



Emotion regulation moderates relationships between body image concerns and psychological symptomatology

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ABSTRACT

The study investigated the moderating role of emotion regulation (ER) in relationships between body image concerns and psychological symptomatology. A community sample of 533 boys and girls (11–20 years) completed measures assessing body image thoughts and feelings, domain-specific and general ER strategies, drive for thinness, and bulimic, depressive and anxiety symptoms. Results indicated that ER moderated relationships between body image concerns and both bulimic and depressive symptoms, but not relationships between body image concerns and drive for thinness or anxiety symptoms. Adolescents who reported frequent body image concerns were more likely to have higher levels of bulimic symptoms if they tended to use avoidance and internal dysfunctional ER strategies. Furthermore, adolescents who reported frequent body image concerns were more likely to have higher levels of depressive symptoms if they used positive rational acceptance and internal functional strategies infrequently. Implications of the findings for prevention and intervention are discussed.

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Introduction

In today's body-conscious culture, adolescents frequently encounter situations and messages which may evoke body image concerns (Dittmar, Halliwell, Banerjee, Gardarsdottir, & Jankovic, 2007). Around 30–50% of girls in developed countries are dissatisfied with their weight and appearance (Thompson, 2001), and increasing numbers of boys are also dissatisfied with their appearance (O'Dea & Yager, 2006). There is growing evidence that such concerns contribute to pervasive body image disturbances and disordered eating (Cash, Phillips, Santos, & Hrabosky, 2004; Verplanken & Velsvik, 2008) and may be associated with other mental health problems such as depression and anxiety (Cash et al., 2004; Kostanski & Gullone, 1998). Body image concerns can cause significant distress for individuals and impact negatively on quality of life, interpersonal relationships and academic/vocational functioning (Cash & Fleming, 2002). Nevertheless, despite many adolescents experiencing body image concerns, only a portion exhibits mental health problems (Cash, 2002a). Therefore, it seems that for many adolescents, body image concerns may be benign or transient experiences which are of little clinical or long-term consequence. Such differences are likely due to individual varia-

tions in important risk and protective factors; that is, factors which increase or decrease the likelihood that body image concerns will lead to mental health problems. One factor known to be of importance for mental health but which has received little attention in relation to body image is emotion regulation.

Emotion regulation (ER) refers to the processes by which emotional experiences are evaluated, monitored, maintained, and modified (Thompson, 1994). To a large extent, it determines the emotions we experience, as well as when and how we experience and express them (Gross, 1998). ER difficulties have been implicated in the majority of psychological disorders (Gross & Levenson, 1997). As such, ER is moving to the forefront of investigations aimed at understanding the risk and protective factors associated with trajectories of mental health and illness, including depression, anxiety, and behavior problems amongst others (Amstadter, 2008; Durbin & Shafir, 2008).

Research suggests that poorly developed ER competencies and the use of strategies that prolong or magnify negative affect pose significant risk for the development and maintenance of mental illness. For example, greater use of emotion suppression, self-blame, rumination and catastrophizing, and less use of cognitive reappraisal and refocusing have been associated with higher levels of depression and anxiety and greater peer problems in adolescents (Betts, Gullone, & Allen, 2009; d'Acremont & Van der Linden, 2007; Hughes, Gullone, Dudley, & Tongue, 2010; Phillips & Power, 2007). There is also some existing research linking difficulties in emotional functioning to disordered eating. For example, anorexia nervosa,

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bulimia nervosa, and binge eating disorder have been variously related to elevated negative affect, alexithymia, suppressed emotion, and poor emotional awareness (Cochrane, Brewerton, Wilson, & Hodges, 1993; Geller, Cockell, Hewitt, Goldner, & Flett, 2000; Legenbauer, Vocks, & Rüdell, 2008; Markey & Vander Wal, 2007).

Studies investigating associations between ER and body image concerns, however, are scarce. In one related exception, strategies used to cope with body image threats were reported to be associated with psychosocial functioning (Cash, Santos, & Williams, 2005). Specifically, greater use of appearance fixing and avoidance strategies, and less use of positive acceptance strategies were associated with greater body dissatisfaction and eating disorder symptoms as well as lower self-esteem and social support.

Given the demonstrated links between ER and mental health and illness as reported in past research, it is proposed that ER may moderate relationships between body image concerns and adolescent mental health. Specifically, it is posited that adolescents who are able to effectively regulate their emotions are less likely to experience mental health problems related to body image concerns. In contrast, adolescents who have a more dysfunctional regulatory style are posited to be at increased risk of mental health problems. It is noteworthy that no studies could be found which have examined the potential moderating role of ER in the relationship between body image concerns and adolescent mental health. Furthermore, studies of body image concerns have typically focused on outcomes such as body image distortion and disordered eating to the neglect of other known correlates of body image concerns such as depression and anxiety (Cash et al., 2004; Kostanski & Gullone, 1998).

The current study therefore aimed to examine the moderating role of ER in relationships between body image concerns and eating disorder, depressive, and anxiety symptoms in a community sample of adolescents. Adolescence was the focus of the research given that this is a period characterized by heightened body image concerns (Levine & Smolak, 2002). It was hypothesized that: (i) body image concerns (i.e., negative emotions and cognitions about one's appearance) would be associated with eating disorder, depressive, and anxiety symptoms, and (ii) emotion regulation would moderate these relationships. Specifically, body image concerns were expected to be more strongly related to mental health problems for adolescents who more frequently utilized dysfunctional ER strategies and less frequently utilized functional ER strategies.

Thompson (1994) has argued that the context and the goals of the individual are important considerations in determining the functionality of ER. This suggests that the ER strategies a person utilizes in one situation may not be appropriate in another situation. Therefore, two types of ER strategies were examined in the current study based on domain specificity. Domain-specific ER strategies were those that adolescents used when faced with body image threats and challenges. They included appearance fixing, avoidance, and positive rational acceptance (Cash et al., 2005). General ER strategies were those that adolescents used to manage emotions generally and were not necessarily specific to body image concerns (Phillips & Power, 2007). It was expected that domain-specific strategies would be more salient in moderating relationships between body image concerns and symptomatology as indicated by larger moderation effects and/or a larger proportion of significant effects.

Method

Participants and Procedure

The study took place in Melbourne, Australia, and was approved by the institutional ethics committee. Participants were drawn

from a longitudinal study of emotional development for which two cohorts of 9- to 15-year-olds had been recruited from metropolitan primary and secondary schools, one cohort at Wave 1 and another at Wave 4 (Gullone, Hughes, King, & Tonge, 2010). At Wave 6, all participants who, at the time of consenting to the longitudinal study, agreed to be contacted about extensions to the main study were sent a questionnaire to be completed at home and returned by post ($n = 619/764$; 81%). A total of 534 questionnaires were returned (86%). One case was excluded due to missing data. The final sample for analysis therefore comprised 533 adolescents (M age = 15.6 years, $SD = 2.5$; range 11–20) of which 208 (39%) were male and 453 (85%) were born in Australia. To reduce outliers, body mass index (BMI) was standardized within the sample, and scores greater than 3.29 were recoded to the next most extreme value ($n = 7$). Following this, mean BMI for the sample was 21.3 kg/m² ($SD = 4.2$). Seventy-five percent had a normal BMI (5th–85th percentile), 6% were underweight (<5th percentile), and 19% were overweight or obese (>85th percentile). Forty-one participants did not state either or both their height and weight.

Measures

Body image concerns. Body image concerns were assessed using the Situational Inventory of Body Image Dysphoria (SIBID; Cash, 2002b) and Body Image Thoughts Inventory (BITI; Hughes & Gullone, 2010). The SIBID assesses the frequency of negative feelings about one's body and appearance in 48 situations on a 5-point scale (0 = *never*, 5 = *(almost) always*). For example, "When looking at myself in the mirror" and "When I am with people who are talking about weight or dieting". The SIBID has been reported to have high internal consistency ($\alpha = .96$) and 4-week test-retest reliability ($\alpha = .80-.86$), and to correlate well with other measures of body image evaluation (Cash, 2002b). In the current study, the internal consistency coefficient (Cronbach's alpha) of the SIBID was .98. The BITI is a 26-item measure assessing the frequency of positive and negative thoughts about one's body and appearance (e.g., "I don't look good enough") on a 5-point scale (1 = *never*, 5 = *very often*). Only the Negative Thoughts scale was used in the current study. This scale has been found to have high internal consistency ($\alpha = .97$), good 4-week test-retest reliability ($r = .87$) and sound construct validity (Hughes & Gullone, 2010). In the current study, the internal consistency coefficient was .97. A single Body Image Concerns composite score was calculated by averaging the absolute standardized scores of the SIBID and BITI.

Emotion regulation. Domain-specific ER strategies were assessed using the 29-item self-reported Body Image Coping Strategies Inventory (BICSI; Cash et al., 2005). The BICSI assesses respondents' use of three strategies for coping with body image threats and challenges: Appearance Fixing (10 items; e.g., "I do something to try to look more attractive"), Avoidance (8 items; e.g., "I try to ignore the situation and my feelings"), and Positive Rational Acceptance (11 items; e.g., "I tell myself that there are more important things than what I look like"). Items are rated on a 5-point scale (0 = *definitely not like me*, 4 = *definitely like me*). The BICSI has been reported to have good internal consistency ($\alpha = .74-.90$) and 2-week test-retest reliability ($r = .66-.86$) as well as sound factor structure and construct validity (Cash & Grasso, 2005; Cash et al., 2005). In the current study, the internal consistency coefficients ranged from .79 (Positive Rational Acceptance) to .90 (Appearance Fixing).

General ER strategies were assessed using the Regulation of Emotion Scale (REQ; Phillips & Power, 2007). The REQ assesses respondents' use of Internal/External Functional/Dysfunctional strategies. Internal Dysfunctional strategies include punishment, rumination, negative social comparison, suppression, and de-

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