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Psychological well-being and the body dissatisfaction–bulimic symptomatology relationship: An examination of moderators☆

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ABSTRACT

Research has examined psychological moderators of the body dissatisfaction–bulimic symptomatology relationship, but the focus has been on variables thought to worsen the relationship. In this study, we examined self-esteem, optimism, satisfaction with life, and self-determination as potential buffers. Participants were 847 female undergraduates. Using hierarchical multiple regression (HMR), we controlled for the influences of social desirability and body mass index on bulimic symptomomatology and then determined the main and interactive effects of body dissatisfaction and each moderator. Self-determination, optimism, self-esteem, and satisfaction with life all buffered the deleterious effects of body dissatisfaction, such that when levels of the moderators were high, the relationship between body dissatisfaction and bulimic symptomatology was weakest. Knowing what psychological variables moderate women's body dissatisfaction can assist psychologists and other health professionals in developing effective treatments for lessening disordered eating among women.

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1. Introduction

Etiological models of disordered eating and subsequent research have identified and established body dissatisfaction (a) as a risk factor for bulimic symptomatology and subclinical eating problems (e.g., Polivy & Herman, 2002; Stice, 2001; Striegel-Moore & Bulik, 2007), (b) as normative among girls and women (e.g., Mazzeo, 1999), and (c) to have markedly increased over the last 25 years (Feingold & Mazzella, 1998). Even so, the actual incidence of clinical, and to some extent subclinical, eating disorders remains relatively low (Striegel-Moore & Cachelin, 2001). This discrepancy begs the question of why relatively few women develop subclinical and clinical eating disorders when so many are body dissatisfied. Thus, it is important to consider the psychosocial factors that may exacerbate or may buffer the deleterious effects of body dissatisfaction. In other words, determining which psychosocial variables moderate the effects of body dissatisfaction is a necessary focus of future eating disorder research (Stice, 2002).

The question of moderation concerns identifying variables that may affect the direction and/or strength of a relationship (Baron & Kenny, 1986). Stice (2002) has argued that to fully understand the risk and maintenance factors of disordered eating, particularly bulimic symptomatology, moderators of established relationships must be examined. Recent research has investigated this issue (Bettendorf & Fischer, 2009; Brannan & Petrie, 2008; Tylka, 2004), hypothesizing that some variables may (a) strengthen relationships, such as when the body dissatisfaction–bulimic symptomatology relationship is increased in women who are high in body surveillance or neuroticism, or (b) weaken relationships, such as when body dissatisfied women with high self-esteem report fewer bulimic symptoms than those with low self-esteem.

Most studies, though, have focused on variables thought to worsen the body dissatisfaction–eating disorder relationship (Brannan & Petrie, 2008; Tylka, 2004). For example, Tylka (2004) demonstrated that body surveillance, neuroticism, or presence of a family member or friend with an eating disorder intensified the effects of body dissatisfaction on disordered eating (i.e., EAT-26 scores; Garner, Olmstead, Bohr, & Garfinkel, 1982) among female undergraduates. Brannan and Petrie (2008) reported similar effects with respect to neuroticism and body surveillance and also found that socially-prescribed perfectionism and an ego goal-orientation strengthened the relationship between body dissatisfaction and bulimic symptomatology, whereas self-oriented perfectionism did so only for anorexic symptomatology (i.e., EAT-26 scores). In one study that did examine potential buffers, Bettendorf and Fischer (2009) found that under conditions of high familism (i.e., when there is a strong, positive, supportive connection with family of origin), the relationships between acculturation and various indices of disordered eating (i.e., control concerns, restricted

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eating, and body dissatisfaction) were weakened in a sample of Mexican-American women. Although this study did not specifically examine the body dissatisfaction–bulimic symptomatology relationship, the findings support the idea that certain psychosocial variables may have protective effects with respect to eating disorder risk factors.

Because so few studies have investigated moderators of body dissatisfaction and because the majority of these studies have examined variables thought to exacerbate its effects, this study examined psychosocial variables that had the potential to buffer the negative effects of body dissatisfaction and thus reduce the level of bulimic symptomatology. Information from this study can inform the development of prevention programs, which focus on strengths and the development of positive characteristics to protect against psychological distress (Lent, 2004).

In Sections 1.1 through 1.4, we define four psychosocial variables that have the potential to moderate the body dissatisfaction–bulimic symptomatology relationship, and discuss the theoretical mechanisms for why such moderation might occur. We chose to examine bulimic symptomatology, as opposed to another index of disordered eating, for three reasons. First, research has confirmed that body dissatisfaction is direct precursor of bulimic symptomatology (e.g., Brannan & Petrie, 2008; Stice, 2002). In fact, in his meta-analysis of eating disorder risk factors, Stice noted that body dissatisfaction was a consistent and robust risk and maintenance factor of eating pathology, particularly for bulimic symptomatology. Second, in past moderator research, Brannan and Petrie found that body dissatisfaction accounted for 50% more variance in bulimic symptomatology than it did in anorexic symptomatology (i.e., EAT-26 scores), providing a greater opportunity for moderation (Frazier, Tix, & Barron, 2004). Thus, it made sense to examine the stronger of the two relationships, increasing the chances of identifying potential moderating effects. Third, bulimic symptomatology, as represented through a continuous measure such as the Bulimia Test – Revised (BULIT-R; Thelen, Mintz, & Vander Wal, 1996), allows for an examination of eating pathology along a continuum, which is important given the high level of subclinical problems that exist among female undergraduates (Cohen & Petrie, 2005). Further, past moderator research (Bettendorf & Fischer, 2009; Brannan & Petrie, 2008; Tylka, 2004), on which this study was based, has used similar continuous measures (e.g., BULIT-R) to represent their disordered eating variable.

1.1. Self-determination

According to self-determination theory (SDT; Deci & Ryan, 2000), there are three broad categories of motivation: intrinsic (i.e., innate tendency to seek challenge, explore, and master the environment in the absence of rewards or external constraints; Pelletier & Dion, 2007), extrinsic (i.e., behaviors that are engaged in as a means to an end and not for their own sake; Deci & Ryan, 2008), and amotivation (i.e., behaviors are though to be caused by external forces beyond ones control, resulting in feelings of incompetence and a lack of control; Deci & Ryan, 1985). These three categories can be viewed on a continuum, with amotivation on one end of the continuum (reflecting low self-determination), extrinsic motivation at an intermediate point along the continuum, and intrinsic motivation at the other end of the continuum (reflecting high self-determination).

Generally, self-determined forms of regulation (i.e., intrinsic motivation) are associated positively with enhanced learning, psychological well-being, increased life satisfaction, greater effort and persistence, and better physical health, whereas the less self-determined styles (i.e., extrinsic motivation, amotivation) are related negatively to these outcomes (Deci & Ryan, 1985). With respect to disordered eating, Pelletier, Dion, and Seguin-Levesque (2004) found that high self-determination was related to less internalization of the thin ideal and, subsequently, less body dissatisfaction. Further, Pelletier and Dion (2007) demonstrated that self-determination acted as a buffer against sociocultural pressures and messages of thinness. They argued that high levels of general self-determination would motivate women to behave in accordance with their own values rather than just responding to external forces, and thus be able to dismiss sociocultural messages about body image and not simply internalize them.

Consistent with SDT, the more self-determined women are, the less they should be affected negatively by body dissatisfaction and the less likely they should be to develop disordered eating. Although these women may be body-dissatisfied, as most women are, they would be expected to be able to dismiss their dissatisfaction as something that does not impede them from living in accordance with their values and reaching their goals. If so, we would hypothesize that women with high levels of self-determination would be less vulnerable to the effects of body dissatisfaction, and as a result, be less likely to experience bulimic symptomatology.

1.2. Optimism

Optimism has been defined as general positive expectancies that are relatively stable and promote psychological adjustment (Scheier & Carver, 1985). Optimism is thought to be associated with and lead to positive outcomes because of the use of more adaptive coping skills, whereas pessimism is associated with and may lead to negative outcomes as a result of relying on less adaptive means of coping (Scheier & Carver, 1985). Optimists have been shown to differ from pessimists in the stability of their coping (Carver, Scheier, & Weintraub, 1989), as well as in how they cope with serious disease (Friedman et al., 1992). Optimists also report fewer depressive symptoms than do pessimists (Scheier & Carver, 1992), and optimism has been shown to buffer the relationship between perceived stress and psychological well-being (Chang, 1998), lending support to its utility as a moderator.

Despite the positive relationships between optimism and different health outcomes, only a few studies have examined it in relationship to eating disorders. For example, Bulik, Wade, and Kendler (2001) found that monozygotic twins affected by bulimia nervosa displayed lower optimism, self-esteem, and less control over their lives than non-affected twins. In a study by Blaydon, Linder, and Kerr (2004), eating disordered and exercise dependent participants had lower optimism scores than non-eating disordered groups. These studies suggest that optimism is related to eating and exercise pathology and may play a role in their development or maintenance.

Optimistic women, who are body dissatisfied, may be able to look beyond the reality that their bodies do not match the ideal and instead may focus on other aspects of their lives such that they do not let their dissatisfaction define who they are. Furthermore, because of their positive expectations and use of more effective coping skills, these women would respond to it in a more positive and adaptive manner. For example, instead of taking drastic measures to alter their bodies to attain an unrealistic societal ideal, these women instead might focus on the pursuit of health, learning to eat and exercise in moderation and live a more balanced life. Thus, for optimistic women, we would expect that the relationship between body dissatisfaction and bulimic symptomatology to be attenuated.

1.3. Satisfaction with life

Diener (1984) referred to life satisfaction as a process of cognitive evaluation of one's life, whereas Shin and Johnson (1978) defined it as a “global assessment of a person's quality of life according to his (or her) chosen criteria” (p. 478). In nonclinical samples, decreases in life satisfaction have been related to maladaptive outcomes, such as

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