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Review Article

Body Dissatisfaction during Adolescence as Part of a Normal Developmental Process: Logic in the Folly of Body Image

Moria Golan[1,2]*

[1]*Department of Nutritional Sciences, Tel-Hai College, Upper Galilee, Israel*

[2]*Shahaf, Community Based Facility for Body Image and Eating Disorders, Ganey Hadar, Israel*

***Corresponding Author:** Moria Golan, Department of Nutritional Sciences, Tel-Hai College, Upper Galilee and Shahaf, Community Based Facility for Body Image and Eating Disorders, Ganey Hadar, Israel.

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Abstract

Negative body image is a prevalent problem for many people and can also figure in many serious disorders. The following personal perspective challenges the current body cult's supervision, characterized by dramatization and unproportional perception and response, from the environment, to adolescents' body dissatisfaction.

Storm and disharmony characterize adolescence, even in normal situations. Thus, body dissatisfaction may be viewed as part of a normal developmental phase during adolescence, given the time needed to adjust to physical changes and its role as transformational object, a non-common perspective. Any unproportional attention given may contribute to it becoming a health problem. Negative body image may be the result of poor emotion regulation, impaired coping skills, and developmental delays, which can be addressed through adequate prevention and treatment programs, such as considering early maladaptive schemas, compassion, and addressing the disparity between physical and emotional development. Environmental efforts to minimize negative body image may encourage self-talk about the normality of body dissatisfaction to a certain extent, as well as efforts to moderate imperfections. By avoiding excessive environmental preoccupation with body dissatisfaction, and expression of panic or other unregulated response, such phenomena may stay just a transitional developmental phase.

Keywords: *Body Cult; Body Dissatisfaction; Adolescence; Transformational Object; Prevention*

Introduction

Body image has long been thought to be important for individual development and quality of life, although it is said to represent only one aspect of self-conceptualization [1]. Storm and disharmony characterize adolescence, even in normal situations. Body image dissatisfaction is so common that, to borrow Shakespeare's idiom, "Though this be madness, yet there is a method in it". Some even refer to it as normal dissatisfaction [2].

The suggested personal perspective is that body dissatisfaction during adolescence is a normal developmental phase that is part of growing up, similarly to dissatisfaction with one's parents, a common step toward becoming a mature, independent, realistic, and well-adjusted person.

Dissatisfaction and opposition as mechanisms for growth

Adolescence is manifested by hormonal changes of puberty, biological sexual maturity, and enhanced cognitive capacity, coupled with disillusionment one's surroundings and with oneself. Before its onset, adolescents describe their relationship with the body as "just a body, part of me-nothing more"-the epitomes of innocence. Self-awareness brings with it an introspective view and dissatisfaction with one's changing body-due, above all, to the time needed to adapt to one's new size. I remember when we moved to a new house, that we had built, as a young family. In the first few months, we felt as though we were living in a hotel-times was a sense of alienation. The same is true with the body. When one's body changes, one may initially feel as though one has lost the familiar "home". Overcoming this loss and accepting the "new home" is part of gaining a sense of a changed/grown-up self. As Bion suggested, the disruption of a long-entrenched reality involves a constant inner struggle between the need to stick to the familiar, and the urge to push for change and development [3].

Differentiating between the physical and the mental, and between the inner self and exterior self-world, is part of our everyday experience. However, Winnicott suggests viewing the body as the innate foundation of the self, rather than as something distinct and separate that co-exists and functions with the self in symbiotic partnership.

In times of emotional turmoil or "peril," such as "losing my familiar body makeup," it is a challenge to maintain self-coherence, a sense of self-control, and a sense of self-agency. In such circumstances, the mind of those with maladaptive defense mechanisms may respond not only by separating the body from the self, but also by turning the future into past danger. Many adolescents cannot cope with the unexpected aspects of their physical growth, or its attendant emotions. Adolescents who are fixed in their beliefs about themselves and their abilities and are less inclined to seek solutions to their problems are at greater risk of developing mental health problems. Indeed, many health-related behaviors that emerge during adolescence may result from the failure of a maladaptive coping mechanism to adapt to the new biological changes and demands, that often are experienced as frightening [4].

Fuchs [5] has suggested that the fundamental alienation of the self from the body in anorexia nervosa results from a conflict of embodiment that arises in adolescence, whereby the body becomes the object of other people's particular gaze. Starting with an attempt to comply with the ideal body image, the anorexic patient increasingly fights her dependency on her body and its uncontrollable nature-above all its hunger and femininity. Gaining total control over her body and becoming independent of it, becomes a narcissistic triumph. The experience of power (albeit only over one's body) enhances one's self-esteem, and one's body image [6,7]. The development of self-esteem and experience of power often goes through periods of false self, and denial of difficulties. Denying the fact that many aspects of the body (or of life) cannot be changed is part of a person's normal development, undermining enhanced self-worth during adolescence. Facing reality; accepting real facts; gradually developing a sense of self-agency and partial control over the external (people) and the internal world (feelings); and permitting oneself to be authentic (rather than false) all enable the growth of a realistic perception of one's capacity to influence "others and things," and the development of self-respect and a positive attitude toward one's body and self. It is also thought to be a protective factor against mental health issues, such as depressive and anxiety symptoms [8].

A sense of belonging and acceptance also mediate levels of self-esteem [9]. A sense of belonging spurs comparisons with peers, as well as an examination of attributes that enhance one's acceptance and popularity. For adolescents, the most readily available way to "upgrade" oneself is through one's appearance.

Any deviation from the conventional norm-or the norm of one's peers-as well as disparities between physical, cognitive, social, and emotional growth, are associated with vulnerability to mood swings and self-regulation problems, that may be transient, or persistent. The latter case may be a result of heightened individual vulnerability, personal attributes (such as attachment style, self-regulation, coping skills, or upbringing), or greater difficulty in progressing through the various stages of puberty.

Negative body image issues often stem from past teasing experiences or negative comments from peers and family members, which may suppress acceptance of one's appearance and body [10]. In their fear of being rejected, adolescents who feel that they are "not good enough" are prone to false-self behavior, imitating risky behaviors, or fixating on an ideal body image in an effort to secure what they perceive to be their peers' appreciation, in a maladaptive social process that replaces the normal developmental process.

Body image as a transformational object; attachment and self-regulation theories

In line with Bollas's view [11], body image might be viewed as a transformational object. Bollas coined that term in reference to the early mother: A transformational object is experientially identified by the infant with processes that alter self-experience [...] by putting the first object as a recurrent experience of being. As the mother helps to integrate the infant's being (instinctual, cognitive, affective, environmental), the rhythms of this process-from disintegration(s) to integration(s)-inform the nature of this 'object' relation rather than the qualities of the object as an object. Thus, in adult life, the quest is not to possess the object, it emerges not from desire, but from a perceptual identification of the object with its function: the object as the enviro-somatic transformer of the subject, which alters the subject's external environment and hence change the internal mood. In finding something in the future to transform the present, it is an object-seeking that recurrently enacts a pre-verbal ego memory [emphasis mine/ in the original].

Subsequently, the transformational process shifts from the mother/environment into countless subjective objects or symbolic equations. By the same token, the relationship with one's body may be viewed as a transformational object, and we may invest in our body or appearance, to change our environment (our new size or build, or negative feelings associated with things that are undesirable, unexpected, or unchangeable because of unrealistic objectives and/or impaired judgment). Frequently, the person's weaknesses are projected onto the body and people try to "fix" the body instead of "fixing" their unrealistic objectives or weaknesses. When adolescents fail to have an integrated self and there is a split between their qualities and disadvantages, the split may be projected onto the body and a sense of alienation from the body may be felt. The most difficult challenge for the growing adolescent is knowing how to embrace the stirrings of one's sexuality.

Kohut believed individuals need people who make them feel calm and comfortable. They idealized the external Other as someone calm and reassuring when they cannot be so, for themselves. Adolescents who have internalized the self-object functions usually maintain self-coherence through periods of crises or changes [12]. Internalizing the experienced security in a relationship allows one to build an inner refuge for themselves. Insecure attachment (avoidance and ambivalence) sparks the development of a "false bodily self" [13]. People who have impaired self-object functioning may project the "idealized parent" onto their body and expect the body to provide self-object functions as an internalized substitute. A secure attachment relationship fosters lower levels of anxiety about one's weight and fewer dysfunctional behaviors, such as restricting eating and dieting. Anxious people, who fail to cope with emotional difficulties, or people who count on external influences rather on themselves, may be driven to disembodiment-namely, the adoption of an observer's perspective of one's body as an "object for others"-as an avoidance strategy in situations of discomfort, when others can observe their body [14]. Thus, disembodiment-or fear of environmental "eyes"-may account for part of the disparity between the physical and the emotional development phase, as well as the unresolved disparity between one's ideal and one's current appearance. This disparity grows after one internalizes socio-cultural ideals and develops the tendency to self-monitor the body and to observe it from a third-person perspective-which also heightens shame, when comparing oneself to others and finding oneself falling short [15].

Relationships of attachment and subsequent models (attachment patterns) are the primary and central basis for the development and integration of the physical and mental self. Children who are classified as anxious (ambivalent or avoidant) often have mothers who exhibit difficulty and resistance to establishing close physical contact [16]. Attachment relationships concerning the development of body image develop through the mechanisms of reflection, sensitive responses to the child's signals, and synchronous relationships [16]. The

emotional deficiencies or losses (loss of a loved one, loss of identity, meaning, or hope-real or symbolic (which cannot be mourned) and traumas (which cannot be represented)-appear to be key to understanding the body's problematization as presented in eating disorders, or body dysmorphic syndrome, for example [13]. Stern [17] suggested that when a child has sufficient intersubjective experiences, they are able in times of stress to connect to other people in a meaningful way and to reassure themselves. According to Kohut, in the absence of an empathetic environment, a coherent self and disintegration can trigger pathology in the self. A weakened self will find it difficult to experience healthy arousal in adolescent sexuality. However, the development of dissatisfaction with the body is part of the de-idealization process of object ability and encourages adolescents to be self-reliant. Viewing the body as an organ that provides "optimal frustration"-as part of the growth-producing process and individual developmental tasks-may help in relieving body dissatisfaction and highlighting self-regulation skills, as well as growth and separation from the idealized objects. Yet many will still be tempted to indulge in Western society's emphasis on physical attractiveness, a slim build, and a perfect and ideal appearance, in a bid to overcontrol the body and lessen the sense of physical and emotional instability.

Early maladaptive schemas and body dissatisfaction

Schema therapy was originally developed to expand on traditional CBT endeavors to address developmental processes and dimensions-such as temperament, attachment, impaired regulation, and more [18]. Schemas are fundamental structures that form how individuals' experiences are interpreted, selected and evaluated. Like a lens, it affects people's perceptions of the world, themselves, and others. Early maladaptive schemas (EMS) are a factor of vulnerability to disturbances and psychological and personality disorders. Negative self-schemas are dysfunctional, self-harming emotional and cognitive patterns, which emerge during childhood, develop over one's lifetime, and affect one's interpretation of experiences and relationships. Young lists eighteen maladaptive schemas, which he groups into five basic maladaptive schema domains: Disconnection and Rejection; Impaired Autonomy Performance; Impaired Limits; Other-directedness (subjugation, self-sacrifice, approval seeking); and Over-Vigilance and Inhibition (negativity/pessimism, emotional inhibition, punitiveness, and more). These maladaptive schemas result from dissatisfaction with the basic emotional needs of childhood and give rise to patterns of emotional and cognitive self-harm [19]. Research has found significant associations between EMS and eating disorders research. [18], as well as mediations of the relationship between body dissatisfaction and sociocultural pressures of attractiveness [20]. Niforooshan., *et al.* [21] examined the early maladaptive schemas and general health among people seeking cosmetic surgery. Participants comprised two groups of 60 (120 individuals in total) who were either applicants for cosmetic surgery or non-applicants selected through convenience sampling. In that study, data was collected using the Maladaptive Schemas Questionnaire (SF-YSQ) and General Health questionnaires (GHQ - 28). It found a significant difference between applicants and non-applicants of cosmetic surgery regarding early maladaptive schemas ($p = 0.02$, $F = 3.34$) in terms of four out of the five domains schemas: Disconnection/Rejection ($p = 0.002$, $F = 12.19$), Autonomy ($p = 0.001$, $F = 15.14$), Impaired Limits ($p = 0.016$, $F = 6.55$), and Other-Directedness ($p = 0.003$, $F = 10.79$).

Ali Abedi [2] studied 334 students (159 boys and 175 girls) selected through cluster sampling among students attending universities in Arak, Iran. EMS and body image disturbance were measured by the Young Early Maladaptive Schemes Questionnaire and Body Image Concerns Inventory, respectively. Two of the five domains of the EMSs were found to be associated with body dissatisfaction. The first domain is Impaired Autonomy and Performance: people with these early maladaptive schemas may experience dependency or incompetence, vulnerability to harm or illness, undeveloped self, or enmeshment and failure. The second domain is Impaired Limits. People with these early maladaptive schemas may experience entitlement and grandiosity, insufficient self-control, or self-discipline.

Pauwels., *et al*. [22] studied the EMS among 348 female patients (Mage = 29.95; SDage = 8.40) who completed the Young Schema Questionnaire and were diagnosed with restrictive or bulimic eating disorders or substance-use disorders [22]. The authors found that ED patients scored significantly higher on unrelenting standards, defectiveness, social undesirability, and failure (schemas in the Impaired Autonomy and Performance domain) than patients with substance-use disorders. Bulimic and substance-use disorder patients scored significantly higher on insufficient self-control (Impaired Limits domain) than restrictive patients.

Coping with imperfection and compassion

Many people-those with eating disorders who acknowledge having a problem with their body image-talk about it in terms of "taking it out of the closet," and often are terrified by the idea of having it treated. They appear to be ashamed of their body dissatisfaction- perhaps because they suspect that body satisfaction is unattainable while fearing letting go of the mindset of being physically flawed. Some girls admitted that if they get rid of their body hostility, they may have to come to terms with their imperfections and the self-hostility that may arise from their high aspirations. In that regard, their criticism of themselves is focused on their body image.

Schemas act as a filter in the process of attention, processing, and action, and are the main and undisputed interpreters and decision-makers of mental structure. Although negative schemas are a natural part of adolescence rather than early maladaptive phenomena, they should be targeted in CBT, as they may also play a significant part in body dissatisfaction. For example, the tendency of adolescents to go to extremes or to view things in absolute terms can be fundamental to the formation of body dissatisfaction. Thus, coping with black-and-white thinking and imperfections, for example, is key to maintaining a healthy body image. These two thinking patterns far exceed the "normal" body dissatisfaction associated with periods of physical and/or unexpected changes. Often people with eating disorders express a sense of being defeated-or even worthless-when their body build or weight is not exactly as they would like, or had imagined, or had set as a goal, based on an idealized body image, or social comparisons. A compassionate look at body dissatisfaction may foster a non-judgmental understanding of its sufferers' distress and their viewing of suffering as a part of being a natural part of a shared human experience [23]. Self-compassion has emerged as a protective factor against body shame and disembodiment and is one of the most effective intervention techniques used in this field to reduce BID [24]. Treating body dissatisfaction as a normal phenomenon, that is typical of a particular period in life, while enhancing one's body appreciation, may enhance body acceptance and positive embodiment-as opposed to stressing body dissatisfaction, which leads to an over-dramatized response to it.

Conclusion

The twentieth-century French philosopher Maurice Merleau-Ponty noted that the body is our general medium for experiencing the world. Since negative body image is a prevalent problem for many people and can also figure in many serious disorders, it is critical to develop positive coping strategies with it and to change one's internal self-talk to maintain a positive and healthy view of self.

The body mediates the subject's engagement and interaction with the environment. The polarity of lived body (body-as-subject) and physical body (body-as-object) arises when our awareness of the body is disrupted-through a sense of clumsiness, in times of change, growth, and developing sexuality during adolescence, or in times of significant injury. Shame and guilt, which are reflexive emotions, are intricately linked to the development of self-consciousness and intersubjectivity [25]. Wishes to "fix" our weaknesses may be projected onto the body and instead of facing the fact that we have self-weaknesses, many try to "fix" the body. Through other people's gaze or one's image in the mirror, one may view one's body as an entity distinct from oneself. A woman who pursues a certain diet to achieve an image of beauty that is valued in her surroundings is a different dynamic from someone with an eating disorder because of severe alienation of their self from their body, which they increasingly experience as an external, alien object that is subjected to an authoritarian regime, and thus a threat to their autonomy, and even identity [5]. Nevertheless, the drive for thinness in most adolescents does not result in happiness. Only integration between the "black and white" thinking and development of a complex view of the self-integration between strength and weaknesses as well as a sense of uniqueness and significance through contribution to the environment, may yield a happier adolescent.

To improve people's ability to cope with a changing body in various circumstances, prevention programs and treatment efforts should address several issues that are not related to body weight.

One such issue is the effect of comparison-which should be minimized. Specifically, the disparity between one's physical and emotional development phase should be reduced, to mitigate the anxiety about how others view oneself; to encourage the development of self-regulation skills to reduce inner negative feelings, to come to terms with one's changing size, body build or undesirable self-perception, and conversely to develop realistic objectives and judgment; to challenge maladaptive cognitive schemas; to enhance emotional chats and dialogs with one's parents to overcome the normal embarrassment accompanying the emergence of sexuality, and above all, not to blow body dissatisfaction out of proportion. Without the excessive environmental preoccupation with body dissatisfaction, and a more moderated response, it may stay just a transitional development phase and minimize adolescent preoccupation with the body cult that underpins eating disorders.

Ethic Approval Statement

The author is the only contributor to this paper. No ethical approval is relevant to this short communication.

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