel motivated and have a generalized expectancy for success. By contrast, individuals who are low in self-competence tend to have arrested motivation and low expectations for themselves.

Despite the distinction, self-liking and self-competence are thought to be highly related facets of global self-esteem. For example, it is not difficult to imagine that an individual who views herself as competent will elicit positive judgment from others. Likewise, it is probable that an individual who feels socially confident will feel more effective in social contexts. Because of the shared empirical relationship between these two facets of self-esteem, it is necessary to study the unique variance of each dimension by holding the other dimension constant (Tafarodi & Swann, 1995).

Which of the dimensions of self-esteem is more associated with change in bulimic symptoms over time? In the only study to look at this issue, Bardone, Perez, Abramson, and Joiner (2003) "dismantled" self-esteem to determine which of the two dimensions was most related to change in bulimic symptoms. They found self-competence to be more predictive than self-liking of bulimic symptom change over time. They proposed that women who had higher levels of self-competence would be more likely to take healthy measures to meet their weight goals because of a belief in their capability to change their weight. They suggested that self-liking was not as closely related to the development of future bulimic symptoms because it reflects an individual's current feelings of self-worth rather than her expectations about the future. For example, a woman may dislike herself currently (i.e., low self-liking) because she feels overweight, but if she believes she can lose weight (i.e., has high self-competence), then she may be more likely to utilize a healthy diet and exercise to achieve weight goals. In contrast, women who are low in self-competence may resort to the self-sabotaging behaviors of bulimia because of their disbelief in their ability to change their body weight. This explanation is consistent with the findings of Bardone, Abramson, Vohs, Heatherton, and Joiner (2003), who found that women with high levels of perfectionism, who perceived themselves as overweight, were particularly vulnerable to bulimic symptom development if they had low self-efficacy (cf. self-competence). In this connection, Heatherton and Baumeister's (1991) escape theory of binge eating and Bardone, Abramson, Vohs, Heatherton, and Joiner's (2004) expanded escape theory of binge eating predict that individuals with low expectations for themselves binge eat as a means of escaping distress about their inability to change for the better.

Do Bardone, Perez, et al.'s (2003) findings about the differential relations between dimensions of self-esteem and bulimic behavior apply to older women as well? Hay (1998) conducted an epidemiological study in a community-based Australian sample, and found that older women had higher rates of eating disorders than expected. In fact, purging was most common among women in the 35- to 44-year age range as compared to other age groups. She concluded that problematic eating disorder behaviors were more common in older women than expected, thus warranting further research attention. However, few studies on eating disorders in older women exist, likely due to the typical association of eating disorders with younger women (high school and college-aged), despite Hay's findings and despite evidence that bulimic symptoms remain fairly stable at least 10 years after women leave college (Joiner, Heatherton, & Keel, 1997). In addition, Cosford and Arnold (1992) conducted a review of case studies of women 50 years of age and older diagnosed with either bulimia or anorexia, and found symptom presentation to be akin to eating disorder symptoms in younger women. Also, studies have found that risk factors for eating disorders (e.g., concern about appearance, weight, eating, and body dissatisfaction) continue throughout the lifespan (Altabe & Thompson, 1993; Pliner, Chaiken, & Flett, 1990; Stevens & Tiggeman, 1998; Tiggeman & Stevens, 1999). One difference that may exist involving the variable of age in eating disorders is that traditionally studied college samples likely involve individuals who are experiencing their first onset of bulimic symptoms (American Psychiatric Association, 1994), while older women