



A prospective study of adolescents' body dysmorphic symptoms: Peer victimization and the direct and protective roles of emotion regulation and mindfulness



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ABSTRACT

In this study, we examined whether peer appearance-related victimization was associated with adolescents' increasing body dysmorphic disorder (BDD) symptoms over 12 months. Also, given emotion regulation and mindfulness have been associated with less body dissatisfaction, we expected that they would protect against the negative impact of peer victimization on BDD symptoms. Participants were 367 Australian adolescents ($M_{\text{age}} = 13$ years). In multiple regressions, two aspects of emotion regulation, strategies and clarity, and two components of mindfulness, acting with awareness and being non-judgmental, were uniquely associated with fewer BDD symptoms at T2 relative to T1. There was evidence that one mindfulness component, observing, was a risk factor for more BDD symptoms. Further, acting with awareness and observing moderated the prospective relationship between victimization and BDD symptoms; low acting with awareness and high observing were risks for symptoms regardless of victimization, whereas high acting with awareness and low observing appeared protective of BDD symptoms, but only for adolescents who reported lower victimization.

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1. Introduction

Body dysmorphic disorder (BDD) is a debilitating mental health disorder, characterized by preoccupation with perceived flaws or defects in physical appearance (American Psychiatric Association, 2013). The preoccupation with physical appearance in BDD includes persistent thoughts about the perceived defect or defects, but also involves behaviors that can interfere with day-to-day living, such as frequent attempts to camouflage or hide perceived defects, a compulsion to check appearance, comparing personal appearance to others', and excessive reassurance seeking. Epidemiologic studies indicate the prevalence of BDD in the community is 1.7–2.4% (e.g., Buhlmann et al., 2010; Koran, Abujaoude, Large, & Serpe, 2008), with onset typically occurring during adolescence ($M_{\text{onset}} = 16$ years; Bjornsson et al., 2013). Symptoms of BDD are even more common, with one study finding that 9% of young Australian adolescents (ages 9–14 years) reported a symptom level that was close to the clinical cut-off for adults (Mastro, Zimmer-Gembeck, Webb, Farrell, & Waters, 2016). Further, in the absence of effective treatment, BDD tends to persist without remission

(Phillips, Menard, Quinn, Didie, & Stout, 2013). Given the debilitating nature of BDD, further developmental research into risk and protective factors for the early symptoms of the disorder is warranted.

1.1. BDD symptoms and peer victimization

Peers are a major socializing force for adolescents, and this socialization extends to influencing body image and other appearance-related beliefs and concerns (Webb & Zimmer-Gembeck, 2015; Webb et al., 2015). For example, in a meta-analysis of 51 effect sizes, a moderate effect size was found for the association between self-reported weight-related teasing and body dissatisfaction (0.39; Menzel et al., 2010). Extending such research to BDD symptoms, a handful of studies have also found that adverse early life social experiences predispose the development of BDD symptoms (Neziroglu, Khemlani-Patel, & Veale 2008). Indeed, studies indicate that when adults (Lavell, Farrell, & Zimmer-Gembeck, 2014) or adolescents (Webb et al., 2015) report more appearance-related victimization they concurrently report more BDD symptoms. When these same adolescents were followed over time, those who were rated by their peers as being more highly victimized were found to demonstrate greater increases in BDD symptoms over a 12-month period (Webb, Zimmer-Gembeck, & Mastro, 2016), and those who self-reported more appearance vic-

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timization exhibited a steeper increase in symptoms over the following 2.5 years (Zimmer-Gembeck, Webb, Farrell, & Waters, 2017). Moreover, compared to controls, adults diagnosed with BDD report significantly greater perceived appearance-related verbal victimization from their childhood and adolescence (Buhlmann, Cooke, Fama, & Wilhelm, 2007), and recall these experiences as more traumatic (Buhlmann et al., 2011). All of this research highlights that social adversity, most importantly appearance-focused victimization and more general victimization by peers, poses a risk for the development or exacerbation of BDD symptoms.

Yet, there has been no research on what might mitigate against the negative impact of victimization on BDD symptoms. Two such possible protectors are emotion regulation and mindfulness. Drawing from Relational Frame Theory (Hayes, 2004), mindfulness is theorized to convey psychological benefits by enabling ‘defusion’ or detachment from maladaptive cognitions, such as those symptomatic of BDD. Moreover, it is through enhanced executive functioning that mindfulness is thought to be linked to more adaptive regulation of emotions (Teper, Segal, & Inzlicht, 2013), which plays a vital role in overall functioning, given that our “emotions call forth a coordinated set of behavioral, experiential and physiological response tendencies that together influence how we respond to challenges and opportunities” (Gross, 2002, p. 281). Thus, BDD symptoms are expected to be more likely when individuals are less competent at emotion regulation and report less mindfulness. In addition, emotion regulation and mindfulness in adolescents should buffer against the negative effects of social adversity on BDD symptoms.

1.2. BDD symptoms, emotion regulation, and mindfulness

Regarding the associations of BDD symptoms with emotion regulation and mindfulness, research and clinical observations suggest individuals with BDD engage in maladaptive strategies related to the recognition and regulation of emotions (Callaghan et al., 2012; Wilson, Wilhelm, & Hartmann, 2014). For example, to cope with body image-related thoughts, individuals with BDD report more attempts to ‘fix’ their appearance, when compared to healthy controls (Hartmann et al., 2015) and psychiatric controls (Hrabosky et al., 2009). Individuals with BDD also report more avoidance of body image thoughts and emotions and less rational acceptance when compared to healthy controls (Hartmann et al., 2015), but not compared to psychiatric controls (Hrabosky et al., 2009). Such reduced use of adaptive strategies may also involve lowered capacity for mindfulness, defined as the ability to focus one’s attention on the present moment in a non-judgmental way (Kabat-Zinn, 1994).

1.2.1. Emotions and emotion regulation

Greater BDD symptoms have been found to be associated with a belief in the importance of controlling thoughts in university students (Lavell, Farrell, et al., 2014), and ineffective thought control strategies, such as worry and rumination, in clinical populations (Kollei, Brunhoeber, Rauh, de Zwann, & Martin, 2012; Neziroglu et al., 2008). Moreover, individuals with BDD, compared to healthy controls, have been shown to engage in attempts to avoid certain internal experiences, such as negative or distressing thoughts, emotions, and memories (Callaghan et al., 2012; Wilson et al., 2014); a process known as *experiential avoidance* in Acceptance and Commitment Therapy (ACT; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Experiential avoidance and thought control strategies (e.g., thought suppression) are known to be maladaptive, as researchers have demonstrated they tend to have paradoxical effects, whereby the frequency of the thought in fact increases with attempts to suppress it (for a review see Kashdan, Barrios, Forsyth, & Steger, 2006).

There is also preliminary evidence to suggest that the ability to regulate emotions may be associated with BDD. More adaptive emotion regulation has been found to be associated with lower body dissatisfaction among adolescents (Hughes & Gullone, 2011) and college men (Lavender & Anderson, 2010). Greater difficulty with emotion regulation, particularly lacking access to effective emotion regulation strategies, has been found to be associated with greater BDD symptoms among university students (Miyamoto, Farrell, Lavell, & Zimmer-Gembeck, 2016). Moreover, individuals with BDD, when compared to controls, are less accurate in correctly identifying others’ emotional expressions (Buhlmann, Etcoff, & Wilhelm, 2006). Taken together, this research indicates BDD symptoms, even in adolescence, may be associated with deficits in the ability to recognize emotions, and a lack of effective coping strategies for dealing with negative emotions.

1.2.2. Mindfulness

Recent years have witnessed a rise in research and clinical interest in the value of mindfulness for supporting psychological well-being (e.g., Bränström, Duncan, & Moskowitz, 2011). Although there has been no research, to our knowledge, into the role of mindfulness in BDD symptoms specifically, individuals who score higher on measures of mindfulness report less body image disturbance, such as eating disorders (Cowardley & Park, 2012) and bulimic symptoms (Lavender, Jardin, & Anderson, 2009). Further, the association between trait mindfulness and body satisfaction has been investigated. For example, in a Dutch study of 1287 adult females, those higher in mindfulness reported less body comparison (i.e., comparing aspects of one’s appearance to others), and higher body satisfaction (Dijkstra & Barelids, 2011). Similarly, among 296 undergraduate males, those who reported more mindfulness reported more body satisfaction, and scored lower on a measure of drive for muscularity (i.e., the pursuit of a muscular body; Lavender, Gratz, & Anderson, 2012). Thus, individuals who report higher levels of trait mindfulness may be less likely to experience body image concerns, including certain behaviors known to be associated with BDD, such as body image comparisons.

Given evidence of selective attention among individuals with BDD (Greenberg et al., 2014; Grochowski, Kliem, & Heinrichs, 2012), treatment programs tend to incorporate modules for attention retraining and/or mindfulness, whereby the treatment is designed to help with learning about how to describe appearance in a holistic way during mirror exposure or how refocus attention to the external environment, rather than internal processes or perceived appearance flaws (Veale & Neziroglu, 2010; Wilhelm, Phillips, & Steketee, 2013). Current treatments for BDD also provide alternatives to maladaptive regulation strategies, such as rumination, suppression of emotions or thoughts, avoidance, compulsive behaviors, and safety-seeking behaviors. Alternative strategies include labelling intrusive and self-critical thoughts, detached mindfulness, cognitive restructuring, and exposure with response prevention. These strategies are thought to facilitate emotional awareness, and increase the ability to tolerate, rather than avoid, uncomfortable emotions (Veale & Neziroglu, 2010; Wilhelm et al., 2013). Therefore, existing clinical work suggests mindfulness and emotion regulation might serve important functions and need to be addressed in order to improve BDD symptoms and alleviate the disorder. However, despite the focus in BDD treatment, we are not aware of any research on the association of mindfulness with BDD symptoms.

1.3. Emotion regulation and mindfulness as buffers

Peer victimization has often been linked to a higher level of psychopathology symptoms in youth (see Reijntjes, Kamphuis, Prinzie, & Telch, 2010 for a review). Yet, some factors may exacerbate

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