

**Social Representation of Body in Individuals with Body Dysmorphic Disorder-Like  
Symptoms: The Effects of Social Media and Social Groups**

by

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## **Thesis Format and Contribution of Co-Authors**

My dissertation adheres to an article-based format. It comprises five chapters. The first chapter including theories and literature underlying social representation, Body Dysmorphic Disorder (BDD) and body, the second chapter deliver Article 1 (Phase 1 of the thesis: The Prevalence of BDD Among Young People in Canada: The Social Representation of Body in Individuals with and without Symptoms of Body Dysmorphic Disorder Like Symptoms). Article 2 (Phase 2 of the thesis: The role of Social Media, Peers, and Family in Shaping Social Representation of Body Among Canadian Youth) is presented in chapter 3. Chapter 4 provide article 3 that demonstrate Transforming Social Representations of Body Dysmorphic Disorder (BDD) into Social Work Practice: Implications for Intervention and Professional Development implications for social work practice and social intervention. Finally, chapter 5 offer a General Discussion and conclusion. The three articles, presented in Chapters 2, 3 and 4. Each article contributes a notable facet to the research on social representations of body among youth in Canada, particularly those with Body Dysmorphic Disorder (BDD)-like symptoms.

As the principal investigator, I designed the study framework, developed all data collection instruments, conducted verbal association tasks, and facilitated interviews with voluntary participants. I also analyzed data for each phase of the study and authored the first draft of each article.

My supervisor, Dr. Lilian Negura, thoughtfully reviewed whole my dissertations, provided insightful feedback step by step across all the chapters, conceptual structure and theoretical implementations which helped more improved and developed the dissertation.

## Abstract

**Background:** Body concerns are prevalent among Canadian youth, considering social media, peers, and family playing a significant role in shaping these representations. This study investigates the social representations of body among youth with and without Body Dysmorphic Disorder (BDD)-like symptoms. By using Social Representation Theory, the study investigates how sociocultural factors contribute to body concerns and explores the differences in how these factors influence individuals with various levels of BDD-like symptoms.

**Method:** A mixed-method approach was utilized, including two phases. Phase 1 employed a mixed-methods approach, combining quantitative and qualitative analyses to assess the prevalence of BDD-like symptoms across socio-demographic factors and to investigate the social representations of the body. To assess associations between BDD symptoms and demographic variables, chi-square tests and logistic regression were used, while verbal association tasks, frequency-rank analysis was performed to examine the central and peripheral elements of body representations. In phase 2, semi-structured interviews have been conducted to compare the social representation of body between participants with and without BDD-like symptoms. In the qualitative section, thematic analyses were performed to investigate the meanings behind the units that form the social representations of the body, with word clouds visualizing how these representations were anchored. In the quantitative analysis, chi-square tests examined the associations between BDD-like symptoms and theme sub-categories. SRT concepts such as anchoring and objectification were used to analyze the data.

**Results:** Results from article 1 showed significant differences in SR structures between the two groups. Participants with BDD-like symptoms exhibited a more appearance-focused and negative view of body, while those without BDD-like symptoms demonstrated a broader, more positive perspective. In article 2, qualitative findings revealed that individuals with BDD-like symptoms were more influenced by external factors, such as social media, family, and peers, while those without BDD-like symptoms attributed their representation of body to internal factors, including cultural values and personal thought processes. These results indicate that individuals with BDD-like symptoms are more susceptible to societal pressures regarding appearance, which play a critical role in shaping their representation of body. Social media, peers, and family were found to be key contributors to these representations, with social media having the strongest impact on participants with BDD-like symptoms. In article 3, the outcomes extend these insights by exploring the implications of SRT for social work practice. Social work interventions that emphasized media literacy, body positivity, and community support were identified as critical for transforming negative representations into adaptive, health-oriented frameworks. These findings highlight the transformative potential of integrating SRT into social work interventions to address body dissatisfaction and BDD-like symptoms among youth.

**Conclusion:** The study shed light on meaningful differences in how people with and without BDD-like symptoms perceive their bodies, emphasizing the role of societal influences in shaping social representation of body. To help individuals with BDD-like symptoms, interventions should emphasize on re-anchoring individual's body representations in health and functionality, rather than appearance. Promoting media literacy and fostering a positive body representation through family and peer support can mitigate the negative effects of societal beauty ideals. By integrating SRT into practice, social workers can help individuals with BDD-like symptoms re-anchor their

body representations in positive, health-oriented frameworks rather than appearance-focused ideals.

**Keywords:** body dysmorphic disorder, social representation theory, body image, social media, peer, family, youth, Canadian youth, social work practice, intervention.

## **Introduction**

Body has become a significant concern in today's society, particularly among youth who are heavily influenced by various external factors such as social media, peers, and family. These influences shape how individuals perceive their bodies, which in turn often leads to dissatisfaction with their body and, in severe cases, Body Dysmorphic Disorder (BDD) (Phillips et al., 2006). BDD is characterized by an obsessive preoccupation with perceived physical flaws, causing an individual significant distress and impairing their daily functioning (Phillips, 2005). Digital platforms and social media have come to permeate everyday life, with societal beauty standards becoming increasingly pervasive. With the highest susceptibility to internalizing these ideals, adolescents and young adults are the group most impacted by this trend. Understanding the factors shaping social representation (SR) of body, particularly for individuals with and without BDD-like symptoms, is the foundation for creating effective interventions aimed at promoting positive SR of body and mental health.

This dissertation aims to explore how SRs of body differ between Canadian youth with and without BDD-like symptoms. By applying Social Representation Theory (SRT), the study examines how societal beauty ideals are anchored in individuals' shared cognition and how these SRs differ based on the presence or absence of BDD-like symptoms. Drawing on both quantitative and qualitative methods, this study provides a holistic view of body concerns and synthesizes a comprehensive understanding of the factors contributing to these issues. This research aims to highlight the immense impact of social influences on the way people give meaning to their bodies and poses the potential of addressing these influences through targeted interventions (Jodelet, 1984).

## **Mapping the Dissertation: Theories, Findings, and Interventions**

This dissertation is structured into five main chapters. The first chapter provides a comprehensive literature review, including the theories explaining SR, body, and body dysmorphic disorder. It sets the foundation for understanding how societal beauty standards are internalized and how these internalizations differ between individuals with and without BDD-like symptoms. This chapter also discusses relevant literature on the role of social media, peers, and family in shaping body representation and compares competing theories such as objectification theory and social comparison theory.

The second chapter presents Article 1, which focuses on the first phase of the study. Using a mixed-methods approach, this first phase combines quantitative and qualitative methods to analyze the SRs of the body among individuals both with and without BDD-like symptoms. The quantitative component specifically examines the prevalence of BDD-like symptoms in relation to various socio-demographic factors, such as age, gender, race, sexual orientation, and marital status, using chi-square tests and logistic regression. The findings from this phase provide insights into how BDD-like symptoms manifest across different demographic groups and contribute to body dissatisfaction and the internalization of societal beauty standards.

The third chapter presents Article 2, which covers the second phase of the study. This phase utilizes a mixed-methods approach, incorporating both qualitative and quantitative research methods. In the qualitative part, thematic analyses were conducted to explore the meaning units underlying the SRs of the body. Word clouds were also used to investigate the anchoring and naming processes within the SRs. In the quantitative part, a series of chi-square tests were performed to examine the associations between BDD-like symptoms and the extracted

sub-categories from the thematic analysis (López-Guimerà et al., 2010). Additionally, correlations were conducted to test the relationship between the importance of social media, peers, and family in shaping the ideal body and participants' scores on the BDD-YBOCS scale. This chapter delves into how Canadian youth with and without BDD-like symptoms anchor societal beauty ideals and how these representations are influenced by social media, peers, and family.

The fourth chapter presents Article 3, outlining the transformative potential of SRT in social work practice. This chapter examines the influence of societal beauty standards and associated processes such as like objectification and rigid internalization, and how they shape the SRs of body among youth aged 16–21 living in Canada. Participants with BDD-like symptoms exhibited appearance-focused and negative body representations influenced by external factors, such as social media, family, and peers (rigid anchoring), while those without BDD-like symptoms demonstrated more adaptive and health-oriented representations driven by cultural values and personal thought processes (flexible anchoring). The chapter highlights practical implications for social work, with a focus on developing interventions that promote media literacy, peer support, and family-focused programs as a method to foster resilience and positive body representations. As outlined in this study, social workers are agents of change and play a key role in advocating systemic transformations to both reduce the prevalence of BDD and promote mental health and well-being. This chapter emphasizes the role of social work in achieving goals related to mental health, empowerment, and social justice, and provides practical recommendations for interventions that challenge harmful societal beauty standards.

The fifth chapter provides a general discussion, synthesizing the findings from all articles of the study. It offers an in-depth interpretation of the results through the lens of SRT, comparing

how SRs of body differ between participants with and without BDD-like symptoms. The chapter also integrates the key findings with existing literature and discusses the theoretical and practical implications (Berry, 2016). Additionally, this chapter concludes the dissertation by summarizing the contributions of the research, addressing its limitations, and offering recommendations for future research and practical interventions aimed at addressing body concerns, particularly for individuals with BDD-like symptoms.

### **Research Goal, Questions and Setting**

The primary goal of this research is to investigate the prevalence and SRs of body among Canadian youth with and without BDD-like symptoms, with a particular focus on understanding how sociocultural factors (social media, family, and peers), shape these representations. The study aims to explore how these influences contribute to body concerns and how the prevalence and manifestation of these concerns differ between individuals with varying levels of BDD-like symptoms. This research is especially significant in the current social climate of rising body dissatisfaction and mental health issues among youth. This study's findings provide a lens to understand the societal pressures that intensify body representation struggles in a media-driven age.

The research addresses the following key questions: (1) What is the prevalence of BDD-like symptoms among young people age 16 to 21 living in Canada, and how do these symptoms vary across socio-demographic factors? (2) What is the content and structure of the SR of body among young people in Canada? (3) How do youth with and without BDD-like symptoms represent the influence of social media, family, and peers on their representation of body? (4) How do participants with and without BDD-like symptoms differ in their representations of body

and beauty? By investigating these questions, the study sheds light on how Canadian youth represent their bodies and the role of sociocultural factors in shaping these representations.

Set in Canada, the research focuses on youth aged 16 to 21, a critical period for the development of body image. This age group is particularly vulnerable to societal influences, given their heightened engagement with social media and peer networks. By examining both the prevalence of BDD-like symptoms and the SRs of body in this demographic, the study provides valuable insights into how digital media, family, peers and social relationships converge to shape body representation concerns during adolescence and early adulthood.

### **Research Objectives**

The research objectives of this study are threefold: (1) to analyze the prevalence of BDD-like symptoms among youth living in Canada, (2) to examine how youth with and without BDD-like symptoms represent the influence of social media, family, and peers on the SRs of body, (3) to explore the differences in SR of body between individuals with and without BDD-like symptoms.

To achieve these objectives, the study uses a mixed-methods approach that combines quantitative surveys with qualitative verbal association tasks and in-depth interviews. The quantitative part allows for a broad understanding of the prevalence of BDD-like symptoms and how these symptoms correlate with socio-demographic factors. Expanding on this, the qualitative part allows for a deeper understanding of how individuals perceive their own bodies, as well as these representations' sociocultural influences. Using a mixed-method approach, our study offers insights into both the prevalence and nature of body concerns.

## **Significance of Research**

This research is significant for several reasons. First, it contributes to the growing body of literature on body representations and mental health by focusing on a relatively understudied population, Canadian youth with BDD-like symptoms. While much research has been conducted on body image in general population, few studies have specifically addressed the SRs of body among individuals with BDD-like symptoms using SRT as a theoretical framework. This study fills that gap, offering a new perspective on how societal beauty ideals are internalized and how they differ based on mental health symptoms.

Second, this research provides practical implications to addressing these issues. By identifying perceived key influences, being social media, family, and peers, this study provides a roadmap for developing targeted social interventions aimed at promoting positive SR of body, as well as reducing the prevalence of BDD-like symptoms. For example, media literacy programs that help youth critically evaluate beauty ideals or family-based interventions that encourage supportive discussions about SR of body could help reduce body dissatisfaction, and peer-led initiatives that foster body positivity and reduce harmful comparisons could help alleviate body dissatisfaction. Furthermore, this study proposes methods of mitigating these influences for individuals with BDD-like symptoms, including re-anchoring their body representations from appearance to health and functionality. By employing the idea of SRs, these insights provide a valuable framework for potential preventive and therapeutic interventions.

## **Theoretical Framework**

This study's theoretical framework is grounded in Social Representation Theory (SRT), employing its approach to understand how individuals internalize societal ideals such as beauty

standards, and in turn how they shape their SR of body. SRT, developed by Serge Moscovici (2008), posits that SRs are collectively constructed frameworks (Moscovici, 2008; Rateau et al., 2012) that help individuals make sense of abstract concepts by anchoring them in familiar, everyday experiences. This process of anchoring allows abstract societal norms, like beauty ideals, to be integrated into an individual's cognitive framework, influencing how they interpret and evaluate their body in relation to these standards (Höijer, 2011; Bauer & Gaskell, 1999). In the context of SR of body, SRT highlights the cognitive mechanisms through which individuals make sense of beauty ideals and the emotional significance they attach to these representations.

For Moscovici (2008), a key concept within SRT is anchoring, which involves translating abstract societal concepts into concrete terms that individuals can relate to (Moscovici, 2008). Anchoring is a key component in understanding the process of how individuals internalize beauty standards and develop representations of their own bodies. Individuals with BDD-like symptoms most often have anchors tied to narrow, appearance-based ideals, which lead to heightened self-criticism and dissatisfaction (Phillips, 2006). In contrast, individuals without BDD-like symptoms may anchor their body representations in a broader range of values, including health, fitness, and self-acceptance. By applying SRT, this study investigates how Canadian youth with and without BDD-like symptoms anchor their body representations in societal beauty ideals, providing insight into the psychological and social processes behind body dissatisfaction.

Another core concept in SRT, objectification (Moscovici, 2008), helps explain the ways in which individuals internalize external standards of beauty and assess their bodies based on these criteria. The concept of objectification refers to the process of individuals evaluating themselves against societal standards that emphasize physical appearance over other attributes,

such as functionality or individuality (Fredrickson & Roberts, 1997). Notably for this study, individuals with BDD-like symptoms often view their bodies through a lens of external validation, evaluating themselves against their perceived standards of idealized beauty norms. By employing SRT's concept of objectification, this study examines how this process contributes to individuals' internalization of societal beauty ideals, and how their perceptions and self-assessments are subsequently influenced.

Lastly, SRT emphasizes the central core and peripheral elements in SRs (Abric, 1993). The central core consists of the most stable, non-negotiable aspects of a SR, while peripheral elements are more flexible and subject to change. Individuals with Body Dysmorphic Disorder (BDD) often hold inflexible beliefs about appearance and perfection. These beliefs are central to their self-evaluation and contribute to their preoccupation with perceived flaws. For example, a meta-analysis by Kuck et al. (2021) found a moderately negative relationship between BDD symptom severity and global self-esteem, suggesting that negative evaluations in BDD extend beyond appearance to other domains of the self. This correlation points to the role of rigid beauty ideals in making up the cognitive framework of individuals with BDD. In contrast, an analysis of individuals without BDD-like symptoms revealed a more diverse range in their central core and peripheral elements. These individuals' perception of themselves integrated values beyond only appearance, for instance health, strength, and individuality. Tylka and Wood-Barcalow (2015) describe positive body images as involving respect for the body by attending to its needs and engaging in healthy behaviors, as well as appreciating the body's functionality and uniqueness. This flexibility allows them to maintain a more balanced and resilient self-perception. Applying this framework, this study examines how these central and peripheral elements differ between

individuals with and without BDD-like symptoms, with the goal of understanding the cognitive structures driving body concerns.

In sum, SRT provides a robust theoretical foundation for understanding the social and cognitive processes that shape social knowledge about the body. By exploring how youth with and without BDD-like symptoms anchor societal beauty ideals, objectify their bodies, and construct central and peripheral elements of body, this study contributes to a deeper understanding of the factors that influence body dissatisfaction. The practical application of this framework provides insight to designing social interventions aimed at improving the mental health and well-being of individuals with BDD-like symptoms.

### **Study Designs, and Methods**

This study utilizes a mixed-methods approach that integrates both quantitative and qualitative research in order to capture a full understanding of body concerns. The initial quantitative phase examines the prevalence of BDD-like symptoms among young people living and studying in Canada and explores how these concerns relate to various socio-demographic factors. The goal of this phase is to uncover the general scope of body dissatisfaction across multiple demographics, and synthesize insights into the most susceptible groups as well as any potential associations with factors such as age, gender, and other socio-demographic characteristics.

In Phase 2, this study uses a mixed-method approach to further explore the cognitive and social aspects of SR of body. The qualitative component of the study employs thematic analysis to uncover the underlying meanings and SRs of body among participants. Participants' responses were analyzed to extract key themes related to societal beauty ideals, body dissatisfaction, and

external influences such as social media, family, and peers. Additionally, word clouds were generated to visualize the frequency and prominence of words used by participants to describe their bodies, providing a visual representation of anchoring processes in SRs. This phase also includes a quantitative component, where chi-square tests were used to examine the association between BDD-like symptoms and the identified sub-categories of body related themes.

Correlational analyses are conducted to investigate the relationship between the importance participants place on sociocultural influences (social media, family, peers).

By integrating these two phases, the study captures both the prevalence and the social-cognitive processes underlying body concerns. The quantitative phase offers a broad, demographic-based understanding of how BDD-like symptoms manifest, while the qualitative phase provides a richer, more detailed analysis of how sociocultural influences shape the SR of body of individuals with and without BDD-like symptoms. By employing this mixed-methods design, this study is able to engage in a nuanced exploration of body concerns, and perform both statistical analysis and in-depth thematic interpretation to address the study's research questions and objectives.

### **Ethical Consideration and Approvals**

On August 29, 2022 I began my thesis ethics application process through the University of Ottawa's e-review system. Multiple revisions and long-term communication with the ethics board constituted the process. After receiving their first revision request on November 26, 2022 the committee convened a meeting to give me detailed feedback. The ethics board requested additional revisions on April 4, May 19, and June 9, 2023 which led to a subsequent meeting to discuss the issues. The project received formal approval on August 1, 2023 after a year-long

process. The official beginning of my research commenced when I received approval on August 1, 2023 (Certificate No. S-10-22-8445). The renewal of the certificate dated July 3, 2024, strengthened the ethical standing of my research study.

### **Reflexivity Statement: Journey to the PhD and Positionality**

My academic journey has always been driven by a deep desire to contribute something meaningful, both to the academic world and to the people who engage with my work. From an early age, I knew I wanted to pursue education at the highest levels, and producing a thesis that reflects my unique contributions has been a lifelong goal. This work is a tangible representation of my efforts and intellectual curiosity, something that reflects my voice and will, hopefully, serve as a tool for others to better understand complex issues related to body.

The topic chosen for this research, Body Dysmorphic Disorder (BDD) and the sociocultural influences on body, has deep personal significance. I have dealt with body dissatisfaction myself, specifically during my teenage years. I often felt self-conscious about my appearance, particularly my nose and my big toe. These concerns led me to undergo surgery at the age of 17 to address the bone on my nose that I thought made me unattractive. I have been incredibly sensitive about the way I dress throughout my life, including meticulously styling and matching everything from my clothing to my accessories in style and color. Through this personal experience, I possess first-hand insight into the impact of the pressures of societal standards, and the struggles individuals face in reconciling that with their appearance and body.

My own fixation on my appearance was often exacerbated by comments mostly from family and then my friends. While I often received compliments on my overall look, such as reference to my pretty shape and face, I received select criticisms of my nose and tall big toe that

would overshadow these praises. On the other hand, members of my family would draw attention to my thinness, and suggest certain diets or pills to help me gain weight. Put together, these external remarks combined with my internal dissatisfaction only served to heighten my sensitivity to my perceived flaws and diminished my ability to appreciate other, positive features. This experience allowed me to fully understand the ways that broader influences, both societal and cultural, fuel dissatisfaction with one's body, and how individuals with a natural inclination for self-critique are more susceptible to their impact.

My positionality in this research is multifaceted in that it is shaped by both my personal experiences and my academic objectives. I acknowledge that my interest in this topic is influenced by my own encounters with body and appearance issues and how sociocultural factors have impacted my self-perception. As someone who has dealt with BDD-like symptoms, I have a personal stake in understanding how body dissatisfaction manifests and how societal ideals influence our internal dialogues about appearance.

However, within this self-reflection I also recognize my position as a researcher. I am not only the subject of these experiences and issues, but also an outside observer. In this regard, I aim to critically examine these topics from an academic standpoint. This dual perspective, both subjective and objective, is key in informing my approach to this study. On one hand, I understand the emotional and psychological toll of body concerns on an individual, and on the other hand, I endeavour to maintain objectivity as a researcher, and ensure that my findings are grounded in rigorous analysis rather than personal bias. My experiences give me empathy and insight into the lives of my participants, particularly those who, like me, have struggled with body dissatisfaction. Because of this, I made sure to take several steps to maintain reflexivity and objectivity in my analysis.

First, I continuously worked with a psychotherapist during my PhD journey. These sessions helped me process my own emotions related to body image separately from my research work. This allowed me to stay aware of my biases and make sure my interpretations were grounded in the participants' voices rather than my personal experiences.

Second, I used independent inter-coder verification. Another trained researcher reviewed a sample of my qualitative data coding to check for consistency and agreement. This helped ensure that my interpretations were not overly influenced by my perspective and that the themes reflected the participants' meanings, not mine.

Third, I maintained a reflexive journal throughout data collection and analysis. In this journal, I noted my emotional reactions, assumptions, and thoughts about participants' stories. Writing them down helped me recognize when my personal experiences might affect my analysis and allowed me to take a step back to re-examine the data with a more neutral lens.

Finally, I followed systematic coding procedures and relied on clear theoretical guidance from Social Representation Theory. This structure helped keep the focus on how participants socially constructed meanings of the body rather than how I personally understood body image.

In this study, I position myself both as an insider, due to my lived experiences with body issues, and as an outsider, as I work to objectively analyze and interpret the experiences of others. With this unique vantage point, I can leverage my own background and experiences to approach this research with empathy as well as scholarly rigor. While this requires a careful balance between personal understanding and critical distance, I have consciously worked to maintain this balance throughout the research process

# Chapter 1

## Body Dysmorphic Disorder and Social Representation

### 1.1 Body Dysmorphic Disorder (BDD)

Body dissatisfaction is characterized by negative affective, attitudinal, and cognitive responses toward one's body image (Bergstrom & Neighbors, 2006). Everyone has their own self-image, shaped by their perceptions as well as the beliefs and attitudes of others. When there is a mismatch between an individual's specific body characteristic and their perceived body, body dissatisfaction may occur (Quick, 2014). Excessive concern about body and appearance is often associated with clinical symptoms, such as those found in Body Dysmorphic Disorder (BDD). In the DSM-IV, body dysmorphic disorder (BDD) is categorized as a distinct disorder within the somatoform section. In the ICD-10, it is grouped under "hypochondriacal disorders" alongside hypochondriasis, also within the somatoform section. BDD has been recognized globally for over a century by numerous psychopathologists, including Kraepelin and Janet. In DSM-III, BDD was referred to as "dysmorphophobia". It is also characterized by a distressing or debilitating focus on a perceived or minor flaw in appearance (Phillips et al., 2010). Individuals with BDD often seek reassurance from others about their perceived flaws to momentarily ease their anxiety. They tend to be highly concerned with how others perceive these supposed imperfections and frequently engage in behaviors to conceal them, such as wearing a hat to hide hair loss. Many people with BDD can be emotionally vulnerable and harbor a deep fear that an "ugly" part of their body is equivalent to a defect. They often believe that others are specifically focused on their appearance and may ridicule them for it. These individuals struggle to accept

that their perceived flaws are imagined and are often fully convinced of their reality, sometimes leading to a diagnosis of somatic subtypes of delusional disorder (Veale, 2004).

Body dysmorphic disorder (BDD) has been described as dermatologic hypochondriasis, “delusions of Dysmorphosis” (Castle et al., 2004, p. 100), “beauty hypochondria”, and “dermatophobia” (Mufaddel et al., 2013, p. 3). Individuals with BDD often perceive their bodies as abnormal due to exaggerated flaws they believe make them unattractive (American Psychiatric Association [APA], 2013; Castle et al., 2004). The term “dysmorphophobia” originates from the Greek word “dysmorphia,” meaning an unattractive body, and appeared in Herodotus’s Histories in the story of the “ugliest girl in Sparta” (Mufaddel et al., 2013). Morselli referred to dysmorphophobia as a form of rudimentary paranoia or monomania (Mufaddel et al., 2013, p. 3).

Individuals with irrational concerns about their appearance are diagnosed with BDD, a disorder first introduced in the DSM-III in 1980, originally classified as an “atypical” somatoform disorder under the name “dysmorphophobia” (Hunt et al., 2008). In 1987, the DSM-III-R identified BDD as a distinct somatoform disorder, a classification that remained until the DSM-IV in 1994 (Bjornsson et al., 2010). In the DSM-5, however, BDD was reclassified under Obsessive-Compulsive and Related Disorders (APA, 2013). “According to DSM-5, BDD is characterized by a preoccupation with perceived physical flaws that are either unnoticeable or minor to others” (Schneider et al., 2017, p. 1). This cognitive distortion leads to compulsive behaviors, as sufferers commonly spend between 3–8 hours daily focused on their appearance and related concerns (Castle et al., 2004).

## 1.2 Prevalence of BDD

The typical onset of Body Dysmorphic Disorder (BDD) is around the age of 16 (Bjornsson et al., 2010), and both adults and adolescents show similar clinical presentations in terms of severity, comorbidity, and impairment (Albertini & Phillips, 1999; Mataix-Cols et al., 2015). Several studies estimate that 80% of sufferers of BDD have contemplated suicide and 28% have attempted it (Winograd, 2016). However, suicide rates are higher among adolescents than adults (Phillips et al., 2006). Prevalence studies have reported rates ranging from 1% to 19% in the general population (Rief et al., 2006; Boroughs et al., 2010; Liao et al., 2010; Barahmand & Shahbazi, 2015; Enander et al., 2018). Specifically, the prevalence is 2.5% in females and 2.2% in males (Koran et al., 2008), although most studies have found no significant gender differences (Buhlmann et al., 2010; Schneider et al., 2017).

A 1995 study involving 803 American women revealed that 48% were dissatisfied with their bodies and 49% struggled with weight issues (Bergstrom & Neighbors, 2006). Additionally, one survey found that one-third of American women attempted to lose weight (Bergstrom & Neighbors, 2006). Women generally express more concerns about appearance than men. For example, 36% of American women reported dissatisfaction with specific body parts like their face, muscle tone, hair, torso, and breasts (Cash & Henry, 1995), while Grogan (1999) found women were particularly dissatisfied with their thighs, stomachs, and hips (Bergstrom & Neighbors, 2006). Veale et al. (2016) reported that rhinoplasty patients had the highest prevalence of BDD, with a weighted prevalence of 20.1%, higher in Iran (31.5%) than in the UK (20.7%) and the USA (2%). Additionally, prevalence rates in general cosmetic surgery, orthognathic surgery, and acne dermatology clinics were 13.2%, 11.2%, and 11.1%, respectively. Italy had the highest prevalence of general cosmetic surgery (Veale et al., 2016).

Despite significant research into the prevalence of Body Dysmorphic Disorder (BDD) across various populations, a noticeable gap exists in the study of BDD among young people in Canada. While global studies point to significant levels of body dissatisfaction and BDD among young people, no research has specifically investigated the prevalence of BDD in Canadian youth. This absence of data presents a major gap in our understanding of how Canadian social factors, media influences, and social interactions may shape body issues and the development of BDD among adolescents and young adults in the country.

The present study aimed to address this gap by investigating the prevalence of BDD among young people in Canada. Given that women, in particular, have shown higher levels of body dissatisfaction and concern about appearance across various regions (Bergstrom & Neighbors, 2006; Grogan, 1999), understanding how these trends manifest in Canadian society is important. Further, the distinct lack of Canadian-specific data points to a deficit in understanding the role of media, peer interactions, parents, and societal expectations in influencing body concerns among youth. This research has brought to light not only much-needed prevalence data, but also key insights into the potential social and cultural factors contributing to BDD in the Canadian context. By filling this gap, the goal of this study is to inform the design and development of social work interventions aimed at addressing the individual and inter-subjective consequences of body disturbances and BDD in Canadian adolescents and young adults.

While the preceding discussion highlights the prevalence, onset, and cultural contexts of BDD, the psychological and social mechanisms underlying the disorder are at the core of this study. Theoretical models illuminate the ways that societal, cognitive, and interpersonal factors contribute to body dissatisfaction and individuals with BDD's obsessive focus on perceived flaws. These frameworks shed light on the full complexity of this disorder by bridging the gap

between individuals' symptoms and their broader socio-cultural environment. In the following section, this study aims to understand this complexity by exploring the theoretical perspectives of the interplay between individual experiences and societal influences in the development and maintenance of BDD.

### **1.3 Theoretical Frameworks Explaining Body Dysmorphic Disorder (BDD)**

#### **1.3.1 Biopsychosocial Model**

The Biopsychosocial Model of BDD integrates biological, psychological, and social factors to explain the development and maintenance of the disorder. This model suggests that BDD is influenced by a combination of genetic predispositions, neurobiological abnormalities, psychological vulnerabilities, and sociocultural influences.

Neurobiological studies have shown that individuals with BDD may have abnormalities in brain regions related to visual processing and emotional regulation. Buchanan et al. (2014) conducted research into the brain activity of individuals with BDD, and found that they exhibited hyperactivity in the occipital cortex, the area responsible for visual processing. This activity was potentially responsible for their heightened sensitivity to perceived flaws in their appearance. Additionally, they found that abnormalities in the amygdala and prefrontal cortex have been linked to emotional dysregulation and obsessive thoughts about appearance.

Biologically, research shows that individuals with BDD may have a genetic predisposition for the disorder, in that it appears more frequently among first-degree relatives, suggesting its heritability. Neurobiological studies, such as Feusner et al. (2010), have shown that individuals with BDD process visual information differently, particularly by focusing more

on minute facial details rather than perceiving faces holistically, which contributes to their preoccupation with perceived flaws. Psychologically, BDD is driven by cognitive distortions and emotional regulation issues. Those with BDD often hold distorted beliefs about their appearance, believing that minor or nonexistent flaws are much more significant than they are. These individuals also tend to have difficulty managing anxiety and depression, which exacerbates their obsessive focus on their appearance (Wilhelm et al., 2012).

### **1.3.2 Evolutionary Theory of BDD**

The Evolutionary Theory proposes that the roots of individuals' concern for physical appearance may be related to factors of mate selection and reproductive success. Employing an evolutionary perspective, physical attractiveness has often been associated with health, fertility, and social status, which are important elements in mate selection. However, in individuals with BDD, these adaptive concerns may become exaggerated and maladaptive.

Stein (2017) suggests that BDD may be rooted in evolutionary mechanisms related to mate selection and social competition. As per Stein's argument, physical appearance has been an important indicator of reproductive fitness and social desirability throughout human evolution. Through this perspective, traits including facial symmetry, clear skin, and overall attractiveness are considered markers of good health and genetic quality, and advantageous for securing mates and passing on genes. Stein argues that individuals with BDD might exhibit an overactive version of this evolutionary concern with appearance. While it is normal for people to be somewhat concerned about their physical traits because of their evolutionary importance, those with BDD take this to an extreme. Becoming hyper-focused on their perceived flaws, these individuals interpret these imperfections as significant indicators of poor social or reproductive

value. According to Stein, this hyper-focus can be viewed as a maladaptive exaggeration of an evolutionary mechanism that was originally intended to aid in mate selection and social competition. Stein's evolutionary perspective explains BDD as a disorder that may arise when normal, adaptive concerns about physical attractiveness are intensified to the point where they become dysfunctional. The cultural amplification of beauty standards in modern society likely exacerbates this overactive evolutionary drive, leading to the obsessive thoughts and behaviors characteristic of BDD. In this way, evolutionary psychiatry helps to frame BDD as a condition that, while deeply rooted in biological and evolutionary processes, becomes maladaptive in the context of societal pressures and unattainable standards of beauty.

Veale and Gilbert (2014) discuss Body Dysmorphic Disorder (BDD) within an evolutionary context in their paper. According to their argument, through evolution humans have integrated their social standing and attractiveness into the social competition for mates, resources, and status. In this sense, it is an evolutionary advantage to be perceived as attractive and socially desirable, helping in securing mates and social alliances. However, in individuals with BDD, this adaptive mechanism becomes dysfunctional, leading to an excessive focus on perceived physical flaws and fears of rejection or low status. Veale and Gilbert (2014) suggest that BDD sufferers are hyper-sensitive to appearance-related threats to their social rank, which drives the obsessive checking and grooming behaviors seen in the disorder. They also emphasize the role of self-criticism and shame, which are linked to evolutionary mechanisms of social rank theory, where individuals evaluate their own worth in comparison to others. In BDD, this results in maladaptive, excessive self-criticism about one's appearance, leading to distress and avoidance of social situations. This evolutionary framework helps explain why individuals with BDD are so deeply affected by societal beauty standards and social evaluation.

### **1.3.3 Neurocognitive Model of BDD**

The Neurocognitive Model of Body Dysmorphic Disorder (BDD) is further explained by studies like those by Blum et al. (2018), Feusner et al. (2010), and Jefferies-Sewell et al. (2017). Blum, et al. (2018) explore neurocognitive functioning in young adults with subclinical BDD, finding deficits in executive functioning, such as poor inhibitory control and heightened attentional biases toward appearance-related stimuli. These impairments contribute to the obsessive focus on perceived flaws and compulsive behaviors seen in BDD. Similarly, Feusner et al. (2010) propose a model that emphasizes the role of abnormal visual processing, positing that individuals with BDD often perceive their appearance in a fragmented way, with an intense focus on specific details as opposed to the whole of their face or body. By narrowing their focus on details, this neurocognitive dysfunction then heightens these individuals' fixation on perceived flaws and is compounded by deficits in executive functioning, such as difficulties with emotional regulation and inhibitory control, leading to compulsive behaviors like mirror checking and grooming. Jefferies-Sewell et al. (2017) expand on this by discussing how cognitive dysfunction in BDD, particularly in working memory and decision-making, affects broader cognitive functions. This impact causes BDD's characteristic rigid thinking patterns and obsessive-compulsive behaviors, illustrating that the disorder should be viewed within the wider context of the nosological systems accounting for these neurocognitive deficits. Together, these studies highlight how visual processing and executive functioning deficits underlie the symptoms and compulsive behaviors in BDD, supporting the Neurocognitive Model of the disorder.

Thus, this model suggests that deficits in visual processing and executive functioning lead to an obsessive focus on perceived flaws and compulsive behaviors. Individuals with BDD

tend to fixate on details rather than seeing their appearance holistically, while poor inhibitory control and cognitive dysfunction contribute to their compulsive actions like mirror checking and grooming.

#### **1.3.4 Cognitive-Behavioral Model of BDD**

The Cognitive-Behavioral Model is one of the most prominent theoretical frameworks used to understand Body Dysmorphic Disorder (BDD). This model suggests that BDD is a result of multiple, intertwined factors, including cognitive biases, distorted thinking, and maladaptive behaviors. As Veale (2004) argues, individuals with BDD often hyper focus on their perceived flaws, which greatly exaggerates the significance of minor imperfections, and triggers a cycle of negative thoughts, self-consciousness, and behaviors like mirror checking or social avoidance. These behaviors then reinforce the individual's distorted self-image, creating a feedback loop of anxiety and avoidance which serves to further perpetuate the disorder.

A more recent study by Fang et al. (2020) offers insight into the specific mechanisms of change within CBT for BDD. Their study shows that CBT helps restructure distorted thoughts about appearance, reduces preoccupation with physical flaws, and shifts attention away from negative self-appraisals. CBT also teaches patients to challenge their obsessive thoughts and to refrain from behaviors that perpetuate the cycle of anxiety and distorted self-perception.

#### **1.3.5 Self-Discrepancy Theory**

Higgins' Self-Discrepancy Theory (1987) postulates that emotional distress arises from discrepancies between how individuals perceive their actual self (who they are), their ideal self (who they wish to be), and their ought self (who they believe they should be). Applied to BDD,

self-discrepancy theory suggests that individuals with BDD experience distress due to a large gap between their perceived physical appearance and their idealized vision of how they believe they should look.

Veale et al. (2003) used Self-Discrepancy Theory to explain Body Dysmorphic Disorder (BDD) by highlighting the emotional distress that arises when individuals experience significant gaps between their perceived actual self and their ideal self. In BDD, individuals have an exaggerated perception of their physical flaws, which creates a large discrepancy between how they see themselves (the actual self) and how they wish to look (the ideal self). According to this theory, such a discrepancy leads to negative emotions such as anxiety, depression, and shame, which are common in individuals with BDD. Veale and colleagues argue that this heightened self-discrepancy is particularly pronounced in individuals with BDD because they hold unrealistically high standards for their physical appearance. These individuals are often driven by a distorted belief that meeting their ideal appearance will lead to increased self-worth and social acceptance. However, in reality they will fail to achieve this ideal and instead exacerbate their emotional distress, leading to common BDD-related compulsive behaviors, such as excessive mirror-checking or grooming. Veale et al. (2003) employ Self-Discrepancy Theory to illustrate that the emotional turmoil in BDD is intertwined with the perceived gap between one's ideal self-image and their actual self. This helps explain why individuals with BDD experience extreme dissatisfaction with their appearance despite others perceiving their concerns as minor or insignificant.

In all these studies, Self-Discrepancy Theory (SDT) explains BDD by focusing on the emotional distress that arises from the gap between individuals' actual self (how they see

themselves) and their ideal self (how they wish to look). Individuals with BDD will often perceive flaws in their physical appearance and see a gap between that and their idealized version of beauty, which induces feelings of anxiety, shame, and worthlessness. This discrepancy between their selves fortifies their dissatisfaction with their appearance, further driving the compulsive behaviors commonly associated with BDD, such as mirror checking, grooming, and seeking cosmetic treatments.

### **1.3.6 Objectification Theory**

The theory developed initially by Fredrickson & Roberts (1997) posits that in cultures where physical appearance is highly valued, individuals, especially women, are socialized to view their bodies as objects to be evaluated by others. This external focus on appearance leads individuals to develop body surveillance, constantly monitoring their physical appearance and comparing it to societal ideals.

Dakanalis et al. (2015) extend this theory into the context of BDD by highlighting that individuals with BDD experience an exaggerated form of self-objectification. They argue that those with BDD internalize societal beauty standards to a pathological degree, constantly monitoring their appearance and focusing on perceived flaws. By internalizing these standards, these individuals become dissatisfied with their bodies, which results in behaviors such as mirror checking and excessive grooming, or in severe cases cosmetic surgery to "correct" their perceived imperfections. Dakanalis et al. (2015) emphasize that societal pressure, especially from media representations, amplifies these tendencies in BDD sufferers, making them highly vulnerable to body-related anxiety and shame.

Pratt (2014) takes a slightly different approach by focusing on the role of interoceptive awareness in BDD, an individual's ability to perceive internal bodily sensations. In Pratt's argument, individuals with BDD may have lower interoceptive awareness, making them more likely to depend on external validation and appearance-based judgments from others. As such, their external focus on appearance, being pushed by the societal standards of beauty, intensifies their self-objectification. Pratt argues that the decreased internal body awareness in BDD patients amplifies their dependence on external appearance, reinforcing their obsessive focus on perceived bodily flaws and perpetuating the cycle of self-objectification and dissatisfaction.

### **1.3.7 The Interpersonal Model of BDD**

The Interpersonal Model of Body Dysmorphic Disorder (BDD) emphasizes the role of social relationships and interactions in both the development and maintenance of the disorder. This model suggests that negative social experiences, such as rejection, bullying, or teasing about one's appearance, can significantly contribute to the onset of BDD. Individuals who are more sensitive to social evaluation or have experienced critical feedback about their appearance are particularly vulnerable to developing distorted body perceptions.

In the study by Didie et al. (2012), the authors explore the severity of interpersonal problems among individuals with BDD. Their findings indicate that individuals with BDD often experience significant interpersonal difficulties, such as conflicts in relationships and challenges in maintaining social connections. These interpersonal struggles are often linked to the preoccupation with appearance and the fear of being negatively judged by others. The study highlights how BDD sufferers' distorted self-image and concern about how they are perceived lead to avoidance of social situations or strained interactions with others. This social avoidance

or withdrawal can worsen feelings of loneliness, isolation, and emotional distress, reinforcing the symptoms of BDD. The authors argue that these interpersonal problems are both a cause and a consequence of BDD, suggesting a cyclical relationship where negative social experiences contribute to the onset of the disorder, and the disorder itself further impairs social functioning.

Similarly, Fang et al. (2014) provide an overview of BDD and incorporate the interpersonal framework in understanding the disorder. They emphasize that individuals with BDD often display heightened sensitivity to social rejection, criticism, and appearance-based judgments. This sensitivity leads to dysfunctional social behaviors, such as excessive grooming, mirror-checking, and social withdrawal, all aimed at avoiding negative social evaluation. Fang et al. (2014) explain that the fear of social judgment can cause BDD sufferers to avoid social situations entirely, which results in poor interpersonal functioning and further reinforces their body concerns. The study also highlights that individuals with BDD often misinterpret neutral or even positive social interactions as negative or critical, further isolating themselves and deepening their preoccupation with appearance. This distorted interpretation of social feedback creates a vicious cycle where BDD symptoms impair social relationships, and in turn, these impaired relationships exacerbate the disorder.

### **1.3.8 Structural and Economic Perspective**

Structural and economic approaches focus on how society, institutions, and money shape the way we see and treat bodies. These perspectives show that the body is not only a personal or psychological matter but is also regulated by rules, policies, and economic forces. For example, Foucault (2012) explained that institutions such as schools and workplaces discipline bodies

through rules about dress and behavior, while Bordo (2003) argued that women's bodies are often controlled and sexualized through cultural and institutional norms.

These perspectives also show how inequalities influence beauty standards. Racialized women are often judged against Eurocentric ideals of thinness, lighter skin, and certain facial features, which reinforces racial hierarchies (Collins, 2004; hooks, 2014). At the same time, class differences matter. Middle- and upper-class women can often afford gym memberships, cosmetic surgery, or skincare products, while working-class women are more often criticized or controlled for not meeting these ideals (Skeggs, 1997).

From an economic viewpoint, dissatisfaction itself becomes a profitable engine of capitalism. As Bourdieu (1984) explained, cultural capital is not only transmitted through formal education and cultural knowledge, but also embodied in the body itself, in ways of carrying, presenting, and cultivating it. Appearance, style, and bodily presentation can therefore operate as forms of embodied cultural capital, affording individuals social advantages such as greater acceptance, better treatment in relationships, or even professional opportunities. The global beauty and cosmetic industries make billions by selling dissatisfaction and offering solutions, reinforcing the idea that women must constantly invest in their bodies (Gill, 2007; Elias et al., 2017). This creates a divide: those with money can buy access to these ideals, while those without are left out and stigmatized.

From structural and economic perspectives, body dissatisfaction is understood not as a personal failure or purely psychological problem, but as a socially produced condition rooted in systems of power, inequality, and profit. These frameworks argue that dissatisfaction with one's

body emerges because social institutions, economic systems, and cultural norms continuously define and regulate what is considered a “normal” or “beautiful” body.

Even though these perspectives are useful, they also have limitations. They mostly look at the markets, and rules, but often miss how individuals experience and talk about these pressures in daily life. They show inequality well but do not fully explain how people make sense of and share these ideas with others. In other words, structural and economic theories identify the conditions that create beauty standards, but they do not show how these standards are represented and reproduced in everyday conversations and practices.

### **1.3.9 Social Comparison Theory**

Social Comparison Theory (Festinger, 1954) posits that individuals evaluate themselves through comparison to others. This theory is especially relevant to BDD, where individuals are likely to compare their appearance to idealized images in the media or to others around them. Negative social comparisons, particularly in the context of upward comparisons (comparing oneself to someone perceived as superior), can exacerbate feelings of body dissatisfaction and trigger BDD-like symptoms.

Mancusi (2015) focuses on the psychological effects of social comparison and disgust in individuals with BDD. She highlights that those with BDD are more prone to upward comparisons, leading them to feel disgust or intense negative emotions when comparing their appearance to idealized standards, which can worsen BDD symptoms. The study links social comparison to heightened self-criticism and preoccupation with perceived flaws.

Morrison et al. (2004) tested the impact of social comparison on body image evaluation among adolescents, finding that media-driven social comparisons, particularly upward comparisons, contribute to body dissatisfaction, which aligns with the experience of those with BDD. Adolescents who constantly compare themselves to unrealistic standards are more likely to develop negative body and symptoms resembling BDD.

Krayer et al. (2008) used a grounded theory approach to explore how adolescents use social comparison in forming their body image. Their research demonstrates that frequent comparisons with peers and media figures create unrealistic standards for adolescents, which can contribute to the obsessive appearance-related concerns seen in BDD. This work particularly underscores how social comparisons during adolescence, an important phase for identity formation, can shape long-term self-perception and vulnerability to BDD.

In their research, Lewallen & Behm-Morawitz (2016) investigate the role of social media platforms, particularly those focused on images such as Pinterest, in facilitating upward social comparisons. Their findings show that an increased frequency of self-comparison against the idealized images on these platforms raises individuals' risk of developing body issues, which may lead to disorders like BDD. In this view, it is the curated, idealized content present across these social media platforms that fuels constant comparisons, amplifying BDD symptoms.

While the above theories offer valuable insights into this issue, they are prone to omitting the role of one's broader societal and cultural influences in shaping their body concerns. Incorporating the impact of collective societal standards in shaping individual perceptions, social comparison theory does provide a bridge to social representation theory in this regard. However,

SRT is most useful in extending this understanding, bringing attention to the processes through which societal norms are constructed, internalized, and challenged within social groups.

#### **1.4 Social Representation Theory as a Relevant Framework for Social Aspects of BDD**

The various theories that aim to explain Body Dysmorphic Disorder (BDD), such as Cognitive-Behavioral Theory (CBT), Self-Discrepancy Theory (SDT), Objectification Theory, the Biopsychosocial Model, the Interpersonal Model, Evolutionary Theory, and the Social Comparison Theory, each offer valuable insights but also face key limitations when compared to Social Representation Theory (SRT). These theories share a common limitation, in that they overemphasize individual cognitive or biological factors, and underplay or even ignore the ways that body concerns are shaped by their broader sociocultural context.

For example, CBT provides an effective view of distorted thoughts and maladaptive behaviors, but fails to fully engage with the influence of societal pressures, such as media representations and beauty standards, in contributing to BDD. Although it helps individuals manage their symptoms, the theory often does not account for how pervasive societal beauty ideals continue to shape body after therapy. Similarly, Self-Discrepancy Theory highlights internal conflicts between an individual's actual and ideal selves, but it neglects the external forces like cultural norms and media influences that create and maintain those self-discrepancies. It frames body dissatisfaction as purely an internal emotional struggle, without addressing how society sets unrealistic beauty standards.

Objectification Theory and Social Comparison Theory do better in explaining external pressures but remain focused on individual experiences of internalized societal standards. Objectification Theory, for instance, explains how individuals, especially women, come to view

their bodies as objects for evaluation due to societal norms. This theory, however, is built on an understanding of the individual psychological processes of internalization, and does not broaden its scope to account for how these societal standards are not only socially constructed, but also maintained or challenged within different cultural contexts. Similarly, Social Comparison Theory illustrates how individuals evaluate themselves through comparison to others, but fails to consider the wider cultural narratives building and influencing these very standards of comparison. By simplifying human behavior into upward and downward comparisons, this theory overlooks how these standards are perpetuated and enforced by societal structures such as media.

The Biopsychosocial Model, on the other hand, does integrate biological, psychological, and social factors. However, by treating these domains as separate influences, it overemphasizes individuals' internal biological predispositions and psychological vulnerabilities, creating a fragmented understanding of BDD. This view fails to fully engage with and explain the collective cultural beliefs that are shaping body concerns. Similarly, the Interpersonal Model takes into account the role of social interactions in developing BDD, such as experiencing bullying or teasing, but also excludes the broader societal context influencing these interactions. This model does not consider how societal beauty standards, which are mediated through friends, peers, and family, shape the feedback loops reinforcing BDD.

Likewise, Evolutionary Theory portrays BDD as being rooted in biological mechanisms, positing that concerns about physical appearance are an evolutionary consequence of its apparent importance in mate selection and social competition. While this theory reaches into certain universal aspects of BDD, it cannot fully account for cultural variations in beauty standards, or

the modern societal pressures exacerbating these concerns. The theory's focus on individuals' inherent biological drives impedes its ability to understand how media-driven beauty ideals and cultural expectations can escalate these innate concerns into maladaptive behaviors.

Social Representation Theory, alternatively, provides a more holistic and contextualized understanding of BDD, exploring how beauty standards and body concerns are collectively constructed by society. SRT offers a comprehensive understanding of how media portrayals, cultural norms, and collective beliefs about appearance intertwine to constrict and shape individuals' representations of their bodies. Going beyond theories that focus solely on individual cognition or biology, SRT investigates how social groups, media, and cultural narratives play a role in creating shared understandings of beauty and appearance. As such, SRT stands as an effective tool in understanding the influence of external pressures in contributing to BDD, and offers a fuller picture of how body concerns are formed and reinforced.

SRT offers a second significant advantage in its cultural flexibility. By acknowledging beauty standards are not universal and instead shaped by historical, social, and political contexts, SRT can account for the variance of BDD across cultures and time periods. Through this more nuanced understanding, this theory offers insights into how beauty ideals are socially constructed and perpetuated in specific societal contexts. By expanding past explanations of only individual behaviors, SRT provides a less limited view of how societal beauty ideals are transmitted through the media, education, and social interactions that influence collective beliefs about the body.

Furthermore, SRT does not treat individuals as simply the passive recipients of societal norms. Instead, it acknowledges that individuals have the agency to challenge and reshape these

norms. This dynamic interaction between individuals and society allows SRT to explain not only how beauty ideals influence body but also how individuals negotiate, resist, or internalize these ideals. Providing a more complete understanding of body concerns, this theory recognizes the active role of individuals in constructing their own perceptions of beauty, and how they are influenced by their social environment.

SRT helps us understand how large social and economic forces are translated into everyday meanings and shared ideas about the body. It shows how beauty standards and body dissatisfaction are not only imposed from above but also circulated, resisted, and reinterpreted in ordinary social life. Because of this, SRT offers a more complete framework than structural or economic approaches alone.

Finally, SRT allows for a multi-level analysis by incorporating how institutions, political forces, and economic systems play a role in shaping societal beliefs about the body. Particularly important in understanding BDD, this analysis can account for how industries like fashion, advertising, and social media create and maintain unrealistic beauty standards. By providing this broader scope, SRT offers a more comprehensive framework to understand the role of these external societal forces in shaping body representation and how they contribute to the development of disorders like BDD.

It is true that BDD involves cognitive distortions; this is well documented in clinical research and acknowledging this is essential. However, to explain BDD fully, it is necessary to go beyond the individual mind and ask why certain appearance-related concerns become the focus of those distortions in the first place. SRT provides this missing link by showing how shared cultural meanings shape what becomes salient, desirable, or threatening. Beauty ideals do

not merely “suggest” concerns; they set the parameters for what is considered a flaw, what must be fixed, and what is socially rewarded or punished.

For example, if thinness, clear skin, or a symmetrical nose are consistently portrayed as prerequisites for attractiveness, success, and even moral worth, then distortions around these specific features are more likely to take hold. In other words, the content of the cognitive distortion is socially shaped even if the process is individual. This is supported by studies showing that BDD prevalence and symptom focus vary cross-culturally: Clinical studies and meta-analyses of rhinoplasty candidates in Asian settings including Iran and East Asia show very high demand for nasal surgery and nose shape is a common concern among Iranian (Ghazizadeh Hashemi et al., 2017). The study “Understanding and Treating Body Dysmorphic Disorder” (Singh et al., 2019) highlights cultural variations, noting that Japanese case reports often identify the eyelids as the primary area of concern, something that is rarely reported in Western clinical settings.

In conclusion, addressing these gaps, Social Representation Theory provides a broader, more encompassing sociocultural perspective that accounts for the collective beliefs and cultural narratives that shape body representations. In turn, this theory offers a more comprehensive and adaptable framework for understanding BDD across diverse societal contexts. Table 1 provides a comparative summary of the theoretical frameworks discussed, highlighting their advantages and limitations in explaining body concerns and BDD.

**Table 1-1**

Comparison of Theoretical Models Explaining Body and BDD: Advantages and Disadvantages.

<b>Theory</b>	<b>Advantages</b>	<b>Disadvantages</b>
<b>Cognitive-Behavioral Theory (CBT)</b>	Compelling in treating misrepresented behaviors and thoughts, decreases preoccupation with perceived flaws.	Does not address societal beauty standards or broader social influences.
<b>Self-Discrepancy Theory (SDT)</b>	Explain emotional distress following by the gap between real and ideal self.	Ovelooks external influences such as sociocultural norms that maintain self-discrepancies.
<b>Objectification Theory</b>	Draw attention to the role of societal beauty standards and self-objectification.	Highlight overly on individual internalization, without exploring the societal construction of beauty standards.
<b>Social Comparison Theory</b>	Recognizes the role of social comparison in shaping body concerns.	Ignoring societal structures and excessively emphasize on individual comparisons.
<b>Biopsychosocial Model</b>	Incorporates psychological, biological and social factors for explaining BDD.	Treats psychological, biological and social factors as separate influences, not integrated well.

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<b>Interpersonal Model</b>	Focus more on the role of social experiences such as bullying and rejection in BDD.	Overlooks the broader societal context that impacts negative social interactions.
<b>Evolutionary Theory</b>	Allocate an evolutionary perspective on the importance of physical appearance.	Emphasizes more on biological drives, ignoring cultural beauty standards and societal pressures.
<b>Neurocognitive Model</b>	Makes connection BDD to visual processing and executive functioning deficits.	overly focused on neurocognitive shortfalls without accounting for sociocultural influences.
<b>Social Representation Theory (SRT)</b>	Extensive framework that comprises sociocultural norms, and collective beliefs. Empowers cultural flexibility and multi-level analysis. Effectively captures individual and societal influences effectively. Appropriate to explain how social representations of body vary across different cultures. Does not treat people as passive receivers of societal norms but instead acknowledges that they engage in a dynamic interaction with these norms. Opens the door	

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for understanding how social norms about body can be challenged and reshaped over time.

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## **1.5 The Foundations and Processes of Social Representation Theory**

Social representation was first conceptualized by Moscovici (2008) to examine common meaning and science transformation (Joffe, 2003). “Psychoanalysis, its image, and its audience”, the thesis defended by Moscovici in 1961, revealed how scientific theories are disseminated in a society, as well as what people think about them and why. Essentially, the topic he addressed was “the specificities and the differences in the appreciation of the psychoanalysis according to the belonging of the individuals to different social categories or the ideological orientation of the speeches” (Manchaiah et al., 2019, p. 21). That is, Moscovici sought to understand what happened to the knowledge of psychoanalysis when the theory became universally known (Manchaiah et al., 2019). For Moscovici, SRT connects a society with the individuals who compose it; it is a social psychological phenomenon (Murray, 2002). Hence, SRT could also be regarded as a theory of communication as it examines the relationship between media, public, and the wider society (Höijer, 2011).

An SR reveals the meaning people ascribe to the world in which they live and the mutual understanding of that world within a group and its networks (i.e., common knowledge or common sense; Manchaiah et al., 2019), as revealed by group members’ behaviors, feelings, and thoughts (Taylor et al., 2017). There is always more than one SR in a given group, and SRs compete to be accepted as the true representation of reality, suppressing or seeking to restrict

other versions of that reality (Sanders & Roberts, 2018). SRs are both internal and external to individuals; thus, a SR system consists of all the values, norms, beliefs, and so on which constitute the common sense of a given social group (Bidjari, 2011).

Rateau et al. (2012) similarly defined SRs as a group's shared and interrelated perspectives, ideas, and values which pertain to its culture and other contextual features: A solidarity of opinion which underpins a codification of behavior which, in turn, informs their relationships with other groups (Manchaiah et al., 2019). SRT explores how the beliefs and structure of these SRs feed into the processes (Duveen, 2000) whereby group forces, whether historical or socio-cultural, relate to individuals' internal experience, what Joffe (2003) describes as how the "we" responds to the "I". The manifold interactions that occur between different areas of life, whether education, work, or social interaction, all mold our culturally-related SRs. Indeed, representations of the concept of culture itself vary according to context (Manchaiah et al., 2019). Hence, mental images form in the minds of individuals as a result of communication, interaction, and cultural forces and beliefs; such images reinforce the mutual understanding of objects and the world in which the individuals live (Purkhardt, 2015). The relationship between communication and representation is therefore bidirectional: Individuals create their reality from the SRs which emerge during communication; if there were no SRs, there would be no communication (Stenzel et al., 2006).

Lahlou (2001) observed that the following are closely connected to SRs: culture, habits, mental models, archetypes, concepts, schemata, rules, mediating structures, scripts, and shared cognition. It can be inferred from this list that SRs, through social evolution, become the mechanism by which culture is conveyed and shaped. They can be considered structures which enable humans to organize communal activity or regulate their everyday relationships with

objects and each other. These structures are passed down from one generation to the next within the group in the shape of daily routines and assumptions. Thus, the structure which enables group actions to be mediated and coordinated to construct or address an object can be seen as the SR of that object (Lahlou, 2001).

The structural approach regards the central and peripheral as the two dimensions of an SR system. The central dimension refers to the consensual cognition of all members regarding an object; an understanding which does not require negotiation and remains stable over time (Bonetto et al., 2018). It is formed from the diverse beliefs which exist within the peripheral dimension which align with ideas governing how life should be lived and normative values (Abric, 1993, 1996). When those beliefs are translated into the central core, their meaning is created and clarified in relationship to how the group organizes itself (Quenza, 2005). The peripheral dimension is in a direct relationship with, and complements, the central one, while remaining more flexible, varied, and sensitive to context. Peripheral elements play a vital role as the interface between the central dimension and concrete conditions. Should contradictions emerge, the peripheral dimension shields the central one as it acts as a mechanism for the integration of information and can shift the relative emphasis given to each element (Quenza, 2005). Under Flament's understanding of peripheral elements as schemas, they determine behaviors, molding some actions independently of the core according to contextual conditions and serving to maintain the central dimension by normalizing strange schemas. When actions and behaviours occur without the participation of the central core, the schemas are considered "normal"; when the central core is involved, they are considered "strange" (Quenza, 2005).

The emergence of SR in terms of familiarization with new relations and objects comprises two key processes. Effects are sustained at different levels, including the anchoring

and objectification mechanisms which enable representations to develop and be connected to the images collectively held of them (Jodelet, 2008). Anchoring “is a process of incorporating new representational elements into an already constituted and operating set, a system of representations” (Manchaiah et al., 2019, p. 25). In this process, a connection is made between cognitive representation and social act as group members are gradually familiarized with unfamiliar ideas, incorporating them into the collective understanding of the world (Bauer & Gaskell, 1999). This incorporation can occur through processes such as naming, thematic anchoring, metaphoric anchoring, emotional anchoring, and anchoring via basic antinomies.

The best-known anchoring process is naming. New objects require names, which are then incorporated into the wider lexical sets already used in a culture. As Wagner et al. (1999) noted, a new phenomenon must have a name if it is to be communicated between individuals (Wagner et al., 1999). Frequently, these names are used in media headlines, helping diffuse a broad understanding of unknown or ambiguous phenomena (Höijer, 2011).

Thematic anchoring of meanings occurs at a deeper level and, according to Moscovici (2000), is applied to determine SRs. Themes which exist at this more profound level remain concealed; consequently, any analysis of media discourse must penetrate further than the names used. Moreover, when global ideas are to be incorporated into a local language, they may be allotted to pre-existing themes (De Rosa, 2013).

Metaphoric anchoring helps capture key issues from a phenomenon (Eccleston, 2021). Some instances of metaphoric anchoring occur when a phenomenon requires further elucidation by being expressed in a phrase such as “life is a journey” or “time is money”. Language is an intrinsic part of metaphors, which pervade every part of our communication and thought (Höijer,

2011). Anchoring, across all societies, also occurs in the form of antinomies (life/death, we/them, hope/fear, etc.). Indeed, Billig proposes (1993) that humans' ability to think rests on their ability to conceive of negatives, such as accept versus reject, which enables societies to evolve and grapple with tensions and conflicts; SRs develop as part of this ability (Höijer, 2011).

Objectification, meanwhile, enables us to make an unfamiliar element of a specific reality familiar by portraying it as something we already know and understand (Abric, 1996; Bidjari, 2011). It can be considered a mechanism which allows represented social knowledge to take on a certain form by identifying a phenomenon, making it knowable, and incorporating it into the common sense of a group (Wagner et al., 1999). Whereas anchoring occurs each time we meet a new phenomenon, objectification requires a greater degree of activation (Höijer, 2011), although both mechanisms have a role in forming representations and linking them to the images of those held by all individuals within a collectivity (Jodelet, 2012). Building on this, the model of representational naturalization developed by Negura & Plante (2021) further explains how these representations, once objectified, become embedded in the collective consciousness as 'natural' truths, perceived as part of the social reality itself. This process of naturalization contributes to the stability of SRs, as shared beliefs become so ingrained that they appear self-evident and unchallengeable within the group.

Emotional objectification occurs whenever the objectification mechanism integrates any emotional element. Examples include images of frightening events such as natural disasters or distressing ones such as suffering animals, which can be connected with other events to represent climate change and global warming (Höijer, 2011). Personification objectification occurs when the phenomenon or idea in question is related to a person; clear examples of this are Freud's

system of psychoanalysis and the media's habit of discussing events or phenomena by discursively attaching them to celebrities or public figures (Höijer, 2011).

In addition to the SRT processes (objectification and anchoring), the SRT offers four functions of SRs, including the function of knowing, the orientation function, the legitimation or justification function, and the identity function, which can be helpful in research (Eccleston, 2021). Understanding how these functions work highlights the role played by SRs in society.

Regarding the function of knowing, SR enables individuals to show the reality occurring around them as well as gain the information required to adjust that reality into the pre-existing framework which underpins communication and the growth of knowledge (Eccleston, 2021). The orientation function, as the name suggests, enables us to orient how we behave: In this regard, SRs guide our actions by giving us an understanding of different situations, social interactions, and objectives so we can anticipate what behavioral responses are most appropriate to them (Eccleston, 2021). After knowledge has been gained through experience and observation, we justify our behavior through the legitimation or justification function, which enables us to explain why we hold a certain belief or that a behavior was caused by a certain concept, as such beliefs and behaviors derive from our understanding of how objects are represented within our social group (Eccleston, 2021). Turning to the identity function, it should be noted that identity is defined by SRs as a process of social construction; hence, an individual's identity is molded by the group. By accepting the ideas and behaviors we see around us, we as individuals integrate them into their own identity and value system, simultaneously furthering the creation of the group's overall identity (Eccleston, 2021).

Ultimately, therefore, SRs enable us to grasp the multiple meanings anchored to a single phenomenon. They are influenced by wider social effects, developments, and institutions, such as media and other sources of information dissemination. Researchers of topics such as illness or mental health must ensure they study and understand context, as without such an understanding they will not properly grasp how members of a group speak of, and communicate with each other about the subject of investigation. The social practices and beliefs of a given group impact how they understand illness and health, and SRs can help uncover the socio-cultural context of the research topic (Maurya, 2009). Similarly, it is important to remember that context impacts how body and appearance are represented, as representations and beliefs of the body are both social and psychological constructions. Thus, although the body can be viewed as an individual object, determined biologically and psychologically, the social influences on the body's social identity and appearance should not be underestimated (De Vignemont, 2018). Therefore, body and appearance should be examined in accordance with contexts and groups, and in the light of the beliefs and values revealed by the discourse of group members. This thesis, therefore, aims to examine how individuals with BDD-like symptoms transform, understand, and communicate the SRs of body/appearance.

## **1.6 Social Representation of Body and BDD**

SRs carry the codes which enable individuals to remain connected with their world. As all codes used within a given context (Asbring, 2012) are commonly understood, individuals' body representations are constructed by the social, cultural, and historical context. Young people attending universities and schools are most affected by the messages disseminated by the media (Stenzel et al., 2006), particularly regarding their representation of body and appearance. Undesirable body types are commonly referred to as unhealthy, whereas muscle building is

frequently conveyed as a sign of masculinity and healthy physique in the media (Marcell et al., 2007). The naming process underlying these messages, as well as the meanings of the names used, differs across cultures. Aim et al. (2018) suggested that researchers investigating how health is represented must investigate the pressure applied to people in different ways through discourse related to health and illness, in addition to the risk inherent in any social, emotional, or medical understanding based on social interactions and societal perceptions. This warning suggests an association between media naming practices and body dissatisfaction and how the resulting shame (Tomas-Aragones & Marron, 2016) can lead to depression and anxiety (Liao et al., 2010).

Höijer (2011) observed that the process of personification can involve links being forged; for example, by the media between well-known individuals and the phenomenon in question (Höijer, 2011). Individuals' representation of their own body and appearance may be affected by the actions and words of celebrities. In Brazil, for example, it has been argued that the breast enlargements carried out by stars known as "Siliconadas", as well as the model Gisele Bündchen, caused notable changes to what middle-class Brazilian women think of as the ideal female physique (Forbes et al., 2012).

The media are not the only factor affecting the way members of a group learn about their body. Thompson et al. (1999) identified the three most important socio-cultural influences on body representation as parents, peers, and media (Du, 2015). Given that ever younger children are aware of body shape in today's world, the role of parents in forming their children's beliefs about ideal bodies is particularly important. One qualitative study found that even preschool children expressed appearance-related concerns and that mothers of girls in this age group can convey messages about the need to lose weight to their daughters if they appear concerned about

their own body shape (Du, 2015). Other research indicates that the parent-child relationship also has an effect on adolescents' body representations: for example, if adolescents are denied autonomy, they can develop anorexia (Du, 2015). Children's earliest experience of social development is parenting and the attachment they develop toward their primary carers; thus, factors such as parental diet, food and exercise-related behaviors, and body size can powerfully influence children's attitudes toward their own bodies (Abraczinskas et al., 2012).

Young people's body representations are also influenced by their peers, to whom they tend to compare themselves (Ricciardelli et al., 2000). Body image is a particularly important factor in determining acceptance in relationships with the opposite gender, although friendship circles also influence appearance-related expectations and norms (Jones, 2001). Friends and peers might, for example, discuss or jointly participate in activities, such as dieting or exercise programs designed to lose weight (Du, 2015); the most attractive way to present oneself in terms of clothes, hair, and makeup; and what is considered physically unacceptable. According to Jones (2004), these practices can be understood as training group members to accept appearance norms and dictate the ideal "look" (Hildebrandt et al., 2008). Teasing among peers can lead to the development of negative body representations. Some young people lose weight as a reaction to being teased and as a way to be accepted by their peers, forming negative behaviors and representations which can last into adulthood (Davison, 2012). Forney et al. (2012) studied how peer context influences body dissatisfaction and found that females are more affected by peer comments than men and are more likely to develop eating disorders because of such comments.

The media also conveys powerful messages concerning what makes physical appearance (un)acceptable. The ideal of thinness is frequently promoted in the media by, for example, the publicity given to new diets, beauty products, and cosmetic surgical procedures, all of which

have a huge influence on audiences, especially younger people (Ricciardelli et al., 2000). Movies, TV shows, magazines, the music industry, and even news broadcasts tend to idealize a single body shape and type of beauty, summed up in the statement “one can never be too thin to look good” (Du, 2015, p. 23). Audiences are so saturated by this message that they internalize it, which influences representations of their own and other people’s bodies and, in many cases, leads to body dissatisfaction (Heinberg, 2001). Such representations can also be molded through objectification or symbolization, which can more easily construct communal knowledge (Joffe, 2002). Young people, for example, are likely to be influenced by the symbols of health used in traditional and social media, and consequently decide to change their body to boost their social status and attract more followers. Jodelet (1984) cited the example of how the male and female images used in fashion advertising impact viewers’ representation of their own bodies.

Therefore, the society and group to which we belong greatly influences our perceptions of and feelings about our bodies, which in turn shape our relationships with others (Davison, 2012). The norms and expectations we internalize from our social context play a key role in molding our appearance representation and can lead to dissatisfaction, especially when these norms are unattainable or idealized.

Research indicates that gender shapes not only what body ideals are internalised, but also how appearance concerns emerge and are experienced socially and emotionally. For example, a systematic review found that while the thin-ideal predominates in research on adolescent girls, the “muscular ideal” is increasingly relevant for adolescent males (Holland & Tiggemann, 2016). Without clear gender distinctions, research runs the risk of implicitly treating body image concerns as a female-only problem, despite strong evidence that boys and adolescent men also

experience appearance-based anxiety, dissatisfaction with muscularity or leanness, and early signs of body-dysmorphic concerns (Jones & Crawford, 2005).

Research among boys and adolescent males shows that their body concerns though different in content from those of girls are equally significant. Rather than thinness pressures, boys frequently face the norms emphasising muscularity, height, and low body fat: a dual-pathway of weight and muscularity has been shown to contribute uniquely to body dissatisfaction in male adolescents (Jones & Crawford, 2005). Studies among mixed-gender adolescent samples have found that while girls were more likely to adopt weight-loss strategies, boys were more likely to pursue muscle-building or weight-gain strategies (McCabe & Ricciardelli, 2001). These findings reveal a parallel but distinct pathway to body distress among boys, one that has until now been under-represented in body-image research and deserves systematic inclusion.

Tesnime et al. (2016) examined social representations of the body among Tunisian sports science students and analysed differences by gender and level of study. Men were more likely to describe and experience the body as a “machine to perform” and a locus for proving masculinity and virility in high-intensity activities, whereas women associated bodily investment with endurance, managing discomfort, and feeling comfortable in social interactions. The authors conclude that femininity and masculinity are expressed through specific bodily forms, postures, and practices, and that students’ SRs of the body differ systematically by gender.

De Rosa and Holman (2011) have a whole research programme on social representations of male and female beauty and aesthetic surgery. It was a cross-cultural study among university students from Italy, Spain and Romania. They showed that gender significantly shapes the

content and structure of SRs of beauty. Using Associative Networks with inductor phrases such as “masculine beauty” and “feminine beauty”, they found that the SRs of feminine beauty cluster around attractiveness, charm and youthfulness. The SRs of masculine beauty are more strongly linked to physique, strength, and markers of social success. Their analyses explicitly report that the indexes and semantic structures of these representations differ by gender, confirming that men and women both produce and are positioned within distinct representational fields of beauty and the body.

These differentiated anchors reflect gendered socialisation processes, peer group norms, and media archetypes which means that interventions based on anchoring and objectification must be gender-sensitive to be effective. Incorporating these insights into the theoretical framework of this thesis strengthens its relevance and underlines the need for gender-specific prevention and intervention strategies in addressing BDD-like symptoms.

This project seeks to explore how these influences operate, particularly through intragroup discourse and interactions with family, peers, and media, which are instrumental in shaping adolescents' body representations and identities (Jodelet, 1984). While the literature on body and appearance SRs is limited, existing studies offer insights into how social values and group norms contribute to body disturbances. For instance, Stenzel et al. (2006) demonstrated how Brazilian female adolescents' body representations are shaped by dualities like body/ideal body and fatness/thinness, with social factors such as group norms and peer relationships influencing these representations. As illustrated by these findings, SRs of the body are rooted in social values and representations, which can lead to body dissatisfaction and even eating

disorders. These findings illustrate the need for further exploration into how SRs transform and shape body representations, particularly within the context of BDD-like symptoms.

In another study, Goetz et al. (2008) applied a Descending Hierarchical Classification (DHC) and an Alceste analysis of how the Brazilian press conveys SRs of the body, finding four distinct classes. Class 1 SRs present the satisfaction and desirability of a beautiful appearance, whereas class 2 covers cosmetic products and applications. Haircare and other self-care products and instructions or advice for how to use them fall within class 3, whereas class 4 covers the daily skincare and body care routines, including consulting professionals such as beauty therapists and dermatologists. Within healthcare, the principal SRs addressed exercise, discussed symptoms of ill health to look out for, and examined healthy eating and the risks associated with being overweight, dieting products, the association between obesity and mood, and contraception.

Secchi et al., (2009) investigated the relationship between SRs and body image among 278 female students. They used an open-ended question regarding SR of body. The words extracted from the question were analyzed using the descending hierarchical analysis. The results showed two sub-corpora, including classes about the beauty of the body to appearance (social status and body as communication and image) and a class about the beauty of the body related to thinness and physically active. In the first sub-corpora, participants indicated that a body can be seen in the notations related to aesthetics, nose, power, wisdom, relationship, and life as well as it can be seen through power and social relationships. In the second sub-corpora, body was seen as slim and physically active. These results indicated that female body is portrayed as needing to be beautiful, slim, powerful, and prestigious, embodying attractiveness while also being healthy.

De Rosa and Holman (2011) applied a multi-dimensional research approach to investigate SRs of beauty and cosmetic surgery among Italian, Romanian, and Spanish females and males. Regarding the SRs of masculine beauty, Italian men (represented by sports students) had a traditional view of the ideal masculine appearance, such as the “six-pack”. Views were more varied among Romanian males, who perceived masculinity as associated with social success and success in attracting women, and saw it as residing in both physique and personality. Spanish men focused on external physical aspects, citing height, posture, and dark skin as elements of attractiveness and sensuality. Turning to feminine SRs, Italian women focused on physical elements including face, posture, and hair but also associated beauty with non-physical attributes such as charm and flirtation. Romanian women suggested a variety of aspects, including health, youth, wealth, originality, attitude, social and professional success, and sex appeal. Spanish females tended to cite gender-dependent attributes including large breasts and a slim waist, as well as personality characteristics which suggest sincerity and refinement. The findings concerning cosmetic surgery suggested that Italians were individually motivated by dissatisfaction and insecurity; Italian women most frequently cited their breasts and nose as most in need of such procedures. Romanians suggested they would be motivated to undertake such procedures by the mass media and celebrity culture, but also thought that altering the body in this manner was in some way related to shame. In summary, SRs can be used in a variety of ways to examine how body meaning is socially determined and establish why people might seek to alter their appearance. Under SRT, people might decide to have surgery to meet the representation both of society and their own inner selves (De Rosa & Holman, 2011).

Camargo et al. (2011) investigated the SR of body among 79 participants. To extract content of SR about body, they used a free evocation task. The results showed that health, life,

and balance were the most frequent words in the free evocation task. Moreover, food and care were also common words which were about health and body homeostasis. These findings indicated that among adults, elements associated with health and well-being were more frequent, whereas younger individuals highlighted social interaction and viewed the body as a physical manifestation. Men tended to activate a smaller number of broad, while women used a wider range of elements which were normative.

De Souza Assunção et al. (2012) studied editions of the Pais & Filhos magazine published between 1968 and 1977 to investigate SRs of children's bodies, finding that they were used to represent an ideal by image objectification. Representations of children's bodies also revealed a healthy/sick and normal/abnormal dualism. Thus, the ideal body size, weight, eye color, and dress represented in images created a gap between actual and ideal appearance. Overall, the authors found that the reality of children's appearance and how they can be expected to develop into adolescence and adulthood is shaped by modernity, lifestyle discourse, and scientific discussions.

Tesnime et al. (2016) examined SRs of the body among students in Tunisia using quantitative research and demonstrated a significant relationship between the body and social contexts. Males understood masculinity as a means to overcome physical boundaries, whereas females associated femininity with physical activities, suggesting socially constructed gender roles. The authors also found a link between representations and level of study: First-year students associated physical wellbeing with being able to effectively perform physical activities, whereas second-year students thought that investing in bodily activity reduced discomfort and

saw their bodies as belonging to others. Third-year students, in contrast, perceived the body in biological terms.

Souza et al. (2019) investigated SRs of the body and health by researching physically active and inactive young Brazilians. Answers to free evocation questions revealed that the core SRs of the body were healthiness, body fat, and muscularity, whereas movement, exercise, fitness, strength, life, food, weight, and self-esteem resided in the peripheral core. The central core of health SRs included quality of life, wellbeing, health, and food, whereas sleep lay on the periphery. These results indicate a pool of common knowledge among both inactive and active individuals concerning the body and health. A key finding was that the SRs of the body relate principally to quality of life and the value of health.

Aim et al. (2020) examined SRs of health among young French people. Focus group findings revealed that females were more concerned than their male counterparts about how society regards health as well as the need to conform to the ideal appearance, including being slim, and a greater awareness of body and social comparisons. These results led the authors to conclude that “the imperative of a healthy body is a more female-oriented duty than a male duty” (Aim et al., 2020, p. 1912); therefore, females “devote greater attention to their body through self-objectification and self-monitoring practices” (Aim et al., 2020, p. 1912).

In a study conducted by Silveira et al. (2021), the authors examined SRs of the body and bodily care practices among older adults, investigating the role of gender in variance among these representations. By analyzing 40 older adults aged 60 to 84, this research revealed a significant differentiation between how men and women perceive and care for their bodies. Generally associating their body with biological functionality and health, male participants held

a stronger belief in maintaining physical health through proper food intake. In contrast, female participants placed a greater emphasis on their physical appearance in social contexts, illustrating the influence of SR of body and societal expectations. Regarding bodily care practices, male participants were more likely to prioritize food and nutrition, while female participants focused on physical exercise to maintain both their health and appearance. As seen in these findings, gender plays a significant role in shaping older adults' SRs of body as well as their corresponding self-care practices.

Bovina et al. (2022) investigated the SR of body image among 314 Russian women. Prototypical analysis on free evaluation about ideal body among younger women showed that health and slender words were in the core zone while toned, sportive, muscular, slim, and good skin were in contrasted elements zone. The first peripheral zone included beautiful word and the second peripheral zone included loved and strong words. These results indicated that the core zone and contrasted elements zone regarding ideal body are more related to normative pressures such as being healthy, slender, and sport.

According to the literature, there is an association between acceptability/attractiveness and social pressures and norms. Therefore, young people's understanding of the pressures and norms within their own social context may cause them to socially compare their own body with that of others, potentially compelling them to make changes to their appearance to become more acceptable/attractive. Nonetheless, there are several gaps in previous studies that the current study aims to address. First, the samples of previous studies were not representative of individuals with clinical/sub-clinical BDD, whereas the current study intends to compare SRs of body between individuals with and without BDD-like symptoms. Second, the targeted

populations were not Canadians, which leads the current research to explore the Canadian population, thus allowing researcher to distinguish cultural differences regarding SRs of body in a sample of Canadian residents. Third, it is unclear in previous efforts how the SRs of body are transformed and shaped. In other words, there is still a lack of analysis into how ideal body is transformed by peers (e.g., discourses within peer groups), but With respect to the media effects, although De Souza Assunção et al. (2012) addressed body objectification through magazines, the findings were not from a human sample with the aim of establishing how individuals explain the effects of media contents and messages by considering SR elements and contents on their representation about body/appearance. It is also key to explore how the ideal body is transformed and constructed through peers' and parents' discourses and communications. As mentioned above, intergroup discourse and interactions within peer and group members are important in shaping adolescents' representation of their appearance (Jodelet, 1984), however, there is insufficient evidence so far underlying the associations based on SR methods.

## **1.7 Conclusion**

The literature surrounding Body Dysmorphic Disorder (BDD) has shed light on various aspects of its prevalence, clinical presentation, and contributing factors. Numerous studies have reported prevalence rates ranging from 1% to 19% in the general population, with similar clinical features in both adults and adolescents, though suicide rates are higher among younger individuals (Bjornsson et al., 2010; Phillips et al., 2006). While these insights are useful in establishing a broader understanding of the issue, there remains a notable gap in understanding the prevalence and experiences of BDD among Canadian youth. Existing research has maintained a focus on the United States, Europe, and Iran, and has not addressed the specific influence of Canadian social and cultural dynamics on the development and expression of BDD.

Addressing this gap provides an essential lens to assist in developing more tailored, impactful social work interventions aimed at young people in Canada.

Theoretical models explaining BDD, such as the Cognitive-Behavioral Model, Self-Discrepancy Theory, Objectification Theory, Social Comparison Theory, and the Biopsychosocial Model, each provide key perspectives in understanding the disorder. While these frameworks highlight individual-level factors contributing to BDD, such as cognitive biases, maladaptive behaviors, self-objectification, and social comparisons, they often fail to fully capture the broader sociocultural forces shaping body concerns. For example, Cognitive-Behavioral Therapy (CBT) focuses on altering distorted thoughts and behaviors but does not adequately address the societal pressures that perpetuate unrealistic beauty standards. Similarly, Objectification Theory and Social Comparison Theory recognize external pressures but remain centered on individual internalization processes without exploring how these societal standards are constructed and maintained.

Positing a more comprehensive framework for understanding BDD, Social Representation Theory emphasizes the role of societal norms, media representations, and collective beliefs in shaping body concerns. Unlike other theories that focus primarily on individual cognition or biology, SRT examines how groups and societies collectively construct and perpetuate ideals of beauty, and how these shared representations influence individual perceptions of the body. This theory recognizes that individuals are not simply passive recipients of societal beauty standards, but are instead actively engaging in the negotiation, resistance, or internalization of these norms. By utilizing this more dynamic understanding of BDD and

analysing the interaction between individuals and their social environment, SRT provides a more nuanced and comprehensive understanding of how body concerns arise and persist.

Adding to this understanding, the literature further explores the role of social interactions and media in shaping body image, revealing that family, peers, and the media are core elements in influencing young people's representation of their bodies (Ricciardelli et al., 2000; Jones, 2001). Teasing, peer comparisons, and parental attitudes can all contribute to body dissatisfaction, while media messages that glorify thinness and certain physical traits reinforce unattainable beauty standards (Du, 2015; Heinberg, 2001). These societal pressures are intensified by the rising prevalence of social media platforms, as they continually disseminate images of the idealized body and lead to further social comparison and dissatisfaction, most notably among adolescents.

Further, studies have illustrated the significant variance in SRs of the body in different cultural contexts, with each society holding unique beauty ideals. Research from different countries showed that while body concerns are universally influenced by societal standards, the specific traits that are valued can vary (De Rosa & Holman, 2011; Veale et al., 2016). This highlights the need for culturally specific research, such as the present study, which aimed to explore the SRs of the body among young people in Canada. Understanding these cultural nuances is essential for developing effective interventions that are tailored to the unique sociocultural landscape of Canadian youth.

Overall, existing theoretical models have offered valuable insights into the individual-level mechanisms driving BDD, but have often failed to engage with the role of broader societal and cultural factors in shaping body concerns. Providing a more holistic approach, SRT goes

further to account for the collective societal forces that ultimately construct and maintain beauty ideals. Moreover, the distinct lack of research on the Canadian context of BDD points to a critical gap in the literature. This study aimed to fill that gap by investigating how SRs of the body, influenced by family, peers, and media, contribute to the development of BDD-like symptoms in Canadian adolescents and young adults. By doing so, it provided much-needed data to inform social work intervention programs designed to address body disturbances in this population.

## Chapter 2

### **Article 1: The Prevalence of BDD Among Young People in Canada: The Social Representation of Body in Individuals with and without Symptoms of Body Dysmorphic Disorder Like Symptoms**

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#### **2.1 Abstract**

**Background:** Body Dysmorphic Disorder (BDD) represents a mental health condition which causes people to obsess over perceived appearance defects that are generally minor or hidden from others. Adolescence is a critical period for identity formation, making young people particularly vulnerable to societal pressures related to body image. While global studies highlight the prevalence of BDD among youth, research on BDD in Canadian adolescents and young adults is limited. This study investigate the prevalence of BDD-like symptoms among Canadian youth and the social representations (SR) of the body in individuals with and without BDD-like symptoms, highlighting the sociocultural factors that shape body representations.

**Methods:** A mixed-methods approach was employed. The study involved 496 Canadian students aged 16 to 21 years, recruited through social media and academic channels. The study's quantitative research component evaluated how BDD-like symptoms spread across various socio-demographic groups using chi-square tests and logistic regression. SRs were analyzed via

textual frequency-rank analysis and prototypical analysis in the qualitative part. The data were collected using the Body Dysmorphic Disorder Questionnaire (BDDQ), BDD-YBOCS and Verbal Association Technique. The study applied Social Representation Theory (SRT) to explore how societal beauty standards and cultural norms influence body representations.

**Results:** The study found that 33.33% of participants exhibited BDD-like symptoms. Women exhibited significantly higher BDD prevalence compared to non-binary individuals, bisexual and questioning individuals as well as those who were in relationships. Key socio-demographic factors associated with BDD included gender, sexual orientation, and marital status, while age, race, education, residency, job status, and immigration status were not significantly related. The central core of SRs for individuals with BDD-like symptoms included words such as "fat" and "pretty," reflecting an appearance-focused representation. In contrast, those without BDD-like symptoms mentioned a broader range of concepts including "healthy" and "confident" suggesting a more balanced and functional perspective on body image.

The words mentioned by participants with BDD-like symptoms exhibited more negative valences.

**Conclusion:** The research demonstrates extensive differences between Canadian youth displaying BDD-like symptoms and those without them in terms of body representation through verbal associations and social representation theory. The study indicates social norms play a fundamental role in determining body representation which highlights the importance of comprehensive methods for social interventions.

**Keywords:** body dysmorphic disorder, social representation theory, body image, verbal association, youth, Canadian youth.

## 2.2 Introduction

Body Dysmorphic Disorder (BDD) is a serious mental health condition where individuals become overly focused on perceived flaws in their appearance, often minor or unnoticeable to others (American Psychiatric Association, 2013). The disorder commonly manifests during adolescence, a period of heightened vulnerability due to rapid physical, emotional, and social changes (Veale et al., 2016). Adolescents with BDD frequently experience significant distress and impairment in various domains of life, including academic performance, social relationships, and overall mental health (Mataix-Cols et al., 2015).

The period of adolescence is a crucial time for self-discovery and forming one's identity. Physical appearance is often a significant factor shaping an individual's self-concept during this period, and concerns over appearance can be intensified by societal pressures, such as unrealistic beauty standards and constant exposure to idealized images on social media. Individuals with BDD experience these pressures, which fuel their preoccupation with perceived flaws and lead to feelings of inadequacy and shame. These adolescents' persistent focus on their physical appearance can become a hindrance in their daily functioning, and cause significant challenges in navigating social interactions or maintaining a positive sense of self (Helfert & Warschburger, 2013).

This chapter further explores the broader context and significance of the research on understanding social representation (SR) of the body among individuals with and without symptoms of Body Dysmorphic Disorder (BDD). Delving deeper, it examines the significance and underlying theoretical framework of how societal beauty standards and personal experiences shape body representation. The goal of this study is to uncover the differences in SRs between

these populations, and how these varying representations are determined or shaped by factors such as media, peers, and cultural norms.

The research utilized a mixed-methods approach, incorporating both quantitative and qualitative techniques to provide a comprehensive understanding of the topic. The quantitative aspect focused on estimating the prevalence of BDD-like symptoms across various socio-demographic factors, with analyses conducted using chi-square tests and logistic regression. Additionally, this study used textual frequency ranks and prototypical analysis to examine SRs of the body, allowing for a detailed comparison in word usage between participants with/without BDD-like symptoms. The study created a representative sample population by adhering to strict inclusion criteria in recruiting high-school, college, and university students in Canada. Multiple recruitment channels, including social media platforms, were employed to attract a diverse group of participants. Data collection was facilitated through the Qualtrics platform, where participants completed socio-demographic questionnaires, BDD screening tools, and the verbal association technique to elicit SRs of the body. In the following sections, we will delve into the study population, materials, and detailed data analysis procedures.

Research into Body Dysmorphic Disorder (BDD) has shown that the typical onset of the disorder occurs around age 16, with adolescents and adults displaying similar clinical symptoms in terms of severity, comorbidity, and impairment (Albertini & Phillips, 1999; Mataix-Cols et al., 2015). Veale et al., (2016) highlights that approximately 1-2% of the general population is affected by BDD, with adolescents being a particularly vulnerable group. Mataix-Cols (2025) indicates that BDD typically begins during adolescence, with a weighted point prevalence of approximately 1% among youth. Notably, the disorder is more prevalent in girls (1.8%) than in boys (0.3%), and more common in adolescents aged 12-19 years (1.9%) compared to children

aged 5-11 years (0.1%). A 1995 study involving 803 American women revealed that 48% were dissatisfied with their bodies and 49% struggled with weight issues (Bergstrom & Neighbors, 2006). Additionally, one survey found that one-third of American women attempted to lose weight (Bergstrom & Neighbors, 2006).

Women generally express more concerns about appearance than men. For example, 36% of American women reported dissatisfaction with specific body parts like their face, muscle tone, hair, torso, and breasts (Cash & Henry, 1995), while Grogan (1991) found women were particularly dissatisfied with their thighs, stomachs, and hips (Grogan, 2021; Bergstrom & Neighbors, 2006). Veale et al. (2016) reported that rhinoplasty patients had the highest prevalence of BDD, with a weighted prevalence of 20.1%, higher in Iran (31.5%) than in the UK (20.7%) and the USA (2%). Additionally, prevalence rates in general cosmetic surgery, orthognathic surgery, and acne dermatology clinics were 13.2%, 11.2%, and 11.1%, respectively. Italy had the highest prevalence of general cosmetic surgery (Veale et al., 2016).

Despite significant research into the prevalence of Body Dysmorphic Disorder (BDD) across various populations, a noticeable gap exists in the study of BDD among young people in Canada. While global studies point to significant levels of body dissatisfaction and BDD among young people, no research has specifically investigated the prevalence of BDD in Canadian youth without offering insights into the prevalence of BDD in Canadian youth or how Canadian cultural and social factors may influence body representations and BDD development. This study sought to address this gap by investigating the prevalence of BDD-like symptoms among youth 16-21 age range in Canada while examining how social and cultural dynamics shape body concerns.

To address this gap, this research aimed to answer the following research questions: 1- What is the prevalence of BDD-like symptoms among young people in Canada? 2-What is the central and peripheral core of the social representation of the body among young people in Canada? The findings of this research will not only contribute to understanding the prevalence of BDD in Canada but also uncover the stable, widely shared societal ideals (central core) and flexible, context-dependent attributes (peripheral core ) that shape body-related representations. These insights into the socio-cultural factors of body disturbances will help inform social work interventions and prevention strategies tailored to Canadian youth addressing both the psychological and societal dimensions of body concerns.

### **2.3 Theoretical Framework: Social Representation Theory in the Context of Body Dysmorphic Disorder**

As the theoretical foundation of this study, Social Representation Theory (SRT), conceptualized by Moscovici (2008), permits a comprehensive exploration of how individuals and groups both construct and share collective understandings of body. SRT emphasizes the role of societal and cultural factors in shaping these shared meanings, providing a valuable lens to identify and assess the cognitive and emotional differences in body representations between individuals with and without BDD-like symptoms. This study mobilized key concepts and processes of SRT, including central and peripheral elements, and the socio-cultural context of representations, to frame its analysis (Jodelet, 2008).

The structural approach to SRT further elucidates how social representations are organized within social groups. This approach distinguishes between the central core, which consists of the stable and consensual elements shared by a group, and the peripheral system,

which accommodates contextual and flexible interpretations (Abric, 1993). In the context of SR of body, the central core might include universal societal ideals, such as beauty standards, while peripheral elements might reflect more individual or context-dependent attributes, such as personal grooming habits or cultural variations in appearance standards. By employing this dual structure, researcher can gain deeper insight into the different ways that individuals with and without BDD-like symptoms construct and prioritize these representations.

Additionally, through its acknowledgement of the broader social and cultural dimensions of social representations, SRT recognizes the collective, not just individual, nature of beliefs about the body, and how they are shaped by their historical, societal, and cultural contexts (Joffe, 2003). These context-specific elements, including media, education, and social interactions, play a key role in influencing representations of the body as they perpetuate, and at times challenge, existing norms. By focusing on these societal influences, SRT offers itself as a valuable tool in examining how collective beliefs about beauty and body are instrumental in the development and persistence of disorders like BDD (Höijer, 2011; Jodelet, 2008). Specifically, media representations are a key factor in reinforcing societal standards, forming collective perceptions, and influencing individual self-concepts (De Rosa, 2013). Collectively, these representations are shaped by media, but also education, and social interactions, and demonstrate the interwoven influence of both societal norms and personal interpretations. This dual structure helps explain how individuals with and without BDD-like symptoms engage with and internalize body-related beliefs within their sociocultural environment.

## 2.4 Methods

A mixed-method approach in this research was used to explore the prevalence of Body Dysmorphic Disorder (BDD)-like symptoms among young people in Canada and to provide an extensive understanding of the structure of social representation (the central and peripheral core) of the body based on SRT, among young people in Canada. Multiple studies have successfully applied hierarchical evocations (frequency-rank method) to identify the structure of social representation (e.g., Guarnaccia et al. 2015; Sañas et al. 2020).

To answer the first research question “what is the prevalence of BDD-like symptoms among young people in Canada?”, the Body Dysmorphic Disorder Questionnaire (BDDQ) was used to determine the prevalence of BDD-like symptoms among Canadian youth. The Body Dysmorphic Disorder Modification of the Yale-Brown Obsessive Compulsive Scale (BDD-YBOCS) was also used to gather more information about BDD symptoms. Chi-square tests and logistic regression were performed to explore correlations between BDD-like symptoms and socio-demographic characteristics.

To answer the second research question “what is the central and peripheral core of the social representation of the body among young people in Canada?”, this research utilized the short version of the Verbal Association Technique to explore social representations of body. Participants produced words and phrases about body and appearance which they then ordered the words based on their importance. The gathered data was analyzed to find the frequency of mentioned words and rank-frequency analysis to identify central and peripheral elements. Chi-square tests were used to identify differences in the structure of social representations of body between participants with BDD-like symptoms and those without BDD-like symptoms. The

research methods produced a comprehensive analysis of both the structure and content of body representations found in the study sample.

#### **2.4.1 Participants**

The study population consisted of students enrolled in high schools and universities across Canadian institutions who also lived in Canada. The inclusion criteria were as follows:

- 1) Being a high-school, college, or university student
- 2) Living and studying in Canada (e.g., Canadian/permanent resident or International students)
- 3) Knowledge of English as the primary or secondary language
- 4) Aged between 16 to 21-years-old

The recommended sample size for logistic regression analyses stands at 500 according to Bujang and colleagues (2017). The study aimed to recruit 500 participants during Phase 1. The survey received participation from a total of 582 volunteers. Researcher excluded 43 participants because they provided incomplete responses and excluded another 43 individuals from participation because their ages exceeded 21 years. The study analyzed data from 496 participants whose average age was 18.81 years old with a standard deviation of 1.09 years, and 68.29% of these participants were female ( $M_{age} = 18.81$ ,  $SD = 1.09$ ; 68.29% female). Multiple platforms including Facebook groups (local and university groups), Instagram, Telegram and WhatsApp served as advertisement channels to recruit volunteers. The current study included participation mostly from students of the University of Ottawa through the Integrated System of Participation in Research (ISPR). Participants obtained 1% course credit as compensation for

their study participation. The Qualtrics platform hosted the questionnaires online throughout a period that began in August 2023 and ended in June 2024 which lasted for 10 months. All participants completed an informed consent form. The University of Ottawa Research Ethics Boards authorized this study under approval number (#S-10-22-8445).

**2.4.1.1 Sociodemographic Characteristics**

Table 2-1 displays the study participants' demographic characteristics across multiple factors including age, sex, gender, sexual orientation, marital status, education level, residency location, employment status, immigration status and race. The study's participants consisted of 68.29% females who had an average age of 18.81 years with a standard deviation of 1.09. The majority of participants (93.45%) fell within the 18-21 year old age range while 86.23% identified as heterosexual and 66.87% identified as women with 90.59% being single. The study included 67.27% undergraduate participants who 87.58% lived in urban areas and 84.19% who held Canadian citizenship or permanent residency. Out of all participants 38.52% identified as White followed by 19.88% as Black, 17.62% South-East Asian, 10.25% Arab, 6.56% Mixed, 2.46% Middle Eastern and West Asian and 1.84% Latin American and another 2.87% had distinct racial identities. Students made up 61.27% of participants while employed participants accounted for 28.28% and unemployed participants represented 10.45%.

**Table 2-1**  
Sociodemographic Characteristics of the Sample (N = 496).

Total	
N	%

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Age, <i>M (SD)</i>	473	18.81 (1.09)
below 18	31	6.55
18-21	442	93.45
Sex	492	
Male	154	31.30
Female	336	68.29
Other	2	.41
Gender	492	
Man	152	31.10
Woman	329	66.87
Non-binary	10	2.03
Sexual orientation	472	
Heterosexual	407	86.23
Bisexual	33	6.99
Lesbian/gay	6	1.27
Queer	10	2.12
Questioning	11	2.33
Other	5	1.06
Marital status	478	
Single	433	90.59
Married/Common law	8	1.67
In a relationship/dating	32	6.69
Widowed/divorced/separated	1	.21
Education	495	

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High school	139	28.08
College	23	4.65
Undergraduate	333	67.27
Residency	467	
Urban	409	87.58
Rural	58	12.42
Job status	488	
Unemployed	51	10.45
Employed	138	28.28
Student	299	61.27
Immigration status	487	
Canadian/Permanent Resident	410	84.19
International student	74	15.20
Race	488	
White	188	38.52
Black	97	19.88
Arab	50	10.25
Asian (south-east Asia)	86	17.62
Middle east and west Asia	12	2.46
Other	14	2.87
Mixed	32	6.56
Latin America	9	1.84

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## 2.4.2 Questionnaires

The participants completed the questionnaires on the Qualtrics. The questionnaires were as follows:

***1-Socio-demographics:*** This form consisted of information regarding gender, sexual orientation, age, race/ethnicity, marital status, residency status, and socioeconomic status. Based on the Canadian Institutes of Health Research (CIHR), gender is measured as woman, man, pangender, transgender, and gender-diverse, etc. (Adisso et al., 2020). Therefore, gender was recorded based on the CIHR description; sexual orientation as lesbian, gay, bisexual, transgender, queer/questioning, and two spirit; age as a continuous variable; and marital status as single, married/common-law, widowed/divorced/separated, and other. Socioeconomic status included education, job status, and residence area. Education categorized as high school, college, and undergraduate. Residence area was recorded as rural and urban; job status was recorded as employed and unemployed.

To address the Canadian demographic diversity, such as visible minority groups, indigenous people, gender diversity (men, women, and LGBTQ2), and immigrants, the following methods were applied:

For gender diversity, a two-step method was used. This method provides two questions which the first one is about birth sex and the second one is about current gender identity. This method can indirectly distinguish biological sex and gender identity when the answers are not the same for step 1 and step 2. The birth sex includes female, male, intersex, and other. The gender identity includes woman, man, not binary, and other. The two-step method is a valid measure across North America (Magliozzi et al., 2016).

I asked participants about their immigration status and then determined if they were members of visible minority groups or indigenous communities. The recruitment procedure took into account various diversity aspects by making it clear in the recruitment ads that the project welcomes individuals from diverse backgrounds. To have enough sample for different diversities, there were methods that was used. For example, recruiting a very large sample size to represent all diversity, however, it might still be hard to present diversity (Sell, 2017). By distributing recruitment ads through indigenous communities and organizations for visible minorities, LGBTQ2 groups and immigrant associations we enhanced the likelihood of including these people in the study analysis. Oversampling represents this approach which ensures adequate group samples for comparative analysis (Anderssen & Malterud, 2017).

**2- The Body Dysmorphic Disorder Questionnaire:** The BDDQ was created by Phillips (1995) to screen for plausible BDD. This action incorporates five items with twofold answer alternatives (yes/no), aside from question 5 which asks for information about the quantity of hours the respondent spends contemplating their appearance (Phillips, 2005). BDDQ scores are somewhere in the range of 0 and 4, with 4 demonstrating the satisfaction of the rules of BDD. A sensitivity range of 94–100% and a specificity range of 89–93% in different clinical samples have been reported (Dey et al., 2015; Grant et al., 2001). The current project utilized scores to bunch members into two gatherings, incorporating people with/without probable BDD manifestations. There are two forms of the BDDQ, one for adolescence and the other for adults 18 years of age or over (Dyl et al., 2006). The two measures have the same scoring and screening criteria; hence, the two versions are comparable. The current study used adolescence version, which wordings are more suitable for them.

**3-Body Dysmorphic Disorder Modification of the Y-BOCS (BDD- YBOCS):** The BDD-YBOCS is a 12-item scale measuring BDD severity during the past week. Items 1-5 measure obsessional preoccupations about perceived appearance defects. Items 6-10 measure repetitive behaviors related to BDD. Items 11 and 12 assess insight related to appearance and avoidance, respectively. The items are scored based on a 5-point Likert scale ranging from 0 (no symptoms) to 4 (extreme symptoms). The total score ranges from 0 to 48, higher scores indicate more severe BDD symptoms. The scale has a good internal consistency (Phillips et al., 2014). There are two forms of the BDDQ, one for adolescence and the other for adults 18 years of age or over. The two measures have the same scoring. The current study used adolescence version, which wordings are more suitable for them. The internal consistency of this scale was .91 in the current dataset.

**4- The Short-Version of the Verbal Association Technique:** This is a data collection method based on SRT. There are two types of tasks in this technique: free association and hierarchical ranking. First, participants were asked to name eight words or phrases that come to their minds when they think of body and appearance. They were subsequently asked to rank words and phrases from the most important to the least important (Lo Monaco et al., 2017). There are a 7-point Likert scale (not at all important, low importance, slightly important, neutral, moderately important, very important, and extremely important) next to each word that they were asked to complete it. In this method, the frequency of word occurrences and their ranks were recorded for analysis (Lo Monaco et al., 2017).

The use of the Verbal Association is directly consistent with the structural approach to Social Representation Theory (SRT), which distinguishes between the central core and the peripheral system of a representation. According to Moliner and Abric (2015), the central core

contains the most stable, consensual elements that organize the representation, while the periphery reflects more flexible, context-sensitive aspects that allow adaptation to individual experiences and changing social conditions. High-frequency words that are evoked early are interpreted as belonging to the central core, whereas less frequent or later associations are considered part of the periphery (Moliner & Abric, 2015; Rateau et al., 2012). In this way, the verbal association method used in this study, operationalizes the elaborateness of SRT by making visible both the enduring, consensual aspects of how the body is represented and the more flexible margins where personal and contextual influences emerge.

### **2.4.3 Screening the Data**

The data was screened based on missing observations and careless responding criteria. The analysis did not include participants who showed incomplete responses on the BDDQ and BDD-YBOCS. 466 participants finished the Body Dysmorphic Disorder Questionnaire and 460 completed the Body Dysmorphic Disorder Modification of the Y-BOCS among the total 496 participants. The analyses excluded participants who had missing more than 10% of the observations. The research studies conducted by Bennett (2001) and Dong & Peng (2013) confirmed that statistical analyses become biased when there are over 10% missing observations. The current dataset identified only 3 participants with more than 10% missing observations for the BDD-YBOCS measure, who were consequently excluded. There were 32 participants with less than 10% missing for the BDD- YBOCS measure, which were kept.

Careless responses were also checked using invariability and outlier criteria. The detection of consecutive identical responses required the use of an invariability measure. The assessment method computed within-individual standard deviations (SDs) for every

questionnaire; responses with a within-individual SD of lower than 0.4 were considered as careless response (Ward & Meade, 2023). The BDD-YBOCS measure showed identical responses from 19 participants. The outliers were also checked. The total scores from both BDDQ and BDD-YBOCS measures were transformed into z-scores as the initial step. The analysis excluded any participants who had z-scores higher than +3 or lower than -3. Only 1 participant met this criterion for the BDD-YBOCS measure. Finally, after excluding outliers and identical responses, measures with less than 10% missing observations were imputed using the expectation–maximization (EM) procedure in SPSS. After screening, the analyses were done on 460 participants and 466 participants for the BDD-YBOCS and BDDQ, respectively. All analyses were conducted considering pairwise-deletion methods.

#### **2.4.4 Data Analysis**

The sample characteristics were initially shown through descriptive statistics with their frequencies and percentages. The study proceeded to calculate the prevalence of BDD-like symptoms and utilized chi-square tests ( $\chi^2$ ) to compare these rates across sociodemographic factors. Simple logistic regression analyses tested the relationship between binary BDD outcomes and sociodemographic factors. Odds Ratios with 95% confidence intervals were reported for the logistic regression analyses. All quantitative analyses were conducted using SPSS with respect to a significance level of .05.

SPSS performed a textual analysis on verbal associations to determine word frequency and their valence scores ranging from negative through natural to positive values. Researcher used Generalized Estimating Equations (GEE) analysis to examine the connection between BDD questionnaires and word valences because they operated with a long-form data structure for these

effects. The statistical approach known as Generalized Estimating Equations (GEE) analyzes correlated data sets particularly in repeated measures investigations and cluster-based correlations (Ballinger, 2004). The analysis treated word valences as the dependent variable while using categorical BDDQ scores and continuous BDD-YBOCS scores as independent predictors. The model was specified as linear due to the continuous outcome and unstructured correlation to estimate all possible within-individual correlations (Ballinger, 2004). Unstandardized coefficients and p-values were reported. Chi-square tests ( $\chi^2$ ) were used to analyze word frequency differences between participants with BDD-like symptoms and those without these symptoms. We performed frequency-rank analyses on both the entire sample population as well as separate subgroups of participants who exhibited BDD-like symptoms versus those who did not. Categorization followed the hierarchical evocation method during extraction. A 2x2 table were used (frequency vs. rank) for which the frequency included high vs low, and the rank order included low vs high rank. The frequency and rank mean were considered as the cutoff to divide the words into low rank/frequency and high rank/frequency. The structure of the SRs was presented as 1) central core (high frequency, low rank); 2) contrasted elements (low frequency, low rank); 3) first peripheral element (high frequency, high rank); and 4) second peripheral element (low frequency, high rank). The analytic plan for the verbal association technique was based on previous studies (Baquiano & Mendez, 2016; Dany et al., 2015; Montiel et al., 2013). The analysis utilized prototypical analyses to display the representation of the words. Analyses were conducted on both the entire sample pool and subsets of participants with and without BDD-like symptoms. The IRAMUTEQ software was used to analyze the data.

## 2.5 Results

### 2.5.1 Prevalence of BDD-Like Symptoms

Table 2-2 presents the prevalence of positive body dysmorphic disorder (BDD) across various demographic factors. In the current sample of Canadian students, 33.33% of participants reported positive BDD. There was no significant association between age groups and positive BDD,  $\chi^2 (1) = 2.53, p = .112$ . There was a significant association between sex and the prevalence of BDD,  $\chi^2 (1) = 36.74, p < .001$ , where females had a higher prevalence (42.81%) compared to males (13.89%). Also, a significant association between gender and the prevalence of BDD was observed,  $\chi^2 (2) = 31.21, p < .001$ . The prevalence of BDD was 42.14% among women, 40.00% was among non-binary gender identity, and 15.38% was among men. Sexual orientation was significantly associated with the prevalence of BDD,  $\chi^2 (4) = 18.08, p < .001$ , where a high prevalence of BDD was observed among bisexual (63.33%) and questioning (63.64%). Marital status was significantly associated with prevalence of BDD,  $\chi^2 (1) = 14.84, p < .001$  with married/common-law or in a relationship/dating participants showing a higher prevalence (62.86%). Education level did not show a significant association with positive BDD,  $\chi^2 (2) = 14.84, p = .485$ , although undergraduates had the higher prevalence (35.18%) compared to high school (30.23%) and college (26.32%). There was no significant association between urban versus rural residency and positive BDD,  $\chi^2 (1) = 0.710, p = .400$ . Job status did not show a significant association with positive BDD,  $\chi^2 (2) = 0.482, p = .786$ . Similarly, immigration status did not show a significant association with positive BDD,  $\chi^2 (1) = 1.43, p = .231$ . Race also did not show a significant association with positive BDD,  $\chi^2 (6) = 6.75, p = .344$ .

**Table 2-2**

Prevalence of Body Dysmorphic disorder (BDD) by Socio-Demographic Factors.

	Positive BDD	
	%	Chi-square (df), <i>p</i> -value
	33.33	
Age (N = 434)		2.53 (1), .112
below 18	48.15	
18-21	33.17	
Sex (N = 450)		36.74 (1), <.001
Male	13.89	
Female	42.81	
Gender (N = 452)		31.21 (2), <.001
Man	15.38	
Woman	42.14	
Non-binary	40.00	
Sexual orientation (N = 435)		18.08 (4), .001
Heterosexual	31.02	
Bisexual	63.33	
Queer	28.57	
Questioning	63.64	
Other	50.00	
Marital status (N = 434)		14.84 (1), <.001

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Married/Common law/In a relationship/dating	62.86	
Single	30.83	
Education (N = 455)		1.45 (2), .485
High school	30.23	
College	26.32	
Undergraduate	35.18	
Residency (N = 428)		.710 (1), .400
Urban	34.13	
Rural	28.30	
Job status (N = 448)		.482 (2), .786
Unemployed	34.09	
Employed	31.54	
Student	35.04	
Immigration status (N = 444)		1.43 (1), .231
Canadian/Permanent Resident	34.49	
International student	27.14	
Race (N = 448)		6.75 (6), .344
White	37.06	
Black	28.57	
Arab	36.96	
Asian (south-east Asia)	25.93	
Middle east and west Asia	27.27	

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Other	47.62
Mixed	39.29

Table 2-3 shows the odds ratios and statistical significance for the prevalence of BDD based on various demographic factors. Participants aged 18-21 years had a non-significant odds ratio (OR) of 0.53 (95% CI; 0.24, 1.17), indicating no significant difference for those who aged 18-21 compared to those below 18 years old ( $p = 0.117$ ). Females were 4.64 times more likely to present positive BDD (OR = 4.64,  $p < 0.001$ ). Women were 4.01 times more likely to exhibit positive BDD (OR = 4.01,  $p < 0.001$ ). Results also showed that the likelihood of presenting positive BDD was higher among bisexual (OR = 3.84,  $p < .001$ ) and questioning participants (OR = 3.89,  $p = .033$ ), and those who were married/common-law partner or in a relationship (OR = 3.80,  $p < .001$ ). No significant differences were found regarding residency, education, job status, immigration status, and race.

**Table 2-3**  
Odds Ratios of Various Demographic Factors for BDD.

	OR	95% CI	Wald	<i>p</i> -value
Age (reference: below 18)				
18-21	.53	.24, 1.17	2.46	.117
Sex (reference: male)				
Female	4.64	2.75, 7.84	32.99	<.001
Gender (reference: man)				

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Woman	4.01	2.41, 6.66	28.56	<.001
Non-binary	3.67	.096, 14.06	3.59	.058
Sexual orientation				
(reference: heterosexual)				
bisexual	3.84	1.77, 8.33	11.61	<.001
Queer	.89	.27, 2.89	.04	.846
Questioning	3.89	1.12, 13.56	4.56	.033
Other	2.22	.44, 11.18	.94	.332
Marital status				
(reference: single)				
Married/Commen law/in a relationship	3.80	1.85, 7.78	13.27	<.001
Education (reference: high school)				
College	.82	.28, 2.45	.12	.728
Undergraduate	1.25	.80, 1.95	.99	.319
Residency (reference: urban)				
Rural	.76	.40, 1.44	.71	.401
Job status (reference: unemployed)				
Employed	.89	.43, 1.84	.10	.754
Student	1.04	.53, 2.04	.01	.903

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Immigration status				
(reference:				
Canadian/Permanent				
Resident)				
International	.71	.40, 1.25	1.42	.233
student				
Race (reference:				
white)				
Black	.68	.39, 1.18	1.89	.169
Arab	1.00	.51, 1.95	.00	.990
Asian (south-east	.59	.33, 1.07	3.02	.082
Asia)				
Middle east and	.64	.16, 2.49	.42	.516
west				
Asia				
Other	1.54	.62, 3.84	.87	.350
Mixed	1.10	.48, 2.49	.05	.821

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### 2.5.2 Social Representation of Body

In total, 3336 words were extracted from the verbal association task. Words with a frequency of 10 and above were included in the textual analysis. The words included **Hair (4.8%), Fat (4.4%), Tall (4.4%)** were the most frequently mentioned, indicating that these

aspects of body and appearance were prominent in the dataset. Also, the less frequent words were Weird, Imperfect and Facial with the same percentage of (0.5%).

Table 2-4 shows the rank-frequency analysis of SR of body on the total sample. In this analysis, words with a frequency of above of 28 were considered as high frequency and words with a frequency of 28 or below were considered as low frequency. Words with a rank lower than 4.5 were regarded as low rank and words with a rank higher than 4.5 were regarded as high rank.

The rank-frequency analysis revealed distinct zones in the representation of the dataset. The terms "fat", "tall", "strong", "skinny", "healthy", "beautiful", "short", "pretty", "big", "height", "ugly", "face", "muscular", "curvy", "weight", "shape", "small" and "chubby" were identified in the central core zone, indicating high frequency with low ranking, signifying their importance and consistent presence.

In the peripheral zone 1, high-frequency terms with high rank words included "hair", "eyes," "fit", "athletic", "skin" and "legs", suggesting they are commonly mentioned but not central to the core representation.

The elements "average", "arms", "slim", "cute", "muscle" "unique", "handsome", "clean", "normal", "thin", "thick", "young", "good", "feminine", "acne", "confident", "amazing", "sexy", "shoulders", "unattractive", "medium", "white" and "weird" fall within the contrast zone, characterized by low frequency and low ranking, indicating their more significant and less frequent words in the dataset.

Finally, in peripheral zone 2, where terms with low frequency but high rank, the following words revealed: "nose", "lean", "overweight", "beauty", "hairy", "look", "attractive", "hands", "feet", "size", "soft", "different", "long", "black", "nice", "mouth", "teeth", "smile", "lips", "wide", "style", "imperfect" and "facial". This zone reflects their occasional mention and peripheral importance in the overall representation.

**Table 2-4**

Rank-frequency analysis of social representation of body on the total sample.

Frequency	Importance	
	High	Low
<b>Total</b>		
<b>High</b>	Fat (88), 4.2	Hair (96), 4.8
	Tall (88), 4	Eyes (67), 5
	Strong (73), 4.4	Fit (45), 4.7
	Skinny (73), 4.3	Athletic (43), 4.8
	Healthy (67), 4.2	Skin (42), 5.2
	Beautiful (63), 4.4	Legs (40), 5.3
	Short (60), 4.1	
	Pretty (51), 4.1	
	Big (50), 4.3	
	Height (45), 4.3	
	Ugly (43), 4.3	
	Face (41), 3.9	
	Muscular (41), 4.5	
	Curvy (39), 4.5	

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**Low**

Weight (39), 4.3

Shape (33), 3.8

Small (32), 4.5

Chubby (32), 4.2

Average (28), 3.9

Arms (26), 4.5

Slim (24), 4.3

Cute (23), 3.9

Muscle (22), 4.3

Unique (20), 4.3

Handsome (19), 4.3

Clean (17), 4.2

Normal (16), 4.5

Thin (16), 4.1

Thick (15), 4.3

Young (14), 3.8

Good (14), 4.1

Feminine (14), 3.6

Acne (13), 4.2

Confident (12), 4.2

Amazing (12), 4.4

Sexy (12), 4.5

Shoulders (12), 4.4

Nose (26), 5

Lean (22), 4.8

Overweight (22), 4.6

Beauty (21), 4.8

Hairy (18), 4.8

Look (17), 4.8

Attractive (16), 4.9

Hands (16), 5.2

Feet (15), 5.6

Size (15), 5.5

Soft (14), 6.1

Different (13), 5.2

Long (12), 5.5

Black (12), 4.9

Nice (12), 4.8

Mouth (12), 6.2

Teeth (12), 4.8

Smile (11), 5.5

Lips (11), 5.7

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Unattractive (11), 4.1	Wide (11), 5
Medium (11), 3.6	Style (10), 5.5
White (10), 4.4	Imperfect (10), 5.9
Weird (10), 4.5	Facial (10), 6

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Table 2-5 and Table 2-6 shows the rank-frequency analysis of SR of body among participants with positive BDD and without BDD, respectively. As shown in Table 2-5, words with a frequency of 18 and above of 18 were considered as high frequency and words with a frequency of 17 or below were considered as low frequency. Words with a rank lower than 4.4 were regarded as low rank and words with a rank higher than 4.4 were regarded as high rank. Also, as shown in Table 2-6, words with a frequency of 24 or higher were classified as high frequency, while those with a frequency of 23 or lower were classified as low frequency. Words with a rank below 4.45 were considered low rank, whereas those with a rank above 4.45 were considered high rank.

*Central Core Zone:* The central core zone among participants with BDD-like symptoms included the terms "fat", "pretty", and "strong". These terms were characterized by high frequency but low ranking, indicating that they were important and were consistently present in the discourse among participants with BDD-like symptoms. In contrast, for individuals without BDD-like symptoms, the central core zone contained terms such as "tall", "healthy", "skinny", "beautiful", "fat", "height", "big", "weight" and "short".

*Peripheral Zone 1:* Terms such as "tall", "short", "skinny", "ugly" and "big" were found in zone 1, indicating that while these words were frequently mentioned, they were not central to the core representation of body among participants with BDD-like symptoms. For individuals without BDD-like symptoms, words such as "hair", "strong", "eyes", "fit", "athletic", "skin", "legs", "pretty", and "muscular" appeared in peripheral zone 1. This suggests that these attributes, while commonly mentioned, did not play a central role in their overall representation of body; however, these words are still changeable.

*Contrast Zone:* The contrast zone for participants with BDD-like symptoms included terms such as "healthy", "face", "chubby", "shape", and "cute". These terms were less frequently mentioned and hold a low rank, indicating that they were less frequent but still hold importance in how these individuals perceived body. In the group of without BDD-like symptoms, the contrast zone included terms like "face", "curvy", "shape", "arms", "handsome", "clean", "average", "ugly", "slim", "unique", "good", "cute" and "young". These terms were mentioned infrequently but were still significant in shaping their SR of body.

*Peripheral Zone 2:* Words such as "curvy", "hair", "eyes", "beautiful", "muscular", "average", "overweight", "small", "weight" and "thick" were identified in peripheral zone 2 among participants with BDD-like symptoms. These terms were mentioned occasionally and hold peripheral importance, reflecting their secondary role in the overall body representation for individuals with BDD. In contrast, the terms "small", "muscle", "chubby", "nose", "lean", "hairy", "beauty", "black", "look", "feet", "size", "overweight", "hands", "confident", "amazing" and "mouth" were found in peripheral zone 2 among participants without BDD. These terms, though mentioned less frequently, still contribute to the overall representation of body in this group.

**Table 2-5**

Participants with positive BDD.

Frequency	Importance	
	High	Low
<b>High</b>	Fat (45), 3.8	Tall (32), 4.9
	Pretty (18), 3.7	Short (29), 4.7
	Strong (18), 3.8	Skinny (26), 4.7
		Ugly (26), 4.6
		Big (18), 4.9
<b>Low</b>	Healthy (17), 3.6	Curvy (17), 4.8
	Face (15), 3.7	Hair (17), 4.9
	Chubby (14), 3.8	Eyes (16), 5.8
	Shape (13), 3.7	Beautiful (15), 4.7
	Cute (10), 3.5	Muscular (15), 4.5
		Average (12), 4.5
		Overweight (11), 4.6
		Small (10), 4.5
		Weight (10), 4.5
		Thick (10), 4.6

**Table 2-6**

Participants without BDD.

Frequency	Importance
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<b>Total</b>	<b>High</b>	<b>Low</b>	
<b>High</b>	Tall (55), 3.5	Hair (76), 4.8	
	Healthy (47), 4.3	Strong (52), 4.6	
	Skinny (45), 3.9	Eyes (49), 4.9	
	Beautiful (45), 4.4	Fit (36), 4.5	
	Fat (41), 4.4	Athletic (35), 5	
	Height (38), 4.3	Skin (32), 5.1	
	Big (31), 3.9	Legs (30), 5.2	
	Weight (29), 4.2	Pretty (29), 4.6	
	Short (28), 3.6	Muscular (25), 4.5	
	<b>Low</b>	Face (23), 3.8	Small (22), 4.5
		Curvy (21), 4.3	Muscle (18), 4.6
		Shape (20), 3.8	Chubby (18), 4.5
Arms (18), 4.4		Nose (17), 5	
Handsome (17), 4.2		Lean (15), 4.7	
Clean (17), 4.2		Hairy (14), 4.6	
Average (15), 3.4		Beauty (13), 5.2	
Ugly (15), 3.7		Black (12), 4.9	
Slim (15), 4.1		Look (12), 5.3	
Unique (14), 3.8		Feet (12), 5.8	
Good (13), 4.3		Size (12), 5.5	
Cute (12), 4		Overweight (11), 4.5	
Young (11), 4	Hands (11), 5.8		

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Confident (10), 4.7

Amazing (10), 4.8

Mouth (10), 6.2

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Table 2-7 highlights the prevalence of the words used by participants with and without BDD-like symptoms, indicating how frequently each word was mentioned by each group. As shown in this table, the most frequent words among participants with BDD included Unattractive (81.82%), Thick (66.67%), Ugly (63.41%), Fat (52.33%), Short (50.88%), Overweight (50.00%), Smile (50.00%), Imperfect (50.00%). In general, there were significant differences in the words used in verbal associations among participants with and without BDD,  $\chi^2(69) = 168.61, p < .001$ .

**Table 2-7**

The prevalence of words among participants with and without BDD-like symptoms.

Words (Frequency > 10)	Without BDD	With BDD
Hair	81.72	18.28
Fat	47.67	52.33
Tall	63.22	36.78
Skinny	63.38	36.62
Strong	74.29	25.71
Eyes	75.38	24.62
Healthy	73.44	26.56
Beautiful	75.00	25.00

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Short	49.12	50.88
Big	63.27	36.73
Pretty	61.70	38.30
Fit	83.72	16.28
Healthy	86.36	13.64
Ugly	36.59	63.41
Athletic	78.57	21.43
Muscular	62.50	37.50
Skin	78.05	21.95
Weight	74.36	25.64
Face	60.53	39.47
Legs	78.95	21.05
Curvy	55.26	44.74
Shape	60.61	39.39
Small	68.75	31.25
Chubby	56.25	43.75
Average	55.56	44.44
Long	58.33	41.67
Good	92.86	7.14

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Nose	73.91	26.09
Nice	75.00	25.00
Slim	65.22	34.78
Cute	54.55	45.45
Arms	72.00	28.00
Lean	71.43	28.57
Beauty	65.00	35.00
Unique	73.68	26.32
Black	100.00	0
Handsome	94.44	5.56
Normal	56.25	43.75
Hairy	82.35	17.65
Size	80.00	20.00
Attractive	56.25	43.75
Thin	69.23	30.77
Overweight	50.00	50.00
Clean	100.00	0
Look	80.00	20.00
Hands	73.33	26.67

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Thick	33.33	66.67
Feminine	53.85	46.15
Acne	61.54	38.46
Feet	85.71	14.29
Different	61.54	38.46
Wide	63.64	36.36
Confident	90.91	9.09
Amazing	83.33	16.67
Mouth	90.91	9.09
Soft	64.29	35.71
Style	90.00	10.00
White	66.67	33.33
Teeth	54.55	45.45
Smile	50.00	50.00
Facial	90.00	10.00
Weird	60.00	40.00
Shoulders	63.64	36.36
Sexy	75.00	25.00
Unattractive	18.18	81.82

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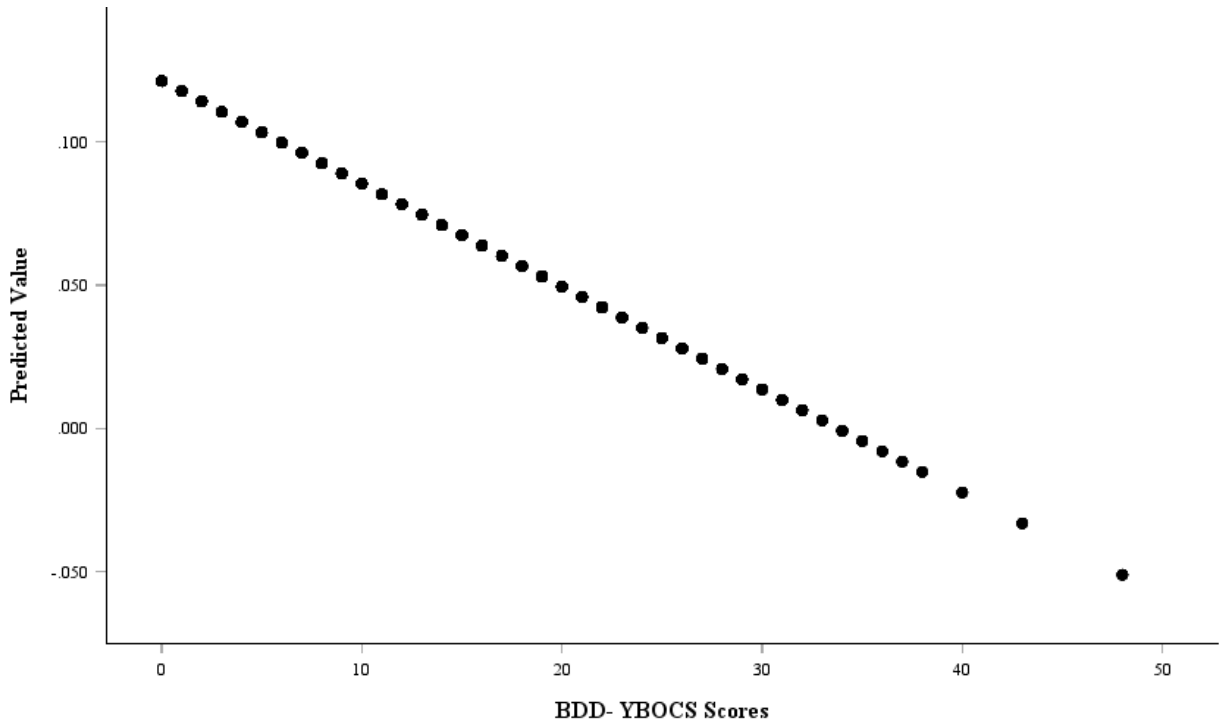
Medium	70.00	30.00
Imperfect	50.00	50.00
Lips	72.73	27.27
Young	78.57	21.43
Muscle	85.71	14.29

### 2.5.3 Valences of the Words and BDD-like Symptoms

Due to using the long-form data structure for the textual analyses, a generalized estimating equation was used to test the relation between the BDD-YBOCS scores and the word valences. The results showed that there was a negative and significant relation between the BDD-YBOCS scores and the word valences ( $B = -.004, p < .001$ ; Figure 2-1). This finding indicates that participants with higher scores on the BDD-YBOCS mentioned words with more negative valences (Figure 1). Likewise, the results showed that participants with positive BDD-like symptoms were more likely to mention words with negative valences ( $B = -.05, p < .001$ ).

**Figure 2-1**

The Relation Between the Valences of the Words and BDD-YBOCS Scores (N = 440).



## 2.6 Discussion

The aim of Phase 1 was to investigate the prevalence of BDD-like symptoms among young people in Canada and to explore the SRs of the body in individuals with and without BDD-like symptoms. A quantitative analysis was employed on quantitative and qualitative data, including chi-square tests, logistic regression, and GEE to assess the BDD prevalence across socio-demographic factors and the relation between BDD-like symptoms and valences of the associated words. Moreover, textual, frequency-rank, and prototypical analysis were used to explore the structure of SRs of body and appearance.

With regard to the prevalence of BDD by socio-demographic factors, significant associations were found between the BDD prevalence and sex, gender identity, sexual orientation, and marital status, but not with other factors such as age, education, residency, job, immigration status, or race.

This study showed that females (42.81%) and women (42.14%) exhibited a higher prevalence of BDD compared to males (13.89%) and men (15.38%), which is well-supported by the previous studies. BDD has been shown to be more prevalent among women, likely due to societal pressures related to beauty standards and appearance (Reddy & Besen, 2015; Buhlmann et al., 2015; Rief et al., 2006). A European study in dermatology clinics also found that BDD prevalence was higher in women (12.7%) than in men (7.7%) (Sampogna et al., 2024). This is likely due to heightened societal expectations and pressures placed on women regarding physical appearance. Additionally, individuals identifying as non-binary reported a high prevalence of BDD (40%), which is consistent with prior research on self-perception in gender-diverse populations. This research, including studies by Reddy and Besen (2015) and Caluya et al., (2023), suggests that these individuals' experiences of gender dysphoria is magnified by the effects of societal stigmatization, leading to their greater vulnerability to body disturbances. Experiencing pressures that challenge societal norms of appearance and gender, non-binary individuals are then more likely to develop body issues such as BDD (Reddy & Besen, 2015). These findings align with broader trends within gender-diverse communities, illustrating how the interplay between identity and societal pressures creates an increased risk of developing BDD. The connection between gender identity and body dissatisfaction is becoming increasingly prominent in BDD research, underscoring the need for more studies that focus on these marginalized groups.

The elevated prevalence of BDD among bisexual (63.33%) and questioning (63.64%) individuals in the current study is consistent with recent findings that highlight higher rates of body dissatisfaction and appearance-related disorders in sexual minorities. Studies have shown that non-heterosexual individuals, particularly those identifying as bisexual or questioning, experience increased body dissatisfaction and are more vulnerable to BDD symptoms due to societal pressures and identity struggles (Henn et al., 2019). These individuals often report greater levels of appearance comparison and obligatory exercise, which further contributes to BDD symptoms. These findings reflect how societal pressures and stigmatization specific to sexual orientation can intensify body concerns as social expectations are based on being either male or female.

An intriguing yet under-explored discovery in this literature is the significant association between marital status and BDD. Research shows that individuals in relationships have a higher prevalence of BDD (62.86%) compared to single individuals (30.83%). While there is limited direct evidence connecting marital status to BDD, it is possible that interpersonal dynamics and romantic relationships influence body dissatisfaction. A review article done by Tignol et al., (2012) indicated that BDD can significantly impact interpersonal relationships and people with BDD may experience difficulties in their relationships due to their preoccupation with perceived defects in their appearance. This preoccupation can lead to behaviors such as excessive mirror checking, seeking reassurance, or avoiding social situations. Future research could investigate whether individuals in relationships face pressures regarding their appearance, which might contribute to heightened body concerns.

Body representation operates within romantic and dating contexts, where intimate partner dynamics play a central role in shaping self-perceptions. Studies have shown that partner

objectification and appearance-focused evaluation are associated with lower body esteem, higher body surveillance, and poorer relationship quality (Zurbriggen et al., 2011). For example, in one study that has been conducted among 1,436 young adults in relationships, negative weight-related comments from romantic partners were associated with lower body satisfaction and poorer emotional well-being, whereas receiving no comments correlated with the highest emotional well-being (Eisenberg et al., 2017). Similarly, Meltzer and McNulty (2010) found that men and women who perceive that their romantic partners are more satisfied with their appearance report higher relationship satisfaction and self-esteem, highlighting the reciprocal link between body image and relational well-being.

Weller and Dziegielewska (2005) also showed that women who reported greater dissatisfaction with their bodies also perceived lower levels of support from their romantic partners. Specifically, esteem-related support was linked to body image disturbance, although no particular support style predicted eating disturbance. Overall, supportive communication from partners and close others can reduce body image distress and appearance-related anxiety, underscoring the importance of fostering positive and affirming interactions within intimate relationships to protect well-being.

In contrast to sex, gender identity, sexual orientation, and marital status, this study found no significant associations between BDD and factors such as age, race, job status, education, and immigration status. These findings are consistent with the study by Brohede et al. (2017), which explored BDD in a sample of 2,891 adults in Sweden using the same BDDQ as the current study. Brohede et al., (2017) similarly found no significant associations between BDD and age, education, and job status, aligning closely with the results of the current research. Although the result of the current study is similar to the Brohede et al. (2017) study, the current study and

Brohede et al. (2017) study was conducted in two different countries, suggesting that the lack of significant associations might not be restricted to a specific region. Grant et al. (2001) showed that there was no difference in education and race between adolescents and adults with and without BDD. In contrast with the current results, Reif et al. (2006) showed higher prevalence of BDD among unemployed participants compared to employed participants; however, no age differences were observed. The discrepancy may stem from methodological differences. Reif et al. (2006) conducted their study in Berlin among participants aged from 14 to 99 years old and used a different measure to assess BDD symptoms, while the current study was conducted in Canada among youth participants.

Considering the lack of significant associations between BDD and factors such as age, race, education, job status, and immigration status, several plausible explanations emerge. First, it is possible that these socio-demographic factors do not independently influence BDD prevalence but interact with other variables such as culture, personal history, and psychological factors, which were not directly measured in the current study. For example, while age or race alone may not be significant predictors, they could influence BDD through complex cultural attitudes toward body that vary across contexts. The lack of significant associations in the current study could also be attributed to the specific sample used (primarily students aged 16 to 21) who may have had less diversity in life experiences regarding job status or education level, compared to broader population samples used in other studies. Moreover, while immigration status is hypothesized to impact body representations through identity shifts or cultural adjustment, individuals each hold unique experiences of immigration, which may be too nuanced to be accurately captured by a simple demographic category. As such, immigration status may not correlate with BDD in reality.

Methodological factors may also play a role in these findings. The use of different instruments, such as the BDDQ and Y-BOCS in this study, could explain why no significant associations were found with certain socio-demographic factors, compared to studies using different tools like the MUSIC survey. These tools may capture various facets of body and appearance-related distress in distinct ways, influencing the patterns of association observed. Another possibility is that certain factors such as race or education might show more significant relationships in broader, more diverse samples or in studies with older participants. Since the current sample was relatively homogenous regarding age, primarily young students, it may not have captured the full spectrum of how socio-demographic variables interact with BDD in the general population.

Finally, the absence of significant findings for some variables could suggest that BDD is not as strongly influenced by broad socio-demographic factors as it is by more personal or psychological aspects, such as self-esteem, body dissatisfaction, or perfectionism. This gap illustrates the need for future research to further explore how these deeper, often internal, factors interact with the broader socio-demographic variables considered in this study. Moreover, by expanding the research in this topic to encompass a more diverse range of samples, including in age, race, and socio-economic background, this study may contribute to a stronger understanding of the nuanced relationships between BDD and the proposed factors.

### **2.6.1 The Structure of the Social Representation of the Body**

This analysis showed how certain body related terms are perceived differently between participants with and without BDD-like symptoms. Based on the frequency-rank analysis, four zones were extracted which are as follows:

### **2.6.1.1 Central Core Zone: Prioritization of Body Features**

Isolating participants with BDD-like symptoms, these individuals' prioritization of terms like "fat", "pretty", and "strong" reflects an internal preoccupation with physical appearance and body shape, consistent with the literature on BDD. As illustrated throughout this research, individuals with BDD experience intensified anxiety concerning their perceived flaws, most noticeably as related to weight and body shape. A study by Malcolm et al. (2018) highlighted that people with BDD often fixate on certain physical features, leading to behaviors such as mirror checking or body comparisons, both of which are forms of obsessive behavior. The term "fat", often linked with body dissatisfaction and weight concerns, supported findings by Stenzel et al. (2006), who noted that being fat is a frequent focus of concern among BDD patients. The presence of "pretty" and "strong" in this central zone may represent a dual struggle on one hand, participants feel inadequate, while on the other hand, they aspire to idealized standards of beauty and strength. This mix of obsessive focus and idealization shows the inner conflict at the heart of BDD: individuals are caught between chasing impossible standards of perfection and feeling they never measure up, which leads to constant self-criticism and emotional pain.

In contrast, the core terms among participants without BDD-like symptoms such as "tall", "healthy", "skinny", "beautiful", "fat", "height", "big", "weight", and "short", suggest a more diverse, less pathological view of body. The term "healthy" in this group's core zone indicates that physical appearance is linked to functionality and overall well-being, a finding consistent with Tiggemann & McCourt (2013) study on body, which shows that those without body disorders tend to emphasize health rather than appearance. The presence of multiple body features in this zone highlights a more balanced representation, with less emphasis on extreme beauty standards. Secchi et al., (2009) showed that the female body is depicted as requiring

beauty, slimness, strength, and prestige, representing both attractiveness and health simultaneously.

Previous studies have consistently reported that the words such as beauty and health are common words in the SR of body and appearance (Camargo et al., 2011; Goetz et al., 2008; Passos et al., 2013; De Souza et al., 2019). For example, Passos et al. (2013) showed that the SR of body among adolescents were around beauty, muscle, slim, and curvy body. Moreover, De Souza et al. (2019) showed that physical activity plays an important role in the SR of body. Although the current findings among participants without BDD-like symptoms are consistent with previous studies, this is the first study that investigated the SRs of body among participants with BDD-like symptoms which indicate that the central core of the SRs of body is different between participants with BDD-like symptoms and without BDD-like symptoms.

### **2.6.1.2 Contrast Zone: Significant but Less Frequent Elements**

In contrast, for BDD individuals, the terms "healthy", "face", "chubby", "shape", and "cute" appeared less frequently but were still significant. The inclusion of "healthy" as a contrast term suggests that while health is relevant to BDD participants, it is secondary to more appearance-focused concerns. This is supported by Veale & Neziroglu (2010) who demonstrated that individuals with BDD often neglect their health in favor of an obsessive focus on appearance. The presence of "chubby" and "cute" also reflects the cultural and personal pressures BDD individuals face regarding body weight and attractiveness.

For non-BDD participants, terms like "face", "curvy", "shape", "arms", "handsome", "clean", "average", "ugly", "slim", "weight", "unique", "good" and "cute" indicated that while some level of body dissatisfaction exists, it is not central to their body representation. Thus, even

individuals without severe body concerns may still experience dissatisfaction with specific body parts, though this dissatisfaction does not dominate their overall self-concept.

### **2.6.1.3 Peripheral Zone 1: High Frequency, Less Central Elements of the Social Representation**

For participants with BDD-like symptoms, terms like "tall", "short", "skinny", "ugly" and "big" were frequently mentioned but held less cognitive weight compared to core concerns like "fat" and "pretty." The inclusion of "ugly" aligns with Damianidou & Georgiadou (2021), who mentioned that individuals with BDD often experience a distorted sense of their overall appearance, seeing themselves as "ugly" or unattractive. However, the relative peripherality of these terms suggests that while participants frequently think about them, they are not as emotionally charged as central core terms. This may reflect the fluctuating nature of BDD, where individuals obsess over different features at different times, as noted by Neziroglu et al. (2012).

For individuals without BDD-like symptoms, the words in peripheral zone 1 included physical features associated with fitness and appearance, such as "strong", "fit", "athletic" and "muscular". These words suggest more focus on health and fitness, aligning with findings from Avalos & Tylka (2006) who argue that individuals without body disorders often link their body image with functionality and strength, rather than purely aesthetic concerns. The presence of these terms in a peripheral zone indicates that they are important but do not dominate the participants' thoughts about their bodies.

#### **2.6.1.4 Peripheral Zone 2: Low Frequency, High Rank**

The peripheral zone 2 for BDD participants included terms such as "curvy", "hair", "eyes", "beautiful", "muscular", "average", "overweight", "small", "weight" and "thick". As these terms indicate, these participants hold an underlying desire for an idealized body matching their preferred descriptors. Perkins (2019) coincides with these findings, attesting that individuals with BDD often aspire to unrealistic beauty standards, regardless of their preoccupation with perceived flaws. As such, these individuals do idealize certain traits while still obsessing over their perceived imperfections, as suggested by the inclusion of words like "beautiful" and "muscular". However, their lower frequency indicates that these attributes are not the primary focus of their concerns.

Among participants without BDD-like symptoms, words such as "small", "muscle", "chubby", "nose", "lean", "hairy", "beauty", "black", "look", "feet", "size", "overweight", "hands", "confident", "amazing" and "mouth" suggested a broader range of body concerns, but these terms were not dominant in their body representation. The presence of "confident" and "amazing" in this zone reflects a more positive self-perception, which is consistent with studies like Wood-Barcalow et al. (2010), who argue that individuals who respect and appreciate their body, tend to have more positive views of their bodies and value non-physical traits such as confidence and personal achievements.

#### **2.6.2 Contributions of the study**

The results of this chapter provide a comprehensive answer to the research questions, particularly regarding the differences in SRs of the body between individuals with and without BDD-like symptoms. This chapter reveals how the presence of BDD-like symptoms distinctly

shapes societal norms, appearance-focused concerns, and representations of the body. The quantitative analysis of this study posed statistical findings that emphasize the significance of associations between BDD and specific socio-demographic factors, such as gender, sexual orientation, and relationship status. Adding to these findings, the qualitative analysis provided a deeper understanding of how individuals with and without BDD-like symptoms cognitively represent their bodies, showing a clear distinction between each group's core concerns.

These results can be explained through SRT, which posits that individuals construct shared understandings of the world around them based on societal influences. As illustrated in this study, participants with BDD-like symptoms exhibited a narrower, appearance-focused representation of the body, with an emphasis on terms such as "fat" and "pretty." Aligning with theories on the topic, these findings suggest that individuals with BDD have a more rigid internalization of societal beauty standards, leading to their obsessive focus on physical flaws. In contrast, individuals without BDD-like symptoms exhibited a more balanced view, including terms such as "healthy" and "confident," indicating that their SRs are less bound by appearance-driven concerns and incorporate broader, more functional aspects of body. As this differentiation shows, individuals with BDD-like symptoms may experience less flexible body representations, which adds to the significance of societal pressures in shaping their body-related distress.

Contributing to the broader research discussions on body representations and BDD, these findings provide valuable empirical evidence of a sociocognitive difference between individuals with and without BDD-like symptoms. The study adds to the growing body of literature that emphasizes the need for interventions focused on broadening the SRs of individuals with BDD to include more positive, functional, and health-related aspects of body. Furthermore, the identification of specific demographic groups that are more vulnerable to BDD (e.g., women,

bisexual individuals, those in relationships) provides a clear direction for future research and social interventions for social work, emphasizing the role of targeted prevention programs and intervention programs efforts towards vulnerable and minority groups.

This study highlights significant opportunities for social work interventions to address BDD and body disturbances among youth living in Canada, particularly in high-risk demographic groups. Women, non-binary individuals, and sexual minorities, including individuals identifying as bisexual or questioning and those in relationships, displayed a higher prevalence of BDD-like symptoms. These findings illustrate the significant need for targeted and inclusive interventions for these groups. By designing and implementing prevention programs in schools and community settings, social workers have the potential to address these concerns early. As an example, they can establish peer-led support groups or workshops aimed at challenging societal beauty norms and promoting body positivity. These targeted resources can then serve as a safe space for vulnerable individuals to explore and redefine their own perceptions of beauty and health.

To address these issues, it is important that, in practice, social work prioritizes community-wide education campaigns to foster and encourage diverse and inclusive representations of the body. In doing so, these campaigns have the potential to challenge the common but narrow societal ideals of beauty, and promote a stronger focus on body functionality and health rather than appearance. By collaborating with local organizations, educational institutions, and media outlets, these campaigns can be spread widely across different audiences, and contribute to broader societal change. Additionally, social workers can take a legislative approach by advocating policies that regulate the prevalence of unrealistic beauty standards in media and advertising. By impeding the dissemination and ubiquitousness of

these unrealistic standards, they can subsequently reduce the societal pressures contributing to body dissatisfaction and the development of BDD symptoms.

Another avenue to address these issues is by integrating social media literacy programs into social work practice. Social media has a significant influence on young people's body representations. Because of this, educating them on the role of filters, curated online personas, and photo editing will broaden their understanding of its impact. By putting on associated workshops in schools and community centers, social workers can help young people critically evaluate media content and strengthen their resistance to internalizing harmful beauty ideals. Aligning with social work's commitment to empowerment, this strategy equips individuals with the tools to navigate and challenge these negative societal influences.

For these interventions to be successful, social workers require specialized training on the social representations of body and their impact on mental health. Practitioners must first understand how societal norms shape individuals' perceptions in order to recognize and intervene in cases of appearance-related distress. To enhance its effectiveness, this training should also focus on fostering cognitive flexibility in participants. This flexibility will help them break away from their rigid, appearance-based representations and embrace broader, more positive views of body. Incorporating this knowledge into social work education programs can prepare future practitioners to effectively address body concerns in their practice.

Collaboration is key to advancing social work's role in addressing BDD and body issues. Social workers can partner with psychologists, educators, and community leaders to deliver holistic interventions that address the psychological, social, and cultural dimensions of body representations. For example, by integrating body representation counseling into mental health

services, or by creating collaborative and culturally sensitive interventions with community organizations, social workers can ensure that these support resources are both comprehensive and relevant. An emphasis on collaboration and inclusivity can be particularly impactful for marginalized groups, such as ethnic minorities and immigrant communities, as they often face unique societal pressures affecting their body representations that are not folded into the general understanding of these issues.

By addressing body concerns through targeted, culturally sensitive, and community-driven interventions, social work is a key component in potentially reducing the prevalence and repercussions of BDD. These strategies not only align with the profession's core values of empowerment and social justice but also contribute to promoting mental health and well-being in vulnerable populations. Further, by advocating large-scale, systemic changes that challenge societal beauty norms, these strategies can promote diverse and inclusive body representations and support social work's commitment to fostering a more equitable society.

From a theoretical perspective, the results can inform the development of new models that further integrate SRT with existing theories of body and BDD, such as the Biopsychosocial Model and Objectification Theory. By exploring how social and cultural factors shape representations, this study suggests that the rigidity in SRs observed in BDD could be targeted through social interventions that challenge appearance-focused narratives and promote more flexible, diverse representations of the body. Additionally, this research reveals opportunities for further theoretical advancements, providing an exploration of how these SRs evolve over time and are impacted by changing societal influences, such as shifts in beauty standards driven by social media and digital culture.

## **2.7 Strengths and Limitations**

One strength of this study is its mixed-methods design, which allowed for a comprehensive analysis of both the prevalence of BDD-like symptoms and the qualitative aspects of the SR of body. By combining quantitative and qualitative approaches, the study offers a nuanced understanding of how SRs of body differ between individuals with and without BDD-like symptoms. The current research aimed to consider various socio-demographic groups in Canada; however, our sample is not fully representative of the youth population in Canada. Nevertheless, the study also has limitations. The self-reported nature of BDD-like symptoms could introduce bias, and the study was conducted online; hence, the researcher was not accessible to respond to any questions during the survey. However, the current study took the careless response detection into account to minimize careless responses which is considered as one of the strengths of this study. Additionally, the sample was limited to students, which may not fully represent the broader population of young individuals with BDD-like symptoms in Canada. Moreover, although the current study tried to recruit participants from diverse backgrounds, the sample size may not be representative of the population.

## **2.8 Conclusion**

In conclusion, this study provided valuable insights into the prevalence of Body Dysmorphic Disorder (BDD) among young people in Canada, revealing a clear differentiation between in how individuals with and without BDD-like symptoms perceive their bodies. By emphasizing the significance of societal pressures in shaping representations, particularly those associated with beauty standards, these findings reinforce the need for more inclusive and diverse approaches to understanding body disturbances. This study's focus on social

representation theory provided a unique perspective on how different individuals internalize and are impacted by societal ideals. These findings show that those experiencing BDD-like symptoms display a more restricted, appearance-focused view, as opposed to the broader views of their symptom-less counterparts.

One of the key contributions of this research is the identification of specific demographic groups, such as women, non-binary individuals, and sexual minorities, who exhibit a higher prevalence of BDD-like symptoms. These findings align with existing literature on the vulnerability of marginalized groups to body disturbances, driven in part by societal pressures related to gender and sexual orientation. The higher prevalence of BDD-like symptoms among women and bisexual/questioning individuals highlights the pervasive impact of societal beauty norms, particularly for those who experience compounded identity struggles.

The research also emphasized the importance of romantic relationships in shaping body concerns. The finding that individuals in relationships report higher rates of BDD-like symptoms suggested that interpersonal dynamics and appearance-related expectations may exacerbate body dissatisfaction. These findings reveal an opportunity for further analysis on how factors such as relationship satisfaction, partner support, and appearance-related conflicts can play a role in developing BDD. This topic is particularly salient for young adults navigating romantic relationships during an incredibly formative period in the development of their identity.

The structural approach of SRT used in this study has provided a rich understanding of how individuals with and without BDD-like symptoms construct their SRs of the body. For those with BDD-like symptoms, the central core of their representations is dominated by a narrow focus on appearance, particularly concerns about weight and beauty. Reflecting this rigid

cognitive structure, these individuals are then obsessively preoccupied with their perceived physical flaws, as commonly observed in BDD. In contrast, individuals without BDD-like symptoms incorporated broader concepts into their body representations, such as health and body functionality, illustrating their more flexible and adaptive view.

These findings have important implications for both social work practice. The rigid, appearance-focused SRs observed in individuals with BDD-like symptoms suggested that social interventions should focus on broadening these representations to include more diverse and holistic aspects of body. Moreover, public health campaigns that emphasize body diversity and functionality, rather than unattainable beauty ideals, may reduce the internalization of harmful societal standards and prevent the development of BDD-like symptoms in vulnerable populations.

The study also brought attention to the role of societal influences in shaping body concerns, particularly in the modern context of digital culture and the prevalence of social media. Beauty standards are continually evolving, driven by changing trends in cosmetic surgery and the use of filters on social media, causing shifts in individuals' SRs of the body and potentially exacerbating body dissatisfaction. Future research should explore this relationship by investigating how these evolving standards influence the development of BDD over time, particularly in younger generations who are highly engaged with digital platforms.

Another significant contribution of this research is its potential to inform the development of culturally sensitive and inclusive social interventions. While this study focused on young people living in Canada, it raises important questions about how cultural norms and media portrayals of beauty differ across regions and ethnic groups. By understanding the specific

societal pressures that different cultural groups face, social work interventions can be tailored to address the unique challenges of diverse populations, promoting body positivity and mental well-being in a way that resonates with their cultural values.

Lastly, this study contributed to the theoretical understanding of BDD by integrating SRT with existing body theories, such as the Biopsychosocial Model and Objectification Theory. The findings suggested that the rigidity in SR of body observed in individuals with BDD-like symptoms can be viewed as a inflexibility, shaped by internalized societal ideals. Future theoretical advancements could explore how interventions that promote flexibility and challenge appearance-driven narratives could help individuals reframe their body representations in a more positive and functional way.

In sum, this study has provided a comprehensive examination of the prevalence of BDD among young people in Canada, and identified a clear differentiation between how individuals with and without BDD-like symptoms perceive their bodies. Outlining the significant impact of societal norms, personal beliefs, and interpersonal dynamics on representations of the body, this research offered valuable insights into the complex factors contributing to body disturbances. These findings informed and opened up new opportunities for future research, social work interventions aimed at promoting more diverse and positive representations of the body, ultimately contributing to the support of young people's mental health and well-being both within Canada and beyond.

## 2.9 Future Direction

To inform a more comprehensive understanding of how BDD symptoms manifest across different ages and social contexts, future research should focus on expanding the population sample to include older adults and non-student groups in its analysis. Broadening the sample would allow researcher to examine how life experiences, such as long-term exposure to societal beauty standards, aging, and changing body representation, contribute to the onset and progression of BDD. Additionally, older adults may face distinct body concerns, such as aging-related changes, that are currently underrepresented in the literature. A more diverse sample population would be instrumental in exploring how additional factors, such as socio-economic status, professional environments, and other life circumstances, converge and intersect with body concerns. This research would further uncover the variance in BDD across one's lifespan and different social contexts, and add to a more comprehensive understanding of the disorder beyond the student population.

By employing longitudinal studies, further research could follow and examine changes in SRs of the body over time, as well as how these changes relate to societal shifts in beauty standards. The constant evolution of beauty ideals, especially during the height of social media and digital culture, may affect or cause changes in individuals' internalized body representations, influencing the development and maintenance of BDD. For example, the increasing prominence of cosmetic surgery, filters, and digitally altered images may have a growing impact on body dissatisfaction in future generations. Longitudinal research would offer valuable data on how these evolving standards shape representations of the body and contribute to BDD symptoms over time. This approach would also allow researchers to assess the long-term effects of societal

interventions, such as body positivity campaigns, and whether they mitigate or exacerbate BDD symptoms across different populations.

Additionally, this study illustrates a need for further investigation into the role of relationship status in BDD development. As this study's findings suggest, interpersonal factors may have a significant impact on the formation and body concerns. Romantic relationships, for example, could influence self-perception and appearance-related distress through the dynamics of partner expectations, societal ideals of attractiveness, or relationship satisfaction. Future research can explore if individuals' relationship status, such as long-term relationships, marriages, or dating, causes them additional pressures related to physical appearance, potentially exacerbating BDD symptoms. This examination can also include the role of relationship satisfaction, partner support, or appearance-related conflicts in impacting body representations, and provide a clearer understanding of the interpersonal dynamics involved in the disorder.

Another important consideration for future research is the inclusion of diverse cultural and ethnic backgrounds to better understand how cultural norms shape body concerns and BDD prevalence. Since this study was conducted in Canada, a country with a culturally diverse population, future studies should focus on the potential cross-cultural differences in SRs of the body and their relationship to BDD. Different cultures may prioritize different beauty standards, which can either exacerbate or mitigate body dissatisfaction. Understanding these cultural variations would allow for more culturally sensitive interventions and treatments for BDD, addressing specific societal pressures that individuals from diverse backgrounds might face.

The current study used self-reports to screen participants with potential BDD symptoms. While self-reports are valuable for capturing large-scale data, they can introduce biases, such as

participants' misunderstanding of the questions or reluctance to admit symptoms. Future research should consider incorporating clinical assessments for more accurate identification of BDD symptoms. Using structured clinical interviews or diagnostic tools administered by trained professionals would ensure that the diagnosis of BDD is more precise. This approach would also differentiate between subclinical body concerns and diagnosable BDD, allowing for a more thorough examination of the disorder. Additionally, clinical assessments could provide a deeper understanding of the severity of symptoms and their impact on individuals' daily lives, improving the accuracy and reliability of BDD prevalence data in future research.

## Chapter 3

### **Article 2: The perception of the role of Social Media, Peers, and Family in Shaping Social Representation of Body Among Youth in Canada**

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#### **3.1 Abstract**

**Background:** The research examines youth aged 16 to 21 living in Canada to understand their social representations (SRs) of body and appearance while investigating the perception of socio-cultural factors like social media, peers, and family through these young people's perspectives. SRs provide a framework for understanding how collective views influence personal body ideal standards especially within media-saturated cultures which perpetuate unrealistic beauty norms and heighten body dissatisfaction and BDD-like symptoms. This study utilized Social Representation Theory to explore the process through which societal beauty norms become embedded into individual self-image while impacting mental health and body image perceptions. The study investigates objectification that occurs when people start seeing their bodies as objects judged through the lens of societal standards.

**Methods:** The research utilized a mixed-method approach by combining qualitative thematic analysis with quantitative chi-square tests to explore how sociocultural factors influence body

ideals through their association with BDD-like symptoms. Qualitative data from semi-structured interviews were examined using thematic analysis in NVivo 14, focusing on the process of anchoring and objectification of SRs. The study used quantitative chi-square tests along with Pearson correlations to examine how BDD-YBOCS scores relate to perceived influences from social media, family and peer groups on body representations.

**Results:** Eight main themes related to body have been revealed from the results including: self-perception, social media influence, fitness and health, cultural expectations, beauty standards, confidence, mental health, and gender identity. BDD-like symptoms contributed to greater body dissatisfaction which was amplified through peer discussions about ideal bodies and family influence and comparisons on social media triggered more intense emotional distress. Statistical chi-square tests validated the connection between BDD-like symptoms and perceived factors like family expectations, peer influence and social media pressure.

**Conclusion:** The study reveals how family alongside social media and peer influences shape body image perceptions among young people who display symptoms akin to BDD. The results demonstrated the crucial function of SRT in addressing body concerns by showing how societal beauty standards become internalized through emotional anchoring and objectification.

**Keywords:** body dysmorphic disorder, social representation theory, body image, social media, peer, family, youth in Canada.

### 3.2 Introduction

The aim of this study is to study the Social Representations (SRs) of body and appearance among youth aged 16 to 21 in Canada, with a particular focus on the role of socio-cultural influences like social media, peers, and family. SRs are the collective frameworks shaping individuals' perceptions of reality and their own identity. These frameworks are essential to understand the body, especially in an environment saturated with social media. Social media, peer influence, and family expectations significantly shape how young individuals perceive their bodies and, in some cases, contribute to the development of Body Dysmorphic Disorder (BDD)-like symptoms. BDD is characterized by an individual's obsessive preoccupation with perceived flaws in their appearance, and often leads to distorted body representations which are then further exacerbated by societal pressures on physical appearance.

Societal beauty standards are constantly reinforced within the platform of social media, which contributes to individuals' internalized representation of the ideal body. Social media provides a space where body is both celebrated and criticized, particularly through the lens of idealized, edited images of slim, toned, and curvy bodies. Studies show that frequent social media use is associated with greater body image dissatisfaction, as users often compare their own appearance to curated images (Perloff, 2014; Fardouly et al., 2015). As a result of these comparisons, individuals can face internalized pressure to achieve unattainable beauty standards, which further amplifies their body concerns. This impact is most pronounced among individuals with BDD-like symptoms.

Peers play a critical role in shaping representations of body and appearance, especially during adolescence. As a source of social validation, peer groups drive discussions about

appearance that can shape an individual's self-concept and body representations. One of the goals of this study is to more closely examine how peer-driven conversations can influence body dissatisfaction and reinforce societal beauty ideals. Individuals with BDD-like symptoms may experience more anxiety and negative emotions during these discussions, further intensifying body dissatisfaction (Forney et al., 2012).

Romantic and dating relationships also play a significant role in shaping body representations during late adolescence and early adulthood. Body representation operates within relational contexts, where intimate partner dynamics influence how individuals perceive and evaluate their appearance. Research shows that partner objectification and appearance-focused evaluations are associated with lower body esteem, heightened body surveillance, and poorer relationship quality (Zurbriggen et al., 2011). For example, among 1,436 young adults in relationships, negative weight-related comments from romantic partners were linked to lower body satisfaction and poorer emotional well-being, whereas receiving no appearance-related comments corresponded with the highest emotional well-being (Eisenberg et al., 2017). Similarly, Meltzer and McNulty (2010) found that when individuals perceive their romantic partners to be satisfied with their appearance, they report higher levels of relationship satisfaction and self-esteem, highlighting the reciprocal relationship between body image and relational well-being. Weller et al. (2005) further showed that women who experienced greater body dissatisfaction also perceived lower levels of partner support, suggesting that supportive communication from partners can reduce appearance-related anxiety and body image distress. Including romantic relationships in this analysis is essential, as young adults often report shifts in appearance concerns when entering dating relationships, where partner comments, whether complimentary or critical can either mitigate or intensify dissatisfaction.

Family is another critical source of influence on body representations, especially during childhood and adolescence. Parents and family members often set standards for appearance, which can become internalized and contribute to body dissatisfaction if they are overly critical or emphasize appearance-based values. Family standards around body, whether supportive or critical, often serve as the foundation for an individual's self-concept regarding their appearance (Bovina et al., 2022).

### **3.2.1 Theoretical Framework**

The study utilizes SRT to explore how societal ideals of beauty and body are anchored in everyday experiences and made emotionally salient through interactions with social media, peers, and family. Anchoring, a key concept in SRT, helps explain how societal beauty standards become familiar and integrated into individual self-perception. Emotional anchoring, specifically, highlights how societal ideals, once internalized, can lead to emotional responses like anxiety, guilt, or pride in relation to body. For individuals with BDD-like symptoms, this emotional anchoring is particularly intense, as they often experience heightened distress in their attempts to meet societal expectations of appearance (Jodelet, 2008).

In the context of SR of body, anchoring allows individuals to interpret and integrate societal beauty standards into their own understanding of the body. This process highlights how societal beauty norms become internalized and contribute to appearance-related concerns, including the heightened focus on perceived flaws seen in BDD (Joff, 2003; De Rosa, 2013).

As discussed by Jodelet (2008) and Wagner et al. (1999), objectification in social representation theory involves transforming abstract societal norms into concrete, recognizable forms through symbols and images. When applied to body, this process helps explain how media

representations and cultural narratives reinforce societal ideals, crystallizing them into tangible standards such as 'idealized physiques'. This theoretical lens can shed light on the tendencies of individuals with BDD to internalize and obsess over specific physical attributes, perceiving them as flaws, a conceptual application aligned with the general principles of objectification.

Several models explain the development and maintenance of BDD by focusing on different mechanisms. The Cognitive-Behavioral Model (CBT) emphasizes cognitive distortions and behaviors, such as mirror-checking, that reinforce negative body image (Veale, 2004). Self-Discrepancy Theory (SDT) links BDD to the emotional distress caused by a gap between one's actual and ideal self (Higgins, 1987; Veale et al., 2003). Objectification Theory focuses on societal pressures that lead individuals to view their bodies as objects (Fredrickson & Roberts, 1997), while Social Comparison Theory highlights how upward comparisons often lead to body dissatisfaction (Festinger, 1954). Lastly, the Biopsychosocial Model integrates genetic, psychological, and social factors in the development of BDD (Feusner et al., 2010; Buchanan et al., 2021).

While existing models offer valuable insights, many fall short in fully capturing the sociocultural factors that shape body concerns and BDD. For instance, CBT focuses on individual-level interventions but overlooks broader societal pressures, such as media-driven beauty standards. Similarly, SDT and Objectification Theory highlight internalized societal standards but fail to explore how these standards are constructed and maintained within cultural contexts. Filling this gap, SRT provides a comprehensive framework that encompasses broader elements such as societal norms, media representations, and collective beliefs. By examining the impact of cultural narratives and social interactions on shaping body representations, SRT offers a more holistic method of understanding the influences contributing to BDD.

For example, Secchi et al., (2009) examined SRs of body image among female students, finding that these representations were closely linked to beauty, thinness, power, and social status. Their study revealed that individuals' perceptions of their bodies are heavily influenced by societal expectations and cultural narratives, illustrating the powerful role of collective beliefs in shaping body representations. The emphasis on attributes such as beauty and thinness, especially within social and status-driven contexts, highlighted the impact of societal pressures on how young women perceive and evaluate their own bodies.

Similarly, in the research of Camargo et al. (2011) exploring SRs of body, they found a strong association between concepts such as health, beauty, and balance, and the SR of body. This in turn reinforced the influence of societal expectations on how individuals view their physical selves. De Rosa and Holman (2013) extended this understanding through a cross-cultural study on SRs of beauty and cosmetic surgery, revealing how different cultural contexts, such as those in Italy, Romania, and Spain, influence body ideals. For instance, Italian men associated masculinity with physical fitness, while Romanian women tied beauty to wealth and social success. Supporting these findings, Souza et al. (2019) illustrated how in Brazil, SRs of body and health were connected to ideals such as muscularity, fitness, and the common cultural norms around physical activity. These studies bring together key elements in understanding the profound influence of societal and cultural norms on SR of body across different populations.

Much of the research using SRT has focused on general body concerns rather than on populations with clinical or subclinical BDD. Studies like those by Secchi et al., (2009) and Souza et al. (2019) examined the SRs of body image among broader groups, such as students or physically active individuals, without specifically addressing individuals with BDD-like symptoms. Given that BDD entails an obsessive preoccupation with perceived flaws, the SRs of

body in this group may significantly differ from those in the general population. Therefore, it is essential to explore how SRs specifically influence individuals with BDD, capturing the full picture of the unique societal pressures and expectations they face.

This study addresses this gap by focusing on individuals with BDD-like symptoms. It seeks to answer two key questions: 1- How socio-cultural factors, including social media, peers, and family, influence the social representations of body and appearance among youth aged 16 to 21 living in Canada, particularly in relation to Body Dysmorphic Disorder (BDD)-like symptoms? and 2- How do the content of the social representations of body and appearance differ between youth with and without BDD-like symptoms living in Canada? By comparing the social representations of body between these two groups, this research unravels the ways that societal norms, media representations, and cultural beliefs contribute to the development and maintenance of BDD. This study's approach emphasizes the distinct societal pressures that those with BDD experience, as well as how their broader social context shapes their body concerns. This analysis informs the understanding of BDD-specific populations, particularly within the underexplored context of youth in Canada.

### **3.3 Methods**

To answer the first research question “how socio-cultural factors, including social media, peers, and family, influence the social representations of body and appearance among youth aged 16 to 21 living in Canada, particularly in relation to Body Dysmorphic Disorder (BDD)-like symptoms?”, this study used a combination of qualitative and quantitative methods to collect data. A semi-structured interview was used to investigate the influence of social media, peers, and family on participants' social representations of the body through detailed analyses of their

experiences. A thematic analysis was performed to analyze the qualitative contents, analyzing primary themes connected to body representation and beauty ideals as well as social influences with word clouds demonstrating anchoring and naming practices in SRs. To answer the second research question “how do the content of the social representations of body and appearance differ between youth in Canada with and without BDD-like symptoms?”, the quantitative analysis involved chi-square tests to determine the differences in the extracted themes between participants with and without BDD-like symptoms. Correlational analyses were also used to investigate the relationship between the influence of social media, peers, and family and BDD symptom severity (BDD-YBOCS scores). The integration of various research methods provided a full understanding of how sociocultural factors affect body representations of youth living in Canada.

### **3.3.1 Participants and Procedure**

After the prevalence of BDD-like symptoms were analyzed across different socio-demographic factors in phase 1, volunteers who showed their interest in survey to participate in phase 2 (this study), were invited via email to participate in phase 2. This research used the gold standard sampling method known as the saturation method for conducting semi-directed interviews. According to Hennink et al. (2017) researchers should recruit between 16 to 24 participants in order to achieve meaning saturation. Thus, it was expected that interviews were conducted on 24 participants. As phase 2 was also involved quantitative methods to compare extracted themes between participants with and without BDD-like symptoms, this study tried to recruit more participants. Although many participants from phase 1 expressed interest in participating in phase 2, after emailing them up to four times, only a few responded. As a result, 31 individuals participated in phase 2 interviews.

To drive more participation, compensation was initially offered through a draw for gift cards. During Phase 2 four gift cards were distributed through a random selection process. However, this was not sufficiently motivating, hence, I decided to provide all Phase 2 participants with either a \$20 gift card or 1% extra credits in the ISPR Student Pool of the University of Ottawa, depending on their preference. Ultimately, 31 participants completed Phase 2 interviews. The recruitment and invitation process for interview participants lasted four months.

The researcher emailed all volunteers simultaneously up to four times and alerted them that available slots were limited following a first come first served basis, resulting in 31 participants completing Phase 2. The researcher sent scheduling emails to participants who expressed interest in Phase 2 to arrange their Zoom meeting times. The volunteers logged into the Zoom meeting after their appointment date was set. The researcher presented the consent form on the screen and asked participants verbally to confirm their agreement to participate in the interview and consent to audio recording. Via email the participants received the consent form. The researcher would have expressed gratitude to the participant before ending the Zoom call if they had verbally declined participation. No interview participant declined to participate during any of the 31 sessions. The interview started after obtaining informed consent. After completing the interview participants received an email containing the debriefing form.

### 3.3.1.1 Sample Characteristics

*Sample characteristics are presented in Table 3-1. In total, 31 volunteers (Mage = 19.41, SD = 1.02; 83.87% women) participated in the interviews. Of 31, 15 participants had BDD-like symptoms based on the screening BDDQ measure in Phase 1.*

**Table 3-1**

Sample Characteristics.

Participant	Age	Gender	Marital status	Job status	Immigration status	Race	BDD symptoms (No/Yes)
P 1	19	Man	Single	Student	Canadian citizen/permanent resident	White	No
P 2	19	Woman	Single	Student	Canadian citizen/permanent resident	White	No
P 3	21	Man	Single	Student	Canadian citizen/permanent resident	White	Yes
P 4	20	Woman	Single	Student	Canadian citizen/permanent resident	White	No

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P 5	20	Woman	Single	Student	Canadian citizen/permanent resident	Asian (South- East Asia)	No
P 6	18	Woman	Single	Student	Canadian citizen/permanent resident	White	No
P 7	20	Woman	Single	Employed	Canadian citizen/permanent resident	Asian (South- East Asia)	Yes
P 8	20	Woman	Single	Student	Canadian citizen/permanent resident	Asian (South- East Asia)	Yes
P 9	20	Woman	Single	Student	Canadian citizen/permanent resident	Mixed	No
P 10	21	Woman	Single	Student	Canadian citizen/permanent resident	Asian (South- East Asia)	No

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P 11	21	Man	Single	Student	Canadian citizen/permanent resident	Arab	
P 12		Woman	Single	Employed	Canadian citizen/permanent resident	White	Yes
P 13	20	Other	Single	Student	Canadian citizen/permanent resident	White	Yes
P 14	20	Woman	Single	Employed	Canadian citizen/permanent resident	White	Yes
P 15	19	Woman	Single	Employed	Canadian citizen/permanent resident	Black	No
P 16	19	Woman	Single	Student	Canadian citizen/permanent resident	Asian (South- East Asia)	Yes
P 17	18	Woman	Single	Student	Canadian citizen/permanent resident	Arab	Yes

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P 18	19	Woman	Single	Employed	Canadian citizen/permanent resident	Asian (South- East Asia)	No
P 19		Woman	Single	Student	Canadian citizen/permanent resident	Asian (South- East Asia)	No
P 20	18	Woman	Single	Student	Canadian citizen/permanent resident	Asian (South- East Asia)	Yes
P 21	21	Woman	Single	Employed	Canadian citizen/permanent resident	Arab	No
P 22	21	Woman	Single	Student	Canadian citizen/permanent resident	Black	No
P 23	18	Woman	Single	Student	Canadian citizen/permanent resident	Black	Yes
P 24	19	Woman		Student	International student	Black	Yes

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P 25	18	Woman	Single	Employed	Canadian citizen/permanent resident	Arab	No
P 26	18	Woman	Single	Student	Canadian citizen/permanent resident	White	No
P 27	19	Man	In a relationship/dating	Student	Canadian citizen/permanent resident		Yes
P 28	19	Woman	Single	Student	Canadian citizen/permanent resident	Mixed	Yes
P 29	19	Woman	Single	Student	Canadian citizen/permanent resident	Asian (South- East Asia)	Yes
P 30	19	Woman	Single	Student	International student	Black	Yes
P 31	20	Woman	Single	Student	Canadian citizen/permanent resident	Black	No

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### 3.3.2 Research Tools

***Semi-directed interviews:*** The interview questions were methodically developed to match principles found in SRT and research about body/appearance. The interview encompassed questions about socio-cultural factors related to body/appearance such as social media and groups (peers, parents, and celebrities). The interview included different questions that focused on social media, family aspects and peer elements. The study required participants to report both family and peer group body discourses and define their ideal body descriptions according to peers and family and also based on social media portrayals.

The interview included questions derived from literature about the social construction of gender. Furthermore, the questions explored key theoretical aspects of SRT with a focus on anchoring and objectification as essential processes in SRT. Anchoring questions covered naming and emotional anchoring. Objectification questions covered topic of personification. The analysis of all responses to the questions involved examining suggested factors and two SRT processes to understand the representational genesis. The approach revealed connections between items which allowed the items with closer resemblance to display their representational structure (Eiguren et al., 2021).

The sample questions of the interview are as follows:

***General:***

*Body in general.* What do you think of your body, in general? Do you feel you have a negative body image, if so, where do you feel this perception come from?

***Social media:***

*Objectification-Personification question type.* Is there anyone, for example a celebrity, on social media that you are both following and would like to be in terms of their appearance or body style? Explain.

*Anchoring-Naming question type.* What do you call the ideal body in social media? What does it look like? Explain.

*Anchoring-Emotional question type.* How do you get close to this ideal body and what are your feelings about it?

***Peers:***

*Anchoring-Naming question type.* What do you call an ideal body in your friendship groups? How do you get close to this/these ideal(s)?

*Anchoring-Emotional question type.* Have you ever had discussions with your friends about the ideal body? If yes, during these discussions, how did you feel? Positive or negative? Explain.

***Family:***

*Family's standards.* Are there any standards/specific attitudes in your family regarding appearance related to your age/gender? Are those standards/attitudes consistent/inconsistent with your attitudes? For inconsistencies (if reported), what are / would be your solutions to these inconsistencies?

*Family impacts.* Do you feel you have a negative body image, if so, where do you feel this perception come from? Do you think your membership in your family and community impact this perception?

***Gender:***

How do you describe women/men ideal body?

What type of women/men body is more socially acceptable?

There was also a question about how they rate the importance of social media, peers, and family in shaping body representation. Participants were asked to rate it on a 10-point scale (from 1 to 10).

### **3.3.3 Data Analysis**

This study utilized thematic analysis as its core analysis method because this qualitative approach helps researcher identify, analyze, and interpret meaning patterns or "themes" present in qualitative data. NVivo 14 software made the process easier because it allowed researcher to systematically retrieve and code relevant information from participant responses. The initial stage required a detailed examination of interview data to sort responses into overarching themes focusing on social media impact and family and peer effects on social representation of body. The analysis revealed key themes through systematic coding which included body acceptance along with social media pressure and family appearance expectations as well as peer body ideal influence. The breakdown of each category into sub-themes contributed to a more complex understanding of the factors that shape individual body representation.

The researcher utilized the theoretical framework of SRT during the thematic analysis process to structure and interpret data findings. The analysis employed specific SRT processes like anchoring with its naming and emotional elements and objectification through personification to organize participants' perceptions of the role of their social environments (social media, family, peers, etc.) on the social representation of body. Objectification demonstrated the transformation of abstract social standards into tangible experiences through media and social interactions while anchoring revealed how participants emotionally bonded with and named particular body ideals. The analysis focused on thematic patterns of meaning while incorporating content analysis methods to measure the frequency of specific themes and vocabulary through word cloud visualizations. By combining thematic and content analysis researcher obtained a complete understanding of how young people's body representation are influenced by media, peer groups and family.

The assessment of coding reliability is a crucial step to ensure consistent interpretation of data across multiple coders. In this study, intercoder reliability was evaluated by inviting an independent coder to apply the predefined coding framework developed by the researcher to a subset of the interview data. This procedure aimed to assess the extent to which the independent coding aligned with the researcher's coding, thereby confirming the consistency, stability, and reliability of the coding system. Following the guidelines of O'Connor and Joffe (2020), 20% of participants were randomly selected for double coding. A detailed description of the codes was provided to the independent coder prior to analysis. After coding, Cohen's Kappa coefficient was calculated in NVivo, yielding a value of 0.72, which indicates acceptable reliability.

The study used Lincoln and Guba's (1985) trustworthiness criteria to assess the research. For credibility, the researcher was trained concerning the theory and ethics (TCPS2). To ensure

transferability the research used a gold standard sampling procedure known as saturation sampling method. The study maintained dependability by using an audit trail to show how conceptual units/categories were reported across transcripts which helped readers understand the study's aims and logic (Carcary, 2009). The data analysis achieved confirmability and rigor through graphical visualization of its elements.

The quantitative analysis included chi-square tests which compared how often themes appeared in participants with and without BDD-like symptoms. The statistical method examined the relationship between BDD-like symptoms and themes including social media influence, peer impact, and family expectations. Additionally, Pearson correlation analysis helped examine the associations between participants' body representation influences by social media, peers, and family and their BDD-YBOCS scores from Phase 1.

### **3.4 Results**

#### **3.4.1 Thematic Analysis Results of Interviews**

Researcher conducted in-depth interviews with 31 participants through Zoom meetings. Through the interviews researcher gained profound understanding of participants' personal experiences and perceptions. The main themes extracted from participants' interviews showed the complex interplay between social, cultural, and psychological factors in shaping SR of body. Participants voiced diverse feelings about their bodies that spanned both feelings of acceptance and satisfaction as well as ongoing battles with dissatisfaction. Social media significantly shaped body and appearance standards which pressured people to adapt to unattainable physical ideals. The views of participants about their bodies were formed through family expectations, peer impacts and and cultural differences which demonstrated the significant effect of external

factors. Additionally, the mental health struggles and anxiety levels increased for many people because gender-specific standards and body objectification prevailed. Overall, the themes analyzed have enabled us to better understand how body representations vary and depend on social pressures in combination with cultural norms and personal psychological experiences.

### **3.4.1.1 Main Themes**

#### ***1. Body Representation and Self-Perception***

*Positive Body Representation:* Some participants, expressed satisfaction with their bodies, emphasizing that they feel their bodies are well-suited to their needs and appreciating their health. They also mentioned that how supportive peer groups could lead them to think positively about their body.

P4: *“I think my body is super suitable for me, and I like my body from head to toe ... Luckily, I think thankfully, me and my friends don't really talk about my body types like me ... We prefer being respectful about each other, I guess.”*

P11: *“I think my body image is positive. I am critical of myself, but I feel that it is in a healthy way and improvement based.”*

P21: *“I would say that between me and my friends, we really try not to talk about it or not to talk about it in those terms, just because we all recognize that ... there's kind of a movement away from talking about an ideal body type and kind of just embracing the one that you have. So I think that kind of reflects the conversations I have with my friends. We try to be very mindful of the fact that different people have naturally different bodies, and then that's not a reflection of their value or their worth.”*

Negative Body Representation: Some participants discussed long-term struggles with body dissatisfaction. They often felt insecure about aspects of their appearance, including weight and height and how their friends impact the way they feel negative about their body.

P7: *“But in terms of, like, insecurities, I'm very insecure about my body shape and my body weight and also my skin, for sure ... since the fifth grade, I've had severe acne, like, all over my chest and like, my shoulders and ... it's definitely, like, brought my self-esteem down a lot.”*

P8: *“I think I think my Thighs are too big. I think my hips are too broad, my bones are too thick. My shoulders are too wide. I don't think I look very feminine. And I wish I Looked thinner and more feminine ... Like I mentioned in the beginning, I do think I have a negative body image and it's, I would say at least 80% from my mom, like growing up in my childhood.”*

P9: *“Like one of the things that all my friends like, kind of aim for, bigger and probably a smaller waist ... Negative... Because, like, although, like, I could have, like, be seen as having, like, an ideal body. Like, I still, like, have aspirations to look differently than I already do. So sometimes when we talk about those things, it's kind of heavy. And it kind of makes me feel a little uncomfortable”.*

Body Acceptance Journey: For some participants, body representation evolved over time, leading to a greater sense of self-acceptance. They described learning to prioritize their well-being over societal pressures and body size.

P21: *“I did have a few years back, an eating disorder that went undiagnosed, and I didn't have a period for, I want to say 7 or 8 months. So I've had I've made a lot of progress since then, and*

*I'm very happy with my body the way that it is now ... I've kind of just given up on trying and accepted that my body is the way that it's going to be.”*

*P27: “I think that there are like areas that I can improve like. But at the same time, like while I'm working to improve my body, I can see the improvements and it like motivates me more to try to like improve the parts that I don't like.”*

*Romantic Relationships and Partner Influence:* Several participants described how romantic relationships shaped their body representation, either by heightening appearance-related self-evaluation or by reinforcing the belief that bodies are “chosen” or validated through partner attention.

*P6: “I think it kind of depends what time like. I don't know why, but this year I've had. This year. Maybe it's because I got a boyfriend this year. So I've been, like, overly critical of myself. But, last year I was very much like, oh, body positive. I didn't feel bad about myself at all, but this year I have pretty bad body image. Yes. I guess it kind of changes with...”*

*P22: “I guess whoever has the ideal body. Usually has like a partner. So it's like. If you don't have a partner doesn't mean that you're not beautiful. It's just. If you have a partner, it means, like, you know, your body got picked in a kind of way...”*

*P20: “if someone was, like, seeing someone like, boyfriend like you need to watch what you eat. And what you eat in case, like, boyfriend needs you because you're gaining weight or something like that...”*

## **2. Social Media Influence**

Ideal Body Standards on Social Media: A common theme was the portrayal of "ideal" body types on social media, often defined as slim, toned, and curvy for women, and muscular for men.

P28: *"There are two different types of bad parties on social media. From what I've seen. Either you're too thin or you're not thin enough. The ideal body is this exaggerated figure of like. Yeah. Yeah. Exaggerated. Exaggerated chest. Exaggerated glutes. I'd say. Very thin waist. But if you're either flat chested or don't have any curves, that's also considered a bad thing."*

P29: *"Like, I think for women it's like small waist fake, but. And like a chest. Yeah. For men, I think it's always been, like, lean and muscular. Yeah."*

Pressure from Social Media: Many participants spoke about the anxiety and pressure they felt to conform to these ideals. P28, for example, even chose to avoid social media to escape the constant comparisons.

P13: *"Well, I wish, like I could get it, but I probably won't. Unless I got, like. Like plastic surgery and stuff like that, or, like, lost a bunch of weight. Yeah, I just, I just feel my feelings are mostly frustrated and upset because people who, like, look like that, they get treated better and they get, like, life just seems easier for them ... I think it would be like social media. Because you see people talking about all these different little things and you think, well, I didn't even think that that could be an insecurity. I better like, try to fix that ... I think it comes from my own, like, low self-esteem. And I think it became made worse with social media."*

P28: *"I decided to avoid most social media stuff around the age of 14, because I was feeling more and more self-conscious every time I went on there ... I think a lot of it has to do, groupthink. Groupthink around social media. Yeah, that's what limits me, because I think, before*

*I step outside, I wonder if my outfit is good enough for me to, like, post for my friends to post. So. Yeah, that absolutely limits my independence and independent independence ... Yeah. If I got if I got told by people in social media that I looked bad, I would probably never not show my face again. Okay.”*

*Comparison with Celebrities:* Several participants mentioned specific celebrities, such as Kim Kardashian and Bella Hadid, whose body types they viewed as the standard for certain cultural groups.

P1: *“Chris Bumstead, although he's like a bodybuilder, but he's on steroids, so I wouldn't personally do it. But if I could achieve his physique, I would.”*

P5: *“Well, I follow Kendall Jenner. Like I like her body ... Like we've definitely talked about celebrities or even people that we see on TikTok or something, or even on Instagram, like some models.”*

P18: *“I like I like looking at models and being like, oh, they really pretty like I wish. I was like kind of toned or like my hair, like face or whatever, but like, like I was like Bella Hadid, I would say is one of them ... I think I like comparisons A lot of comparisons. You know, when you open social media and you see other things. And I Think I do Have a tendency to compare But I get Tendency to Compare to other people, other what I see online, what I like hear people say.”*

P28: *“Probably very. Kim Kardashian. You know, curvy, but also still very thin, which is. Not very possible.”*

### **3. Fitness, Health, and Diet**

Exercise as a Means to Achieve Ideal Body: Many participants, described working out as an empowering way to achieve their desired body type, viewing it as a positive step toward their goals.

P9: *“Working out mostly. Not so much diet, but working out. Definitely.”*

P16: *“On TikTok ... there's been like workout influencers ... I want my bodies look like that and then following them also like different like exercise ... seeing someone would like the ideal ... either makes us like, want to work that much harder ... spend more time in the gym ... okay, like if I want to get like that, then I have to like put in like the work per se.”*

Health and Body Representation: Some participants highlighted health as an important factor in their body representation, focusing on maintaining a healthy body rather than simply achieving aesthetic goals.

P1: *“For me. Just a body that, you know, keeps me strong and at the same time doesn't drain me of my energy.”*

P2: *“it's just about health for me. I'm all about body positivity and things like that, and. If anyone's healthy, regardless of how like petite they are or how big they are. Because again, I'm aware of all different types of body types. It comes down to the health.”*

Muscular vs. Slim Ideals: There was frequent discussion about the contrast between slim, fit bodies for women and lean, muscular bodies for men. Preferences varied by culture and personal values.

P3: *“I'd say for the male, probably like muscular. Again, you could be muscular and like a bit bulkier or like skinnier. Depends. And for the women, it's probably. Somewhere between, like, not too big, not too skinny. That would be like.”*

P13: *“I would say like women. Ideal body is kind of more strict, I guess. Like, it's we've got to be, like, slim, but, like, also curvy. And then with men, it's like, I feel like there's more leeway because, like. Not everybody like is into like the whole like six pack and like muscles and stuff.”*

#### **4. Cultural and Societal Expectations**

Cultural Differences in Body Ideals: Participants noted that body ideals differ across cultures.

While slimness is emphasized in some cultures, others value fuller figures.

P7: *“Because like if I look back at, you know, just my family is used to like, we're Indian. So it's like being fair skinned is like so like, oh my gosh.”*

P16: *“it's pretty common. Like where like in our culture, like a lot of the women, like that's just what our bodies look like ... lot of like Western or like white communities. It's more so like the ideal, like super duper thing, like for mostly white communities. But I feel like when it comes to like my own community, like the black community, or even just like African community in the ideal body type would be like bigger, like larger breasts, larger...”*

Family Expectations: Parental influence was a recurring theme, with most participants mentioned the pressure they felt from their families to conform to specific body standards. However; a few mentioned the support from their family that push them against negative thoughts and having body positive.

P2: *"I kind of want to say very accepting of like all body types, you know, they're aware that some people are bigger than others, some people are smaller than others, but they know everyone has different body types."*

P5: *"Well, let's say like. If I was like. I say, if I was like really big, my parents would focus on the health point of it and like. Trying to, like, find out. Like why, you know, they're like, what's the reason for this and all that and. Yeah."*

P8: *"It's difficult to, you know, try to love your Body when you've been hearing, like, the Same stuff all your life from a parent ... Definitely to be skinny, feminine, you know, traditional, clean, cook, serve men. It's very my family is very traditional."*

P13: *"Yeah, I would say yes. Because I'm a girl. Especially, like when I was little, my mom was always very particular about my hair. She said that I always had to be very long. She'd never let me cut it or anything like that. And then, like, the women in my family are always making remarks about, like, you know, staying thin and stuff like that, and they're always, like, giving you tips on, like, anti-aging and stuff or like, you know, don't, don't put your head down so you don't get double chin and stuff like that."*

Gender-Specific Standards: Many participants pointed out the differing body expectations for men and women. While men are expected to be muscular and strong, women are expected to be slim yet curvy.

P6: *"Definitely woman is more criticized because ... if a girl did that and she wasn't pregnant, society would be like, oh my God, lose weight, thin ... And for guys a lot is accepted. But. Generally, guys, like, have abs. And they're tall be muscled ... "*

P12: *“Woman. It's a little bit more be slim body an sexualized and men is more about strength and muscle. Yeah. So for a woman, you have to look pretty. You have to look attractive. For men, it's really more like. Are you, strong?”*

### **5. Beauty Standards and Objectification**

Objectification and Hypersexualization: Some participants expressed discomfort with the way women’s bodies, particularly their curves, are often objectified and hypersexualized on social media.

P15: *“I’m a bigger chested girl. So like it's the boobs that are always like the feature point. And sometimes it can be incredibly uncomfortable when you know that people are just looking at your chest. And so like, that's one of the things I was very like, oh, and you know, sometimes you're just going to comment like you're just going to come and talk to you and be like, you really like big boobs. And you're like, wow, thanks. I'm also a person.”*

P30: *“I remember a teacher made a comment on my body on how I looked and told me to cover up, but I wasn't trying to intentionally sexualize myself or present myself in a certain way. I was just dressing like a normal 13 year old child would, which I thought was normal, and it was definitely normal.”*

Social Pressure to Conform to Beauty Standards: A recurring theme was the societal pressure to conform to beauty standards that emphasize features like slim waists, large chests, and toned bodies.

P23: “we were just talking about all of this societal pressure and what comes with and just feeling like, is it the perfect body? Why do you have to be like that when everyone comes in, you know.”

P24: “In social media. I think over the years we've seen like trends in bodies. Usually you think of trends as like clothing or makeup, but I see trends as, body types too, which is kind of which is very toxic, actually, because how can you, you know, change your body shape so quickly to match these trends?”

## **6. Confidence and Empowerment**

Confidence Despite Societal Pressure: A few participants, discussed how they have gained confidence in rejecting societal norms and embracing their own bodies.

P22: “tried to be a bit more like. Confident with my body. I'm not like 100% of the way there yet, but I try to. I try to be more. Out there, I guess that way, the way I dressed by just like my posture in the way I talk to people and stuff like that and the way I stand.”

P26: “I think for me personally, just my own body right now, like I'm pretty comfortable within my own skin. Like I don't think much of it to get close to ideals ... Like not necessarily much of it in the sense that, like, I don't ruminate over. If my body is good or bad, you know what I mean? Like, it's working hard and I just. It is like, I love it.”

Fitness and Confidence: For some participants, working out is a source of empowerment, providing confidence even if they haven't yet reached their ideal body type.

P10: *“Working out is one of the big ones. I've been working out for a few years now. I don't feel like it's giving me more power, just more confidence.”*

P30: *“Workout became kind of my therapy. But also it helped to change my confidence and how I felt with my body. And it made me like how I looked in the mirror.”*

Body Acceptance and Empowerment: Some participants, noted that as they age, they've become more comfortable with their bodies, developing greater self-confidence and acceptance.

P19: *“it can affect me. And sometimes I feel really good about myself. I feel I'm all my period, so I'm not bloated ... But as I grew older, I learned to appreciate, my curly hair.”*

P31: *“Well, when I see women who are confident in their bodies, no matter if they're like smaller or larger, it definitely gives me a sense of like, you know, relief, like, oh, it's okay. Especially if they're larger, because then I feel like we're more on the same ground.”*

## **7. Psychological Impact of Body Representation**

Mental Health Struggles: Several participants, discussed the connection between body and mental health, sharing experiences of anxiety, depression, and struggles with eating disorders.

P20: *“Negative. Because for me, like I've noticed recently, like, throughout the different stages in my life, I was never happy with my body ... t's like being youth right now is very difficult because, there's just. More. Like we in the time of like being very, like a very social media age. So. Like, we see a lot of things and we are influenced by a lot of things, and that can make us feel like we're not enough ... So that plays a lot into just. Mental issues like depression, anxiety and*

*things like that, people find themselves. Like I would say, depressed also because we are like. They might see things on social media and be like.”*

*P29: “I'd say a low self-esteem. Not a lot of confidence just yet. A bit of, like, lack in maturity. And I think you may be sensitive. You take everyone's opinions to, seriously, and. Maybe just pressure. Pressure to fit in. Pressure to look good. Pressure to be liked by others.”*

*Body Dysmorphia:* Some participants mentioned body dysmorphia, describing a tendency to fixate on perceived flaws in their appearance, which affected their mental well-being.

*P30: “I became hyper fixated on how how big my lips were, how big my stomach was because I had a big stomach. And I guess just like everything that was wrong about my body.”*

*Anxiety from Social Comparison:* Many participants referred to the anxiety they felt when comparing themselves to others, especially on social media platforms.

*P16: “think that it can kind of make you have like a negative type of introspection ... oh goodness, like, why don't I look like that? Or I should look like that and kind of feeling like. Like having like a negative self-image about yourself, because the comparison that you're making to somebody else.”*

*P24: “Like as a young girl growing up. In society, I think girls will always be susceptible to just. Terrible. Like. Terrible ideal ideals and stuff. And that comes from, I guess, the media. But yeah, I think I've had like issues when I was a younger girl. That still influenced me a little bit today. But, I think it's kind of like also competition with the things that I see in my everyday life, like almost like a competitive attitude compare myself for what I have, and that I need to achieve something.”*

## **8. Gender Identity and Body Representation**

Non-Binary and Transgender Experiences: Some participants highlighted the struggles faced by their trans non-binary sibling, discussing how body representation is intertwined with gender identity.

P31: *“I have one direct sibling who is, trans non-binary. So I know that they have a difficult time with their body as well.”*

Gendered Body Expectations: Many participants reflected on the gendered expectations surrounding body, with men feeling pressure to bulk up and women expected to maintain slim, curvy figures.

P1: *“The mayor. Okay, so starting with the female, I would say. You know, bigger body parts that are more sexually attractive. You know that hourglass figure that a lot of people, talk about and, say just toned body, not, like, super ripped or anything. Not, you don't have vascular do or anything. You just have tone, a tone body. You can see the definition just very slightly. For men it would be like a lot of vascular, pretty a lot of muscle mass. You know, you can see all the striations in your muscles and you would have, like a perfect chiseled jaw.”*

P28: *“when I am trying to achieve more power. I tend to dress more masculine. Masculine? Lee. I will bind my chest, I'll put my hair up, and I'll even sometimes do make up to, like, more. To accentuate the more masculine features on my face. And people do listen to me more when I do that...”*

Analysis of participant interviews revealed main themes which demonstrate a multifaceted comprehension of bodily understanding influenced by cultural, social, and

psychological elements. The prominent theme of body satisfaction emerged as some participants such as P11, expressed positive body representation while feeling grateful for their health. The main contrasting theme in the interviews was body dissatisfaction which was especially prevalent among participants such as P7 and P8 and P9 who reported enduring struggles with feelings of being "different" because of their weight, height or appearance leading to negative self-perception. The body acceptance journey stood as an essential theme because participants described their evolving body representation which transitioned from dissatisfaction to improved self-acceptance over time according to P21 and P27. Participants like P28 and P29 identified social media platforms as critical influencers on body because they promote unrealistic standards by showing women as slim and toned and men as muscular. Participants experienced substantial social pressure to match these ideals which caused some of them, such as P28, to stop using social media to avoid feelings of inadequacy. The discussion included comparisons with celebrities such as Kim Kardashian and Bella Hadid, Kendall Jenner, Chris Bumstead who represent body standards that some participants find difficult to achieve. Participants primarily defined their body image through fitness and health while they used exercise to attain their ideal body shape and enhance their confidence. The study showed cultural and family expectations were prominent topics because participants from various cultural backgrounds pointed out different body ideals between cultures with one participant like P16, discussing African-American communities' preference for fuller bodies. The pressure from family members to maintain particular body standards had a significant impact on some participants. The discussion of gender-specific body ideals revealed that men experience societal expectations to develop muscular and strong physiques while women are expected to maintain slim and curvy figures. The persistent pressure created feelings of objectification and hypersexualization especially

among women who often experienced their bodies as subjects to societal beauty standards. Finally, the psychological effects of body representation were thoroughly investigated during which participants explained how dissatisfaction with their bodies caused mental health problems like anxiety and depression as well as body dysmorphia which worsened due to social media comparisons with others. Together, these themes provide an all-encompassing perspective on how social and cultural factors alongside psychological influences determine participants' body representation and self-worth.

### **3.4.2 Mixed Method Results**

#### **3.4.2.1 Social Representation of Body**

This study explored in more depth the content and structure of the SR of body/appearance identified in the previous article through semi-structured interviews. The interview contained questions about a general body representation, the impacts of social media, peers, and family on body, and what gendered body is socially represented. The social representation of body and appearance among young people aged 16 to 21 in Canada reflects a complex interaction between individual perceptions, social influences, and cultural norms. For many youth, body image is not only a matter of personal satisfaction but a deeply social construct shaped by comparisons, expectations, and the pursuit of belonging. Participants described how family attitudes, peer feedback, and social media collectively create powerful norms around what constitutes an “ideal” body often slim, toned, or muscular leading to both admiration and distress.

Altogether, these interviews show that body representation is not fixed but constantly shifting between personal acceptance and outside pressures. Positive experiences grow when people focus on health, gratitude, and personal strength, while negative ones arise when family,

culture, or media enforce narrow ideals. The journey toward acceptance is ongoing, made up of small steps and daily choices rather than one final decision. Even with strong societal pressures, many participants are finding ways to resist, reshape, and reclaim their relationship with their bodies.

### **3.4.2.2 Body Experience**

Table 3-2 presents body experience among people with BDD-like symptoms against those without such symptoms and reveals significant perception differences between both groups,  $\chi^2(2) = 14.46, p < .001$ . Participants with BDD-like symptoms showed a majority (81.25%) who experienced negative body representation while only 18.75% of participants without BDD-like symptoms reported negative body representation. According to the data, 15.38% of individuals with BDD-like symptoms experienced positive body representation contrasting with 84.62% of those without BDD-like symptoms who reported positive body representation. 100% of respondents without BDD-like symptoms described their body experience as mixed (participants had both negative and positive experiences about their bodies, which was varied depending on the environment, their interactions with different individuals, and how they perceived or were perceived by others) whereas none of the individuals with BDD-like symptoms reported mixed, positive and negative, experience. The data supports this, indicating a significant association between BDD-like symptoms and a negative body experience, whereas individuals without these symptoms tend to have more positive or mixed representation of their body. This analysis demonstrates that those who expect to develop BDD-like symptoms have strong connections to negative body evaluations.

**Table 3-2**

Comparison of Experience of Body Between Individuals with and without BDD-like Symptoms

	Without BDD-like symptoms %	With BDD-like symptoms %
Negative body experience	18.75	81.25
Positive body experience	84.62	15.38
Mixed	100	0

### 3.4.2.3 The Perceived Factors of Social Representation of Body

According to the participants, several elements were found to influence their SR of body including family and parents along with social media, social comparison, personal thought processes, peers and friends, cultural values, environment and school. Among all mentioned influences the family and parents stood out as most frequently cited factors affecting body representation. The study shows that intimate family connections greatly influence how people perceive their own bodies. Social media following family was the next most cited factor, underscoring the powerful impact of media in promoting certain body ideals and standards. Participants exhibiting BDD-like symptoms identified family and parents as well as social media and the environment as the main sources of their body representation. Participants who did not display BDD-like symptoms pointed to cultural values along with personal thought processes and school as the essential elements that shaped their body representation. The distinction reveals that people who show BDD-like symptoms are more influenced by external elements while those

who do not show these symptoms depend on internal and societal influences to shape their body representation.

#### **3.4.2.4 Family Standards Regarding Body**

Table 3-3 compares the presence and consistency of family standards regarding body, beauty, and appearance between individuals with and without BDD-like symptoms. Four categories were presented:

No standards: An equal proportion (50%) of participants in both groups reported that there were no family standards regarding body and appearance.

With standards and consistent with attitudes: Slightly more participants with BDD-like symptoms (54.55%) reported having family standards that aligned with their attitudes compared to those without BDD-like symptoms (45.45%).

P12: *“Yes. So my mom was never a fan of like, super short short. So it it like the this value, is now ingrained in me too. I don't like showing up too much, but it's because of how I was, educated.”*

With standards that are not consistent with attitudes: A higher percentage of participants without BDD-like symptoms (54.55%) indicated that their family standards did not align with their personal attitudes, compared to 45.45% of those with BDD-like symptoms.

P17: *“...my dad doesn't like my tattoos because I have many...also, my brother make fun of me for like overweight...”*

With standards, consistent but try to change it: Notably, 100% of individuals with BDD-like symptoms reported having family standards that were consistent with their attitudes, but they still tried to change them, whereas none (0%) of those without BDD-like symptoms reported this.

P13: *“I would say because I am girl, especially when I was little, my mom was very particular about my hair. She said that my hair had to be very long, like always.... staying thin, ...always giving tips on, like, anti-aging and stuff, ... I would say they are consistent but I’m trying to change them like I don’t shave as much as the women in my family do...”*

The chi-square analysis suggested that there was no significant association between the prevalence of BDD-like symptoms and family standard categories,  $\chi^2 (3) = 1.15, p = .284$  (Table 3-3).

**Table 3-3**

Influence of Family Standards on Body, Beauty, and Appearance Representation in Individuals with and without BDD-like Symptoms.

	Without BDD-like symptoms %	With BDD-like symptoms %
No standards	50.00	50.00
With standards and consistent with attitudes	45.45	54.55
With standards and not consistent with attitudes	54.55	45.45

---

With standards, consistent but try to  
change it

---

0

100

### 3.4.2.5 Family Impacts

According to participant responses about family influences, family dynamics through parental behaviors and sibling relationships significantly and intricately affected individuals' body representations and self-perception. Direct interactions through comments and expectations combined with indirect influences stemming from family attitudes and cultural heritage shaped how individuals understand their body. Many reported that their family's beauty standards and body expectations directly influenced their self-view. The majority of participants reported that their family significantly influenced their body and appearance especially regarding their body weight. Family feedback and standards served as significant factor that shaped body image because they demonstrate the strong impact family dynamics have on body representation development.

P6: *"If I started getting, like, a crazy amount of weight, my parents would probably be like, what's going on?"*

P21: *"... my family has a very conventional view of the body. So their view of the body is very much. The ideal body type is very skinny, and I would say on the flatter side. And then I kind of grew up in an environment where my mom and my grandma would always diet once every few months to try to lose a few pounds and get back to that."*

P26: *“I'm Muslim myself, so I don't, I don't look like your typical most love wearing a hijab. However, there is still some standards within my family in terms of how I should adhere to the world ... my mom, I still saying that like, oh, maybe like you should lose a little bit more weight ...”*

Family is not only important in shaping risks around body and appearance but also in providing protection and support when communication is affirming. Thus, family also emerged as a source of resilience.

P15: *“Luckily they're not very strict with, like, how I dress or anything Like that ... they don't mind ...”*

### **3.4.2.6 Peers**

#### **3.4.2.6.1 Naming**

The word cloud that reflects the impact of peers on representation of the ideal body, described by participants when asked about ideal body in their friendship groups (Figure 3-1) Larger words in the cloud, such as slim, healthy, fit, and skin, likely represent the most mentioned characteristics associated with the ideal body. Other terms such as attractiveness, petite, toned, breast, skinny, gym, and exercising also suggest that peers emphasized physical fitness and health-related traits, while appearance-focused attributes such as butts, curvy, arms, waist were highlighted to a lesser extent.



P11: *“I think that overall, it is a positive conversation because it is a conversation about realistic ways that we can better ourselves to not only look healthy but feel healthy and most importantly, the goals we set for ourselves are achievable.”*

P13: *“During the discussions, I feel kind of negative, to be honest, because it just, like, makes you upset. To, like, see our friends be upset with how they look. And knowing that, like, you feel the same, but knowing that, like, no matter what you tell your friends, like nothing's really going to make them feel better. Because nothing that anybody tells me makes me feel better.”*

#### **3.4.2.6.3 Sentiments-based responses between participants with and without BDD-like symptoms**

Table 3-4 compares the sentiment-based responses of individuals with and without BDD-like symptoms when discussing body, beauty, and appearance with their friends. The results revealed significant differences between the two groups. The chi-square test result indicated that there were significant differences in sentiment-based responses between participants with and without BDD-like symptoms,  $\chi^2(2) = 3.93, p = .047$ . A higher percentage of individuals with BDD-like symptoms (72.73%) reported negative sentiment during these discussions, compared to only 27.27% of those without BDD-like symptoms. The results showed that a bigger proportion of participants without BDD-like symptoms (61.54%) expressed positive sentiment, compared to 38.46% of those with BDD-like symptoms. Surprisingly, 100% of participants without BDD-like symptoms reported neutral sentiment during these discussions, while none (0%) of those with BDD-like symptoms expressed neutral sentiment. This data implies that individuals with BDD-like symptoms tend to experience more negative sentiment during

discussions about body, beauty, and appearance with their friends, likely due to heightened sensitivity to these topics or internalized pressures about their appearance. On the other hand, those without BDD-like symptoms are more likely to feel positive or neutral sentiments, suggesting a greater sense of ease and acceptance when engaging in such conversations.

**Table 3-4**

Sentiment-Based Responses to Body, Beauty, and Appearance Discussions Among Peers in Individuals with and without BDD-like Symptoms.

	Without BDD-like symptoms %	With BDD-like symptoms %
Negative	27.27	72.73
Neutral	100	0
Positive	61.54	38.46

### 3.4.2.6.4 Social Media

#### 3.4.2.6.4.1 Naming

The ideal body portrayed in social media was mostly characterized by a combination of both **curvaceous** and **slim** features (Figure 3-2). The most frequent words, such as "curvy", "boobs", "big", "skinny", "waist", "slim", and "muscular" suggest a preference for bodies that are both well-toned and proportionately curvy, highlighting a desirable balance between being slim and having pronounced curves. The subsequent words, including "stomach", "nice", "toned", "face", "butt", and "bigger" further reinforce this image by highlighting a fit and well-defined



try to change, and not important. Generally, there was a significant association between the celebrities' impacts and BDD-like symptoms,  $\chi^2 (2) = 4.11, p = .043$ .

Important and try to change: Most of the participants with BDD-like symptoms (77.78%) were significantly impacted by celebrity body images and actively attempt to change their own body based on these influences. In contrast, only 22.22% of those without BDD-like symptoms feel this impact and take action to change their body.

P25: *"I do like remember a few times where we were like talking about like Bella Hadid and like how they're like models and like super tall and like, have what media perceives as, like, the perfect body...I wish I could be the same like...going to gym trying to like be like her..."*

Important but not try to change: Among those with BDD-like symptoms, a smaller percentage (33.33%) was observed regarding the influence of celebrity body image as important but do not attempt to alter their body. On the other hand, a larger proportion of individuals without BDD-like symptoms (66.67%) considered celebrity body as important but do not engage in efforts to change their own body.

P1: *"...Chris Bumstead, although he's like bodybuilder, but he's on steroids, so I wouldn't personally do it."*

Not important: A higher percentage of individuals without BDD-like symptoms (58.33%) was found regarding the impact of celebrity body image as not important compared to those with BDD-like symptoms (41.67%). These results may suggest that individuals with BDD-like symptoms are more likely to be influenced by celebrity body image and take action to change

their own body, while those without BDD-like symptoms are less affected and more likely to regard it as unimportant.

**Table 3-5**

Impact of Celebrity Body Image on Efforts to Change Personal Body in Individuals with and without BDD-like Symptoms.

	Without BDD-like symptoms %	With BDD-like symptoms %
Important and try to change	22.22	77.78
Important but not try to change	66.67	33.33
Not important	58.33	41.67

### 3.4.2.6.4.3 Achieving the Ideal Body Portrayed on Social Media

Participants reported various actions and considerations in their pursuit of achieving the ideal body often portrayed on social media:

*Exercise and Fitness:* The most commonly mentioned approach was engaging in regular exercise and fitness routines. Participants perceived physical activity as the primary means to get closer to the ideal body shown on social media.

P9: *“Working out mostly. Not so much diet, but working out. Definitely.”*

Diet: Following exercise, diet was frequently cited as another crucial factor in striving for the ideal body. Participants recognized that dietary changes could significantly impact their body shape and appearance.

P3: *"I'd say maybe just like watching what you eat..."*

Impossibility: A notable portion of participants expressed the belief that getting close to the ideal body portrayed on social media is unattainable. This acknowledgment reflects an understanding of the challenges and limitations in reaching such standards.

P3: *"... again it's like not attainable for me because, again, you know, it's hard work."*

Genetics: Some participants pointed to genetic factors as a limiting factor in achieving the ideal body, suggesting that inherent genetic traits play a significant role in body shape and size.

P16: *"I would say, luckily, my current body type is exactly how my mom looks and it's just always like my natural..."*

Unrealistic Standards: The ideal body portrayed on social media was also described as unrealistic by some participants. They noted that these standards are often unattainable for most individuals.

P19: *"There's so much Photoshop going on nowadays that like, you don't know what is actually true. Like, a girl can look like she has the most beautiful body online, but when you like could see her in person, she does not look like that at all."*

Body Modification: A few participants mentioned body modification as a potential method for achieving the ideal body, indicating an awareness of cosmetic procedures as an option.

P13: *“Well, I wish, like I could get it, but I probably won't. Unless I got, like. Like plastic surgery and stuff like that...”*

Clothing: The role of clothing in enhancing or altering body appearance was also mentioned, suggesting that fashion choices can contribute to achieving a desired look.

P7: *“like at the end of the day, like you clothes are meant to fit you. You're not meant to fit clothes, right?”*

Skin Care: Lastly, skin care was noted as an important aspect of achieving the ideal body, highlighting the role of maintaining healthy skin to align with social media standards.

P27: *“The ideal is like like toss, like they work out, you know, they have good facial, they have nice skin and like...”*

#### **3.4.2.6.5 Relations between the BDD- YBOCS scores and Body Sources.**

To test the relations between the BDD- YBOCS scores and body sources, Pearson correlations were performed. As shown in Table 3-6, peers were positively and significantly associated with increased BDD- YBOCS scores ( $r = .42, p = .033$ ).

#### **Table 3-6**

Correlations between the BDD- YBOCS scores and Ratings on the Importance of Family, Peers, and Social Media in Shaping Body representation.

	<i>M</i>	<i>SD</i>	1	2	3	4
1-BDD- YBOCS	18.29	8.58	1			
2-Family	6.56	2.29	.21	1		
3-Peers	5.62	2.43	.42*	.36	1	
4-Social media	6.88	2.70	.12	.19	.40*	1

\*  $p < .05$

### 3.4.2.7 Gender

#### 3.4.2.7.1 Men’s SR about Men and Women

Across interviews, the men anchor the ideal male body in muscularity, leanness, and often height. They repeatedly name traits like “muscular”, “toned”, “big arms/legs”, “visible abs”, “Dorito shape”, and “tall” alongside appearance cues such as a “chiseled jawline” and “good haircut”. They also objectify the ideal through celebrity exemplars (e.g., Chris Bumstead/bodybuilders), while acknowledging limits (steroids, genetics, time). Emotionally, this produces mixed feelings: respect and motivation from hard work and fitness, but also awareness that the fullest ideal is unrealistic or too costly. In peer contexts, men report relatively few deep body-talks; when they occur, they focus on attainable fitness goals (lift more, lose belly fat, clear skin). Some describe a broader acceptance for men ranging from very muscular to “average” or even “dad bod” and less social penalty for not fitting the ideal.

The same men consistently describe a narrower, more prescriptive ideal body for women that combines thinness and curves: a “slim/skinny” figure with a “small waist” with “toned but not too muscular” plus “clean skin”. Several explicitly say women face stricter social standards and more objectification; they link women’s perceived social advantage and “pretty privilege” to conforming to these appearance norms.

P1: *“So then toned body you know big muscles not super out of proportion. You know chiseled jawline, good haircut, everything perfect... like Chris Bumstead, although he's like a bodybuilder, but he's on steroids, so I wouldn't personally do it... I would say a good body image. Is more average. Just. Not super muscly or active or anything like that. Just looks like, see your stereotypical body type, right? And then a bad body type image.... I guess for women it would be, you know, a larger, body parts...along with that same figure... But for women, there's more of a push standard of having to have all those very narrow and, specific traits to, you know, be accepted..”*

P3: *“for the men, it's like the. Dorito shape. So it's like a bigger upper body and then like, slim towards the waist... Ideal body. One that's like well toned, but like very muscular. Like. Big arms, big legs, like all of it... Again, you could be muscular and like a bit bulkier or like skinnier...for the women, it's probably. Somewhere between, like, not too big, not too skinny... women who would probably be like the butt or like the leg portion... Somewhere between, like, not too big muscle, not too skinny...”*

P11: *“for men you want the broader shoulders and bigger arms... becoming more muscular and becoming leaner and more toned tends to be the focus... We talk about skin sometimes it's something we're working on because acne prone faces are, not beautiful... The men in my friendship group desire to have bigger muscles to lose belly fat“ ...and women, a*

*smaller waist, and as small as possible tends to be... clear skin in the women... like be thinner, have smaller waists and nice skin... a smaller waist... for women. Less muscled, but still toned. You want small waist, big hips, perfect skin...”*

*P27: “For a man like, they would have to be, like, tall. Like you would have to be like. These and lee like toned or like work a lot and then like good skin they would probably like. Maybe we tan... I think for women it definitely helps if they're like, if they look prettier, if they look more beautiful, it gives them advantage over other people. But for men, I think it just be the same...”*

#### **3.4.2.7.2 Women’s SR about Men and Women**

From the women participants, the social representation of the body is deeply shaped by gendered expectations and ideals promoted through media, family, and peer influences. Women tend to describe repeatedly the ideal female body mostly as “sexy” appealing, “slim” with “curves” especially an “hourglass figure” with a small waist, wide hips, and larger breasts and buttocks. This ideal, repeatedly reinforced by social media influencers and celebrities such as the Kardashians, Kendall Jenner and Bella Hadid, represents femininity, desirability, and social value.

In contrast, the ideal male body is described as “muscular”, “tall”, and “V-shaped”, with broad shoulders and a slim waist, symbolizing strength, control, and attractiveness. Women perceive that men with these features are often more socially valued and respected, while those who are overweight face stigma and are judged as lazy or less disciplined.

*P9: “...So if men more fit, people are like, oh, well, you know, they're driven and they're ambitious and they want to, like, make themselves feel good and they're doing stuff. But if you're overweight, then people are like, oh, well, you're lazy or you don't want to...”*

P12: *“Woman. It's a little bit more sexualized and men is more about strength and muscle. Yeah. So for a woman, you have to look pretty. You have to look attractive. For men, it's really more like. Are you, strong? So are you. Do you have muscle or are you tall? Do you have abs? But for women, it's more like. Are you curvy? Do you have boobs? Are you, well, proportionate and. Yeah...”*

P17: *“I feel like the ideal body for a woman is, like, small and, like, skinny and, like, curvy, I guess. But. For a man. I can definitely see it with, like, the men in my life like. And they get shamed for being, like, skinny. So it's like men have to be, like, strong and like jacked...”*

P25: *“I think, like right now it's more like an hourglass body shape. So like small waist, like larger hips and breasts. And then. But like overall, still a pretty thin. And then for males, I think it's like tall. Like taller than six feet and like muscular. Like have visible like our muscles, like biceps and like abs. So. Yeah...”*

According to both male and female participants, **height** was frequently mentioned as an ideal attribute for men. A taller stature is often associated with attractiveness and confidence.

These results provide a comprehensive understanding of the intricate factors forming SR of body, highlighting the profound influence of social, cultural, and psychological dynamics. Participants' testimonials during in-depth interviews varied widely from feeling positive about their bodies to ongoing battles with body dissatisfaction. Cultural and familial expectations became a powerful force of certain ideals which displayed differences among genders and cultures to showcase the sophisticated mechanisms through which society establishes individual and communal body standards. Social media worsen societal pressures through its depiction of unrealistic "ideal" body standards.

Comparing people who experience BDD-like symptoms with those who do not, showed distinct variations in how each group socially represents their bodies. People displaying BDD-like symptoms tend to have negative body experience, which external influences like family connections and social media amplify. People who do not exhibit BDD-like symptoms showed more positive or balanced body experience and they described the ideal body in more flexible and diverse terms valuing traits such as confidence, strength, and self-care rather than adhering to rigid or narrowly defined physical standards. The study reveals how outside forces intensify body issues in susceptible populations and shows why we need solutions that confront limited beauty ideals and support body positivity and resilience to social pressures. The research provides essential understanding of the multifaceted factors affecting body representations which supports developing customized strategies to enhance mental health and body perception among varied populations.

#### **3.4.2.8 Romantic Relationships**

Romantic relationships also emerged as an important interpersonal context shaping how participants perceived and evaluated their bodies. Several participants described how entering or being in a dating relationship influenced the intensity of their self-monitoring and appearance concerns. For some, partners served as a source of reassurance and validation, while for others, romantic contexts heightened vulnerability by making appearance feel more evaluated. P6 clearly illustrated this shift, noting:

*“P6:”This year. Maybe it's because I got a boyfriend this year. So I've been, like, overly critical of myself. But, last year I was very much like, oh, body positive. I didn't feel bad about myself at all, but this year I have pretty bad body image. Yes. I guess it kind of changes with...”*

It shows how romantic relationships can amplify self-surveillance, making individuals more sensitive to perceived judgments from partners. The transition from feeling body positive to experiencing pretty bad body image highlights how partner presence can reshape body representation from resilience to heightened vulnerability. Overall, participants' reflections suggest that intimate relationships can either buffer against or exacerbate body dissatisfaction. Supportive partner communication has the potential to reduce appearance-related anxiety, whereas critical or appearance-focused interactions may intensify negative self-perceptions.

### 3.5 Discussion

The current article aimed to explore the perception of the role of family, peers and social media on the content and structure of SRs of body/appearance among young people living and studying in Canada. The interview themes included a wide range of factors that are perceived to influence body representation and self-perception among the participants. These 8 themes were shaped by socio-cultural influences such as social media, peers, and family. The themes and subthemes that were extracted from the interviews by considering the influence of peers, family, and social media are: **Body experience and Self-Perception**, which includes subthemes such as Positive Body experience, Negative Body experience, and the Body Acceptance Journey; **Social Media Influence**, with subthemes like Ideal Body Standards on Social Media, Pressure from Social Media, and Comparison with Celebrities; **Fitness, Health, and Diet**, which is broken down into Exercise as a Means to Achieve Ideal Body, Health and Body Representation, and Muscular vs. Slim Ideals; **Cultural and Societal Expectations**, with subthemes of Cultural Differences in Body Ideals, Family Expectations, and Gender-Specific Standards; **Beauty Standards and Objectification**, which includes Objectification and Hypersexualization and Social Pressure to Conform to Beauty Standards; **Confidence and Empowerment**, featuring

Confidence Despite Societal Pressure, Fitness and Confidence, and Body Acceptance and Empowerment; **Psychological Impact of Body Representation**, with subthemes of Mental Health Struggles, Body Dysmorphia, and Anxiety from Social Comparison; and finally, **Gender Identity and Body Representation**, which includes subthemes of Non-Binary and Transgender Experiences and Gendered Body Expectations. In this section, I will delve deeper into the SRs of body, beauty, and appearance, with a focus on SR and how these findings contribute to existing theories and research.

The data collected from this study's interviews provides a picture of the complex relationship between social representation theory and body, illustrating how individuals' representations of their bodies are shaped by social, cultural, and psychological factors. According to the underpinning logic of SRT, our understanding of the world is not objective, but socially constructed through collective beliefs, norms, and shared knowledge within our own cultural context. Applying this theory to the body, individuals' perceptions of their bodies are similarly not formed in isolation, but are constructed and deeply influenced by their social interactions, cultural expectations, and psychological experiences. One of the main themes that emerged was body experience and self-perception, with participants displaying a broad spectrum of body satisfaction and dissatisfaction. Positive body experience, as noted by a few participants, was linked to feelings of well-being and health, aligning with the SRT concept of anchoring, where individuals use existing societal norms of health to anchor their sense of self-worth. On the other hand, negative body experience, specifically among participants with long-standing body dissatisfaction, reflects the objectification process in that societal ideals about appearance become internalized and personified, resulting in the perception that one's body is inadequate or flawed. This process of objectification was apparent through participants' fixation on specific

physical attributes such as weight and height, which were often held as indicators of social status and attractiveness (Tiggemann, 2013).

The theme of fitness and health also played a critical role in how participants navigated their body representations. Many described exercise and fitness as empowering, viewing it as a way to take control of their bodies and move closer to their ideal body. This reflects the anchoring process within SRT, where fitness becomes a socially endorsed means of attaining and maintaining a socially acceptable body (Martin Ginis et al., 2007). However, there was also a tension between health and aesthetics, with some participants prioritizing the former while others pursued fitness primarily to meet societal beauty standards. The convergence between health and aesthetics demonstrates the fluidity of SRs, and how different groups or individuals anchor their representation of body in varying, sometimes conflicting, societal norms (Prichard & Tiggemann, 2008).

A significant factor in participants' body representations is the role of family expectations. Many participants indicated that they felt most pressure from their parents to conform to certain body standards. This finding aligns with the process of emotional anchoring, within SRT, as individuals internalize family norms and values around appearance, and experience feelings of guilt, pride, or shame associated with their bodies. There is also a gendered aspect, as gender-specific standards are reinforced through familial and cultural expectations. In this regard, men often feel pressure to have a more muscular body while women are expected to maintain a slim yet curvy figure and more sexy appealing. As seen through the reinforcement of these standards, gendered representations of the body are socially constructed and perpetuated through both familial discourse and broader societal narratives.

Participants' body representations are mostly influenced by their familial expectations, and vary between their own cultural ideals. The specific cultural backgrounds of each participant establishes their own unique standards of beauty, for example an admiration for slimness in some cultures but fuller figures in others (Swami and Tovée, 2006). Aligning with the concept of SR, this inconstancy in deals illustrates how different cultural groups form distinct representations of the body. As an example, participants from African-American backgrounds were inclined to value full body with more curves, while White participants valued skinnier body types. These cultural representations are not universal, and are anchored in their own deeper societal values and historical contexts. This in turn has varying influences on how individuals perceive both their own bodies and those of others.

Social media emerged as another important influence on body, reinforcing unrealistic standards and ideals that participants felt pressured to conform to. In terms of SRT, social media serves as a powerful tool for the diffusion and objectification of body ideals, with platforms like Instagram and Facebook acting as modern-day arenas where societal representations of the "ideal" body are repeatedly reinforced. These representations are anchored in ideals of slimness for women and muscularity for men, creating a narrow and often unattainable vision of beauty leading to dissatisfaction (Perloff, 2014). The most noticeable areas of influence for these representations was within discussions addressing social media pressure and celebrity comparisons. In these discussions, celebrity figures like Kim Kardashian and Bella Hadid became tangible symbols of the unattainable body types that participants felt they were expected to emulate. This speaks to the symbolic role that these celebrities play in anchoring societal ideals of body image, which are then internalized by individuals, shaping their representations of beauty and desirability (Fardouly et al., 2015).

Objectification and hypersexualization were common experiences for many female participants, who described how their bodies were often viewed and judged based on societal ideals of femininity and sexual attractiveness. The process of objectification, a core concept in SRT, provides a lens to understand how abstract societal ideals of women's bodies are realized through everyday interactions and their portrayal in media (Fredrickson and Roberts, 1997). Participants expressed discomfort with the constant hypersexualization of body parts like breasts and hips, highlighting how these representations reduce women's bodies to objects of desire, rather than complex, multi-dimensional selves (Moradi and Huang, 2008). For example, some participants explained how rules at schools or other places made her feel singled out as a sexual object:

P15: *"I'm a bigger chested girl. So like it's the boobs that are always like the feature point. And sometimes it can be incredibly uncomfortable when you know that people are just looking at your chest. And so like, that's one of the things I was very like, oh, and you know, sometimes you're just going to comment like you're just going to come and talk to you and be like, you really like big boobs. And you're like, wow, thanks. I'm also a person..."*

P7: *"I did go to a Catholic, like I was in the Catholic school board for high school. And like we obviously did have a dress code ... like girls couldn't wear certain shorts that were too short, which is like understandable or like, but like, like they couldn't be more like tank tops and stuff. And like, I remember like, I don't know how true this was, but I think that policy was made because of male hormones or that's what, like girls would say, which is like so stupid to me. Like guys can't control themselves. So we have to control what we wear..."*

P28: *“My old my old school had, uniforms and a big thing was that girls can't show their show clips and that continues to be an issue and I don't understand why shoulders are so distracting on girls...”*

P30: *“I remember a teacher made a comment on my body on how I looked and told me to cover up, but I wasn't trying to intentionally sexualize myself or present myself in a certain way. I was just dressing like a normal 13 year old child would, which I thought was normal, and it was definitely normal.”*

These captures how institutional settings positioned girls' bodies as responsible for controlling male attention, which is a clear experience of hypersexualization. Plus, it demonstrates how ordinary clothing choices were interpreted through a sexual lens, pushing girls prematurely into adultized, sexualized roles.

In an attempt to navigate these pressures, some participants found alternative methods to build their confidence and reclaim their sense of self. In some cases, participants described how as they grew older, they eventually learned to reject societal beauty standards and embrace their bodies. Aligning with the concept of re-anchoring, through this process individuals were able to build more positive representations of their bodies. These new representations were no longer grounded in external societal expectations, but instead in personal experience and self-acceptance. Through this psychological and social transformation, individuals were able to move away from objectification and toward a more holistic and empowered perception of their own bodies (Tylka and Wood-Barcalow, 2015).

The intersection of gender identity and body representation emerged as a key theme throughout these findings, most notably for non-binary or transgender participants. As these

individuals described, they faced unique challenges in navigating these societal expectations, reflecting the multifaceted relationship between body representations, gender identity, and SR. The experience of non-binary and transgender participants often clashed with traditional ideals of gendered bodies, illustrating how rigid SRs of the male and female body can serve to further marginalize individuals who do not conform to these binary norms.

The findings also highlight the significant role that romantic relationships play in shaping young people's body representations. Consistent with research showing that partner objectification and appearance-focused feedback can heighten body surveillance and dissatisfaction, several participants described how entering a relationship intensified their self-monitoring and concern with appearance. From an SRT perspective, romantic partners function as powerful social anchors who reinforce or challenge dominant cultural ideals about attractiveness. When partner interactions centered on support and acceptance, body representations remained more stable and resilient; however, when relationships introduced comparison, fear of judgment, or appearance-based validation, participants reported increased insecurity and negative self-evaluations. This suggests that intimate relationships serve as both potential protective factors and sources of vulnerability in the construction of body meaning, illustrating how interpersonal dynamics intersect with broader sociocultural pressures to shape young people's embodied self-perception.

Participants with and without BDD-like symptoms demonstrated different anchoring tendencies, with BDD sufferers often anchoring their self-worth more rigidly to appearance-based standards, and those without BDD-like symptoms anchoring themselves in broader values such as health and well-being. Those without BDD-like symptoms demonstrated what I call **flexible anchoring**, meaning their representations of the body were not fixed around rigid beauty

ideals, but open, adaptive, and multidimensional. They could hold multiple meanings of the body at once, seeing it not just as an object to evaluate, but as a source of health, strength, self-expression, and identity. In contrast, those with BDD-like symptoms showed **rigid anchoring**, meaning their body representations were locked into appearance-based standards. They couldn't easily shift or reinterpret these ideas, which made them vulnerable to distress, comparison, and obsession. Objectification further helps explain how participants evaluate their bodies based on external validation, particularly among those with BDD-like symptoms, who often described their bodies in terms of societal attractiveness norms. In contrast, participants without these symptoms placed less value on appearance and instead leaned towards functionality and intrinsic qualities, indicating a lower degree of objectification.

In conclusion, these interviews established notable themes that helped inform the complex, intertwined nature of body representations and SR processes. These social, cultural, and psychological factors compound with each other to shape how individuals perceive their bodies. As highlighted in this study, social media, familial expectations, and gender norms serve as powerful forces that can anchor and objectify body ideals. However, these findings also illustrate the potential for resistance and re-anchoring, as individuals find ways to reclaim their bodies, escape societal expectations, and enhance their own self-acceptance and empowerment.

### **3.5.1 *Family and Parents***

A core element of this study is the extent to which family shaping SRs of body, acting as the primary environment where societal ideals of beauty and appearance are first introduced, reinforced, and made concrete. In SRT, the family serves as a key site for anchoring abstract societal ideals into lived experiences. Through interactions with parents, siblings, and extended

family, individuals receive norms and values about body representations that become deeply ingrained. Participants in this study consistently described how their family's standards about beauty and appearance shaped their representation from an early age, which aligns with the findings of Du (2015) and Abraczinskas et al. (2012), both of whom noted that parental behaviors, such as body criticism and dieting, strongly influence children's body image. The transmission of these ideals within the family highlights the family's pivotal role in the SR process.

One of the key concepts in SRT that applies to family influence is emotional anchoring, where family norms and expectations become emotionally charged and internalized. Participants in this study that experience BDD-like symptoms described how comments from family members on their weight and appearance caused feelings of inadequacy or increased pressure to conform to certain standards. This emotional anchoring helps explain how family-specific standards around body and beauty become ingrained in individuals' emotional responses, shaping their representation and self-worth. Bovina et al. (2022) noted a similar process where family-driven beauty standards are internalized across generations. Participants described feelings of guilt, shame, and frustration when they failed to meet their family's expectations about body size and appearance, demonstrating the family's powerful influence over SR of body.

Moreover, participants described how their bodies were often viewed and evaluated through the lens of family expectations about beauty, where parents, in particular, were seen as enforcers of societal beauty standards. This objectification often occurred through monitoring weight, encouraging dieting, or commenting on physical appearance. These findings are consistent with Forney et al. (2012), who found that parental monitoring of appearance can lead to higher levels of body dissatisfaction and self-objectification. This trend is reflected by the

experiences of this study's participants, who internalized family standards which became sources of emotional distress and self-criticism. This dynamic illustrates the dual role of families in both supporting and critiquing one's body representations.

Parental modeling and commentary about weight, shape, and attractiveness contribute to early body image development (Mastro et al., 2016). Research shows that family appearance-focused comments and teasing are associated with higher perfectionistic standards and greater body dissatisfaction, which are risk factors for BDD-like symptoms (Kluck, 2010; Smith et al., 2024; ). Conversely, supportive family environments characterized by unconditional acceptance can buffer against body dissatisfaction and BDD vulnerability (Rodgers et al., 2011).

The influence of family standards on body representation is particularly impactful for individuals with BDD-like symptoms. These participants described how family-driven SRs of beauty continued to shape their body representations into adulthood, leading to chronic dissatisfaction. Even when family standards aligned with personal beliefs, participants with BDD-like symptoms still felt immense pressure to conform to these ideals. These findings reflect the argument of Swarr and Richards (1996), who emphasize the long-lasting influence of parental expectations on body representations. Participants in this study expressed that despite feeling supported by their families, they continued to feel pressure to meet their expectations, which was a source of emotional distress. This continued effect illustrates the powerful and lasting impact of family on body representations.

In SRT, the family acts as a crucial site for the transmission of body and beauty ideals, which aligns with the concept of anchoring. Abstract societal ideals about beauty, such as slimness and attractiveness, become tangible through family interactions and expectations.

Bovina et al. (2022) discussed how family members, particularly parents, serve as key transmitters of beauty standards across generations. In the current study, participants described how their families set specific body attitudes from an early age, reinforcing traditional beauty norms. Parental behaviors, such as monitoring weight, commenting on appearance, and modeling certain beauty practices, served to objectify these abstract societal ideals, making them part of daily life for individuals growing up in these environments.

The role of family in shaping SRs extends beyond direct influence through comments or criticism, and into a more implicit transmission of values. Parents not only set explicit expectations about weight and appearance for their children, but also act as models for behaviors related to health, fitness, and dieting. Regardingly, some researches shows how bodily care practices, such as regular exercise or healthy eating, are often passed down from parents to children and reinforce these associated cultural norms (Abraczinskas et al., 2012; Stojcic et al., 2020). In the current study, participants frequently cited family-driven behaviors, such as adhering to diets or fitness routines, as contributing factors to their body concerns. This familial transmission of health-related behaviors further anchors societal ideals of beauty within the family context, integrating them into individuals' lived experiences.

This study offers another significant finding, being the revealed differentiation in emotional responses to family standards between individuals with and without BDD-like symptoms. Participants with BDD-like symptoms reported higher levels of dissatisfaction and a stronger drive to alter their appearance, even when their family's beauty standards aligned with their personal attitudes. Forney et al. (2012) highlighted the emotional toll family comments can take on vulnerable individuals, and the current study extends this by demonstrating that participants with BDD-like symptoms are particularly sensitive to family expectations. This

emotional anchoring illustrates how deeply family interactions influence body dissatisfaction, especially for those already vulnerable to societal pressures regarding appearance.

Interestingly, while previous research has often focused on the negative effects of critical or unsupportive family behaviors, the current study reveals that even positive family dynamics can contribute to body representation. Swarr and Richards (1996) found that supportive parental relationships could buffer against body dissatisfaction. However, this study suggests that for individuals with BDD-like symptoms, even when family standards were aligned with personal beliefs, the pressure to meet these standards still led to dissatisfaction. This finding highlights a more nuanced relationship between family influence and body representations, suggesting that even well-intentioned family support can contribute to feelings of inadequacy when high standards of appearance are involved.

SRT emphasizes that family dynamics contribute to the collective shaping of body ideals. Families reinforce societal standards within the home, pulling these ideals into the individual's immediate social environment. Objectification, being the process in which bodies are evaluated based on societal criteria, then occurs both explicitly through verbal comments and implicitly through family behaviors and routines. In the current study, participants reported that family standards regarding beauty, fitness, and most importantly, **weight**, were directly communicated through comments and critiques, but were also subtly reinforced through daily practices like diet and exercise. This reinforces the objectivation process described in SRT, where abstract beauty ideals become concrete through family interactions.

Finally, the study underscores the importance of understanding family influence through the lens of social comparison theory and objectification theory. Festinger's (1954) social

comparison theory suggests that individuals evaluate themselves by comparing their bodies to others, and in the family setting, these comparisons often occur between siblings or between children and parents. Participants with BDD-like symptoms in this study demonstrated higher levels of self-objectification and increased emotional distress related to family standards, which in turn reinforces the cyclical ties between family influence, self-perception, and body dissatisfaction.

In conclusion, families are significant factor shaping SRs of body and beauty. Through the processes of anchoring and objectification, families both explicitly and implicitly transmit societal ideals about beauty, fitness, and appearance, and embed them into the individual's day-to-day interactions and expectations. This study reveals the profound and lasting impact of family standards, whether supportive or critical, on body representations, particularly for individuals with BDD-like symptoms. Many who struggled with their body and appearance said this begin early often with family comments about weight and skin and the rigid ideal body coming from family expectations and attitudes which made the central core of their body representation. By providing both direct and implicit feedback, families help shape the SRs that individuals carry into adulthood. As such, family a key site for the construction and reinforcement of societal ideals of the body.

### **3.5.2 Social Media**

Social media plays a significant role in shaping SRs of body and beauty, saturating the online space with the curvaceous and slim features of the ideal body type. As participants described, they observed the societal preferences in this space for toned, curvy, and muscular physiques, and felt pressure to meet these physical standards by engaging in regular exercise,

dieting, and even body modifications. These findings align with the research of Perloff (2014) and Tiggemann & Slater (2013), who identified social media as a key component in the perpetuation of idealized body norms.

Extending beyond superficial beauty standards, social media is a key platform through which abstract ideals are transformed into tangible anchors in users' everyday lives. By being constantly exposed to curated images of ideal appearances, individuals internalize this ideal as the standard of beauty, forming a concrete representation of an acceptable or attractive body. This is the process of anchoring, a key concept within SRT defining how societal ideals are translated into collective norms. In this study, participants identified the ideal body type as slim, toned, and muscular, displaying the palpable influence of their repeated exposure to these images. Social media platforms like Instagram and TikTok perpetuate these ideals, and have a real-world impact in shaping how individuals perceive themselves and others. As a result of this process, many individuals, especially those who cannot achieve these apparent standards, experience significant psychological consequences.

Objectification is one of the main mechanisms through which social media influences individuals' representation of body. Through this process, bodies are reduced to objects and are evaluated by their ability to meet the societal standards of beauty. Participants in this study described their perceived pressure to conform to these online representations, despite understanding that these images were often heavily edited or filtered. This somewhat contradictory perspective is explained by the SRT concept of objectification, as abstract ideals, such as beauty, are translated into tangible expectations for one's body. As demonstrated by participants' feelings of pressure, these representations are actively internalized and shape how individuals view their own bodies. By feeling compelled to meet these standards, individuals

often experienced body dissatisfaction, reinforcing their perspective of beauty as a fixed standard that they can, and must, achieve to be desirable.

As this study shows, social media perpetuates unrealistic beauty standards by bombarding individuals with heavily edited images, distorting their view of normal and attractive body representation. These findings align with Perloff's (2014) argument that social media warps reality by perpetuating unattainable body ideals. Consistent with this analysis, the participants in this study often experienced increased anxiety and self-doubt while engaging with these images and comparing their own bodies to these ideals. This process of comparison is consistent with the logic of Social Comparison Theory (Festinger, 1954), in that individuals evaluate their own self-worth by comparing themselves to others. Through this lens, social media is an instrument for comparison, contributing to heightened body image dissatisfaction and promoting harmful behaviors such as extreme dieting and cosmetic surgery (Ahmadpanah et al., 2019).

Beyond the personal and psychological impacts of social media, these pressures are embedded within larger economic and cultural systems. The image of the female body as slim, fit, and high-status is not only a symbol of attractiveness or health, it is also tied to ideas of success, productivity, and social value. Women who align with these ideals are often perceived as more capable, employable, and socially desirable, which transforms the body into a form of symbolic capital that can be exchanged for social and economic advantage (Bourdieu, 1984; Hamermesh & Biddle, 1993).

Social media plays a crucial role in commercializing body ideals, linking appearance to happiness, confidence, and success. The beauty, fashion, fitness, and cosmetic industries strategically use these platforms to sell dissatisfaction while offering products and procedures as

“solutions” (Gill, 2007; Elias et al., 2017). This process reinforces a culture of consumption in which maintaining beauty becomes a form of aesthetic labour, an ongoing investment of time, money, and emotional energy in order to remain “valuable” and socially visible (Warhurst & Nickson, 2007).

In this sense, social media does not simply reflect beauty norms; it drives profit by producing insecurity. The global beauty market, valued at over USD 579 billion in 2023, thrives on idealized representations of body and beauty, especially through influencer marketing and personalized advertising (McKinsey & Company, 2023). These industries, supported by social media algorithms, continuously promote unattainable ideals that encourage endless self-monitoring and consumption (Featherstone, 2010).

From a social work perspective, this dynamic challenges the idea that body dissatisfaction is an individual failure. Instead, it is a socially produced condition rooted in capitalist structures that commodify the body and profit from insecurity. Addressing this issue thus requires systemic solutions such as media education, critical awareness, and policy interventions that promote diverse and realistic representations of beauty (Bordo, 2003; Foucault, 1977).

In this sense, while social media facilitates social comparison, it reinforces the pressure to conform to societal beauty standards, leading to the internalization of these ideals. Participants described the behavioural effects of this internalization, such as checking their body, uploading photos, and comparing themselves to others on social media platforms. Reflecting this behavioural trend, research by Ahmadpanah et al. (2019) found that social media use increased users’ body image dissatisfaction and escalated disordered eating habits. Experiencing this

significant pressure to conform to societal standards causes individuals, particularly adolescences, to internalize social expectations of appearance and prompts them to engage in drastic behaviors or choices such as cosmetic procedures (Petersen, 2007). Social media is then both a site for the anchoring of beauty ideals and a mechanism for the objectification of the body. Abstract ideals of beauty, often shaped by their historical, cultural, and social context, are constantly exposed to individuals. By making these abstract beauty ideals accessible, relatable, and understandable to its users, social media is a core driver in these processes. Individuals internalize these ideals (anchoring) and simultaneously evaluate themselves against these standards, even reducing their perception of themselves to physical objects (objectification). Together, these processes contribute to body dissatisfaction, low self-esteem, and attempts to conform to these unattainable beauty standards, such as extreme dieting or cosmetic surgery.

While participants were generally aware of the social construction of beauty ideals, and its caveats, many still pursued these unattainable standards. This conflicting logic reflects the dual role of social media in shaping body representations: it reinforces cultural norms while also providing a space for critique. To examine this dual nature, this study extends past a narrow focus on body dissatisfaction, and instead explores how participants recognized the impossibility of achieving these ideals but continued to strive for them. For example, despite understanding the unrealistic nature of social media representations, some participants engaged in dieting, exercise, or body modifications to reach them. These findings build on the work of De Rosa and Holman (2013), describing the role of social media in not only reinforcing beauty norms, but also allowing individuals to question and critique these standards while navigating their influence.

A key difference in this study's findings lies in the contextual challenges participants face when trying to achieve idealized body standards. Participants not only discussed the emotional

and psychological toll of body dissatisfaction but also addressed the social and genetic barriers that make conforming to these ideals particularly difficult. This critical perspective has often been underexplored in previous research. Participants did not passively internalize these representations; instead, they engaged with them critically and recognized the limitations imposed by their personal circumstances. However, despite this critical awareness, they still felt the pressure to conform, demonstrating the deep-rooted influence of social media on body representations.

For individuals with BDD-like symptoms, social media poses an even greater threat. Participants with BDD-like symptoms reported feeling a stronger need to conform to idealized body standards, echoing findings by Fardouly et al. (2015). Peer-driven social media activities amplify self-scrutiny and self-objectification, making these individuals more vulnerable to the negative effects of social media. This heightened pressure leads to an increased focus on perceived flaws and a stronger desire to meet societal beauty ideals. As a result, these individuals are more likely to experience body dissatisfaction and engage in harmful behaviors to achieve their idealized self-image.

Moreover, these processes of objectification and comparison, facilitated by social media, contribute to a cycle of dissatisfaction, particularly for those already vulnerable to body concerns. As individuals compare themselves to the idealized bodies they see online, they further internalize these ideals, leading to greater dissatisfaction when they cannot achieve them. This process aligns with the findings of McComb et al. (2023), who argue that social media influence comparisons that exacerbate negative self-assessments. The findings of this study support this view, as participants consistently reported feelings of inadequacy when comparing themselves to the unrealistic standards perpetuated by social media.

Interestingly, this study found that participants did not passively internalize these SRs, but instead critically engaged with them and their own limitations. Many participants recognized the unrealistic standards perpetuated by social media and identified their challenges in meeting them, such as genetic and social barriers. This self-awareness reflects a more nuanced understanding of SRs, where individuals critically navigate objectified representations of body and beauty rather than wholly accepting them. These findings challenge previous research by VanVonderen (2011) and Cusumano & Thompson (1997), which focused on the internalization of the thin-ideal body type. While it was true that participants in this study were influenced by ideals of a slim body type, they described a more complex and multifaceted SR of the ideal body, such as including an affinity for physical fitness and curves.

This shift reflects contemporary trends in social media, where "fit" and "healthy" bodies are often idolized alongside slimness. As noted by Camargo et al. (2011), beauty standards have evolved to incorporate representations of health and fitness, which coexist with traditional ideals of thinness. The findings of this study correspond with this idea of evolution, as participants often described their ideal body as both slim and fit, blending these two seemingly contradictory ideals. This highlights the fluidity of SRs of body and beauty, as individuals adapt their representations to align with both traditional and contemporary standards.

In conclusion, social media plays a central role in shaping SRs of body and beauty, and is a powerful platform for anchoring societal ideals into the everyday lives of individuals. Through repeated exposure to curated images, social media perpetuates the objectification of the body, fostering unrealistic beauty standards that contribute to body dissatisfaction. While participants in this study were critically aware of these unrealistic standards, they still felt pressured to conform, demonstrating the significant influence of social media on body representations. For

individuals with BDD-like symptoms, social media amplifies self-objectification, leading to heightened anxiety and dissatisfaction with their appearance. However, the study also reveals that individuals are not only passive recipients, but also critically navigate these representations, challenging the unattainable standards set by social media while still engaging with them. The complexity of this relationship demonstrates the need for further exploration of how social media shapes body representations, particularly for vulnerable populations.

### **3.5.3 Peers**

Peers play a pivotal role in shaping the SRs of body and beauty, particularly during adolescence, a critical period for identity formation. Adolescents are highly susceptible to peer influence, as peer groups establish shared standards of attractiveness and appearance that become central to an individual's self-concept. Shen et al. (2022) highlighted how peer-driven discourses contribute to shaping these SRs, emphasizing that peers not only reflect societal ideals but also reinforce them. In the current study, participants revealed that peer conversations about body shape, fitness, and appearance are key in forming their own body representation. This aligns with previous research (Du, 2015; Hildebrandt et al., 2008; Jodelet, 1984), which emphasizes the role of peer interactions in perpetuating societal standards of beauty.

A core concept in SRT, anchoring, helps explain how peer groups embed societal ideals of body and beauty into everyday life. Adolescents often seek validation and acceptance within their social circles, which encourages the internalization of these norms. Peer discussions act as sites where societal standards of attractiveness are made concrete, transforming abstract ideals into attainable (or perceived attainable) goals. Participants expressed that certain descriptors, such as "slim", "fit", and "healthy", were most prevalent in peer conversations. The tendency to

discuss these traits illustrates the influence of ideas of fitness and appearance in maintaining social status within their groups. This dynamic resonates with Jones (2001), who demonstrated that peer influence is particularly critical during adolescence, as it helps shape how individuals perceive their attractiveness. In this way, peers are not passive conduits but active participants in constructing SRs of body.

Within SRT, the concept of emotional anchoring helps explain why vulnerable individuals internalize negative peer discourse about appearance. Emotional anchoring refers to the process by which abstract societal ideals become emotionally charged, shaping not just cognitive perceptions but also emotional responses. The emotional impact of peer-driven SRs is particularly profound, especially for individuals with BDD-like symptoms. This study revealed an emotional divide between participants with and without BDD-like symptoms. Those with BDD-like symptoms reported significantly higher levels of negative emotions during peer discussions about body (72.73%) compared to their non-BDD peers (27.27%). These findings align with Forney et al. (2012), who showed that peer comments can exacerbate body dissatisfaction, particularly for individuals already sensitive to appearance-based judgments. Individuals with BDD-like symptoms found that peer-driven discussions amplified their insecurities, reinforcing the cycle of emotionally anchoring societal beauty ideals, and leading to heightened self-criticism and distress.

Moreover, peer-driven interactions also tie societal beauty ideals to individuals' emotional responses. The emotional toll of these interactions was especially pronounced for participants with BDD-like symptoms, who described feeling heightened distress in social situations where appearance was discussed or evaluated. As this emotional anchoring demonstrates, SRs are not only cognitive or intellectual constructs, but deeply affective ones.

They play a significant role in shaping how individuals feel about themselves in relation to their peers. This emotional dimension of SRs amplifies the pressures to conform, as individuals feel the weight of both broader societal and closer peer-driven expectations.

The long-term effects of peer-driven SRs of body can be identified in the accounts of this study's participants. As many described, in an attempt to align their bodies with peer-driven ideals, they adopted unhealthy practices such as extreme dieting or excessive exercise. This reflects Du's (2015) findings that peer influence during adolescence can lead to chronic body dissatisfaction. While individuals internalize these SRs at a young age, they carry them into adulthood and continue engaging in unhealthy behaviors to pursue these unattainable beauty standards. The persistence of these peer-driven ideals throughout one's life leads to a deeply engrained cycle of dissatisfaction, as individuals strive for body representations that conform to societal expectations long after their adolescent years.

As this study also reveals, peer-driven SRs are not simply passive transmissions of societal ideals; they are actively engaged with, critiqued, and resisted. Some participants, particularly those critically aware of the social construction of beauty ideals, acknowledged the unrealistic nature of the standards perpetuated by their peer groups. However, even with this awareness, participants continued to strive to meet these ideals, reflecting the tension between personal agency and societal pressure. This negotiation between conformity and resistance aligns with the findings of De Rosa and Holman (2013), suggesting that individuals can simultaneously critique cultural beauty norms and be influenced by them. In this way, peer groups reinforce societal standards while also providing space for reflexive practices.

The critical engagement with peer-driven SRs highlights the complexity of the relationship between peer influence and body representations. While participants recognized the unattainability of certain beauty standards, they still felt compelled to conform, demonstrating the powerful role peers play in reinforcing societal expectations. As this dual process of critique and conformity suggests, individuals cannot be simplified as passive recipients of peer-driven norms. Instead, they are active participants in negotiating their body representations within the constraints of societal ideals. This negotiation process is particularly evident in participants' descriptions of their attempts to balance the pressures of fitting in with their peers and their personal recognition of the limitations of these standards.

The ways that individuals perceive their own bodies is further complicated by objectification within peer groups. Participants in this study noted that they viewed their bodies through a lens of societal expectations, with objectified notions of beauty being reinforced by peer evaluation. This objectification, as McLean et al. (2016) argued, leads to increased self-scrutiny as individuals perceive their bodies as objects to be modified to better meet external standards. The study's findings showed that peer groups not only perpetuate societal standards but also create their own set of norms, intensifying the pressure to conform within social circles. This peer-driven objectification process reinforces the notions that peer groups act as microcosms of broader societal expectations, where objectification is internalized and played out through daily interactions.

The impact of these peer-driven SRs extends into adulthood, as individuals continue to experience the pressures of internalized ideals from adolescence. Participants described how the desire to meet peer-driven beauty norms persisted into adulthood, continuing to influence their self-perception and behavior. This aligns with Du's (2015) findings that peer influence can lead

to chronic dissatisfaction, as individuals continue to pursue unattainable beauty standards throughout their lives. The long-term effects of peer-driven SRs suggest that adolescence is a critical period for shaping body representations, with peer interactions playing a central role in the construction and reinforcement of these ideals.

In conclusion, peers are crucial agents in shaping the SRs of body and beauty ideals. Through processes such as anchoring and objectification, the dynamics of these peer groups translate abstract societal norms into concrete standards, which are internalized by individuals and influence their behaviour. As illustrated in this study, peers have a dual role in both reinforcing larger societal beauty ideals and creating subcultural norms within their own groups. The emotional and psychological toll of these peer-driven SRs is particularly evident for individuals with BDD-like symptoms, who experience heightened distress and dissatisfaction in response to peer-driven beauty standards. However, the study also reveals that individuals critically engage with these norms, challenging and negotiating their place within the broader societal expectations that peers help perpetuate.

#### **3.5.4 Gender Differences**

These gendered representational patterns also reveal stark differences in how men and women internalize or reproduce body ideals. Although all men and women participants of the study live within the same country, they interpret and experience these norms differently because they inhabit different social positions in relation to them (Fredrickson & Roberts, 1997; Moradi & Huang, 2008). For women, socially constructed body ideals carry emotional weight: beauty becomes tied to belonging, self-worth, and social visibility. As a result, women's representations of the ideal body anchor to sexual desirability and attractiveness because society consistently

rewards women for conforming to these ideals through validation, attention, and symbolic social capital (Cash & Smolak, 2011; Tiggemann, 2013). Men, however, typically experience beauty norms from a position of distance, they are socially positioned as observers rather than as the observed. Therefore, their representations of ideal femininity emphasize social and moral judgments such as “clean”, “natural” or “not too much” reflecting broader cultural scripts of respectable femininity rather than emotionally internalized standards.

This contrast demonstrates how the same cultural messages function differently for men and women: women feel societal norms, while men often police them. Women’s descriptions show deep internalization of appearance-based expectations, consistent with objectification theory’s premise that women learn to view their bodies through an external perspective (Fredrickson & Roberts, 1997). In contrast, men’s evaluations of women’s bodies are shaped by social approval, modesty norms, and ideas about appropriate femininity norms that are taught and reinforced through patriarchal beauty systems (Bartky, 2015; Bordo, 2003). Meanwhile, men’s own body ideals are anchored to function and strength but symbolized by hyper-muscular influencer bodies that circulate globally through social media platforms. Women’s ideals, by contrast, are linked to thin-curve proportions, representations produced through celebrity culture and intensified through algorithmic beauty on platforms like Instagram and TikTok (Fardouly & Vartanian, 2016). Together, these patterns demonstrate that although both groups draw from the same cultural pool, their social representations differ because their embodied experiences within that system are unequal.

### **3.5.5 Contributions of the Study**

The study adds to our understanding of SR of body through evidence that social media alongside peer and family relationships function as vital forces in constructing beauty standards

and personal body representation. By building upon social representation theory, this study shows body representations evolve through ongoing negotiation between societal forces and personal life experiences. Prior research focused on social media producing body dissatisfaction whereas this study shows people process beauty ideals through acceptance and resistance which reveals a dynamic representation construction process.

A significant contribution of this study is using of emotional anchoring within SRT which shows how emotions derived from peer and family conversations about body, influence young people's acceptance or rejection of beauty standards. People who show symptoms similar to Body Dysmorphic Disorder demonstrate stronger emotional anchoring effects through the reinforcement of their body flaw concerns by appearance-related criticism from friends and family. Participants who did not exhibit BDD-like symptoms demonstrated greater flexibility when they integrated health-oriented perspectives into how they perceived their body.

Importantly, my research expanded Social Representation Theory (SRT) by introducing the new concepts rigid versus flexible anchoring. Those with rigid anchoring were emotionally stuck on appearance-related flaws which mostly visible among BDD-like symptoms, while those without BDD-like symptoms showed flexible anchoring viewed their bodies with acceptance and appreciation. Understanding this difference is essential for developing interventions to reduce body dissatisfaction because it emphasizes the requirement for emotion-centered approaches in social work practice for people with BDD-like symptoms.

This study contributes to knowledge about how social media functions paradoxically in the formation of body representation. Previous studies focused mainly on social media's negative effects like body dissatisfaction (Fioravanti et al., 2022) yet this study uncovers social media

dual nature as both an unrealistic beauty standards source and a resistance platform. Participants used social media platforms to create counter-narratives that challenged traditional beauty ideals and advocated for body diversity. Effective interventions need to combine media literacy education and the promotion of critical thinking with the support of users to create new content which provides alternative beauty standards that challenge existing harmful norms.

The research delivers new empirical data which explores how body representations differ between genders. Existing literatures usually examined women's body dissatisfaction but this research shows that young men face significant social pressures about muscularity and fitness which get reinforced through peer and media effects. In the study participants exhibited distinct patterns of resistance and engagement as women primarily challenged unrealistic body standards whereas men frequently accepted self-objectification and competitive body comparisons. The finding calls more for gender-specific interventions since societal beauty standards affect both men and women differently in their experiences and coping strategies.

These contributions enable social work interventions to approach body dissatisfaction as both a social issue and a structural challenge beyond individual psychological aspects. The study identifies emotional, cultural and interactive body representation factors to establish a comprehensive base for developing interventions that oppose destructive beauty standards and help people build healthier relationships with their bodies through adaptive and socially conscious approaches.

### **3.6 Strengths and Limitations**

One of the main strengths of this study is the combination of qualitative and quantitative methods. The use of thematic analysis in conjunction with chi-square tests and correlations

allows for a more nuanced understanding of the SRs of body and beauty. This mixed-method approach provides both depth (through the qualitative interviews) and breadth (through quantitative comparisons), enabling the study to capture the complexity of how socio-cultural factors like social media, peers, and family influence body representation, particularly for individuals with Body Dysmorphic Disorder (BDD)-like symptoms.

Another significant strength of this study is its narrowed focus on individuals with BDD-like symptoms. By examining two groups of individuals, those with and those without BDD-like symptoms, this study uncovers the different ways that vulnerable populations experience body representations. By delineating a specific sub-group, this research established a more comprehensive understanding of the emotional and psychological impact of societal beauty ideals, adding a deeper layer to the existing research on SRs and body. Employing this strategy, this study was able to explore the different ways that external influences, such as media, peers, and family, disproportionately affect these individuals.

The study's use of SRT to frame the analysis of body representation is a key strength. Through the incorporation of concepts such as anchoring and objectification, this research adds to the theoretical perspective of how individuals internalize these societal beauty standards. Additionally, by integrating the concept of emotional anchoring, this study deepens the understanding of how family and peer dynamics contribute to body dissatisfaction. This theoretical grounding not only strengthens the analysis but also offers a practical framework for interpreting how participants perceive their bodies in relation to external pressures. I also developed two new concepts; rigid anchoring and flexible anchoring, to describe how some participants were trapped in fixed, appearance-based identities, while others were able to see their bodies more positively and functionally.

However, this study does possess select limitations. While the initial objective was to collect a large sample size, only 31 participants were included in Phase 2, limiting the generalizability of the study's findings. Additionally, the gender imbalance (83.87% women) may skew the results, particularly since body issues and societal pressures can manifest differently across genders. A more balanced sample would provide a more comprehensive understanding of how SRs of body affect both men and women, and potentially reveal gender-specific dynamics that were underexplored in this phase.

Although the study captures some cultural variation among participants, the sample is predominantly composed of Canadian residents, with limited representation of international perspectives. Given that body ideals can vary significantly across cultures, the findings may not fully capture the diversity of SRs regarding body and beauty. More diverse sampling, particularly in terms of racial and cultural backgrounds, would enhance the study's ability to explore how different cultural norms interact with social media, peer, and family influences to shape body representation.

### **3.7 Conclusion**

The findings of this study provide both useful and surprising insights into the SRs of body and appearance among young people aged 16 to 21 living in Canada, employing lenses of social media, peer influence, and family dynamics to understand these dynamics. This includes the ways that external socio-cultural factors shape body representation, especially for individuals with Body Dysmorphic Disorder (BDD)-like symptoms. This phase of the study provides unique contributions to the literature by integrating qualitative and quantitative analyses to explore how

social media, peers, and family expectations lead to the internalization of societal beauty ideals and perpetuate body dissatisfaction.

First, these findings reaffirm the pervasive role of family, which causes the intergenerational transmission of beauty standards. Families serve as a foundational site where societal expectations about appearance are reinforced, with parents acting as key transmitters of these ideals. Participants with BDD-like symptoms reported heightened sensitivity to family comments and expectations, feeling more pressure to conform to family-driven standards about weight, fitness, and appearance. This is consistent with previous research pointing to parental monitoring of appearance as a strong predictor of body dissatisfaction. Individuals with BDD-like symptoms experienced a more pronounced emotional toll from failing to meet family expectations, further demonstrating how emotional anchoring within the family causes long-term body dissatisfaction.

An equally significant factor in shaping SRs of body is the social media in shaping SRs of body, and how it perpetuates idealized and often unattainable standards. Participants with BDD-like symptoms were particularly affected by these constant images on social media, and often held unfavorable comparisons to the curated images of celebrities and influencers online. The results of this study's quantitative analysis demonstrated a significant correlation between the importance placed on social media and higher BDD-YBOCS scores, reinforcing the idea that social media amplifies body dissatisfaction. This study informs a more nuanced understanding of how social media not only serves as a platform for the objectification of bodies but also anchors societal ideals into users' everyday experiences, making these ideals seem more achievable or expected.

The influence of peers, especially during adolescence, emerged as a key factor in shaping SR of body. Peer groups act as a social space where societal beauty standards are reinforced, discussed, and internalized. Participants frequently described how peer discussions centered on fitness, body shape, and attractiveness, with significant differences between those with and without BDD-like symptoms in their emotional reactions to these conversations. While participants without BDD-like symptoms viewed these discussions neutrally or positively, those with BDD-like symptoms often experienced negative emotions, illustrating how peer interactions emotionally anchor societal beauty ideals into individual self-perception. As this emotional anchoring process demonstrated, individuals with BDD-like symptoms are more vulnerable to peer influence, which in turn magnifies their self-scrutiny and dissatisfaction.

One of the most significant contributions of this phase lies in its application of SRT to body research, particularly in the domains of anchoring, objectification, and emotional anchoring. The study demonstrates how abstract societal ideals of beauty are anchored into everyday experiences through media, peers, and family, and how these ideals become emotionally charged, particularly for vulnerable individuals.

While social media, peer, and family influences are often critiqued for promoting unattainable beauty standards, the study reveals that individuals critically engage with these ideals as well. Many participants in this study were aware of the unrealistic nature of images on social media, recognizing the effects of editing, filters, and plastic surgery. Despite this critical awareness, many participants continued to feel pressured to conform to these standards, showing a distinct tension between critique and conformity that characterizes contemporary body struggles. Some participants, particularly those without BDD-like symptoms, were able to resist these societal pressures by prioritizing values of health over aesthetics, or by rejecting the

influence of social media altogether. This dual nature of critique and conformity provides a more complex understanding of how individuals actively navigate societal beauty standards, as these ideals are internalized, actively resisted, or reframed.

This phase also contributes to the broader understanding of how cultural contexts impact SRs of body, particularly as they relate to race and immigration status. Participants from different cultural backgrounds highlighted how their cultural norms shaped different ideals of beauty, with some cultures emphasizing slimness while others valued curvier figures. The study provides a foundation for future research to further explore how cultural and racial factors intersect with social media, peer, and family influences to shape SR of body, potentially offering protective factors against body dissatisfaction in some cultural contexts.

Finally, the mixed-method approach of this study offers significant methodological contributions. By integrating a qualitative thematic analysis with quantitative chi-square tests and correlations, this study offers a more nuanced exploration of the influences of socio-cultural factors on body representations. This study compares individuals with and without BDD-like symptoms, to formulate unique insights into how vulnerable populations experience body representations differently. The use of NVivo software for thematic analysis adds rigor to the qualitative data, while the quantitative findings offer statistical support for the study's conclusions. As such, this phase provides a comprehensive and methodologically robust exploration of SR of body.

In conclusion, this study offers a detailed exploration of how social media, peer influence, and family dynamics shape SRs of body and beauty among youth in Canada. While SRT has been previously applied to body-related research, this study contributes to the

theoretical understanding by extending the application of SRT to body research, particularly through the concepts of anchoring, emotional anchoring, and objectification. The findings underscore the powerful influence of external socio-cultural factors on body representations, especially for individuals with BDD-like symptoms, and highlight the critical engagement and resistance individuals demonstrate when navigating societal beauty ideals. Future research should build on these findings by exploring gender and cultural diversity in greater depth, as well as developing interventions to mitigate the negative effects of societal beauty standards on vulnerable populations.

### **3.8 Future Direction**

Given the gender imbalance in this study's sample, future research should aim to explore the SRs of body and beauty across a more gender-balanced sample. Men and women often experience different societal pressures related to appearance, and a comparative study could further elucidate how these pressures are internalized through family, peer, and social media influences. Additionally, a potential avenue for future research is an analysis of how non-binary and transgender individuals navigate these SRs while facing unique challenges in their relation to traditional gendered body ideals. By understanding these variations, researchers would be able to build a more comprehensive understanding of how SR of body differs across gender identities.

The study focused primarily on young people in Canada, which limits the exploration of how cultural diversity influences SRs of body. Future research should examine social representation of body across different cultural contexts and to better understand how societal beauty ideals vary globally. Cross-cultural studies could reveal how family, peer, and media influences operate in different societies, and how these factors intersect with cultural norms

related to body size, fitness, and beauty. This would help identify whether certain cultural practices offer protective factors against body dissatisfaction or whether some cultures may reinforce more damaging body ideals.

While this study provides valuable insights into body representation among young adults, to capture a broader view of these effects, a longitudinal approach could be employed to track how SRs of body evolve over time. Future research could examine how individuals' representation of their body changes from adolescence into adulthood, especially as social media platforms and cultural ideals continue to evolve. Longitudinal studies could help identify the long-term effects of family and peer influences on body representations, as well as the role of social media in perpetuating or mitigating body dissatisfaction. This would also allow researchers to investigate whether individuals are able to develop resilience against harmful body ideals over time.

In social work practice, it is essential to develop interventions to mitigate the negative effects of social media, peer pressure, and family expectations on SR of body. To do this, social workers can develop programs promoting media literacy and critical thinking about societal beauty standards. Additionally, interventions that foster self-compassion could be particularly beneficial for individuals experiencing BDD-like symptoms. By employing a family-centered approach, social workers can facilitate discussions about beauty standards and body representations within families, and help reshape emotional anchoring around appearance while fostering healthier, supportive dialogue. These interventions provide practical solutions to help social work reduce body dissatisfaction and improve mental well-being.

## Chapter 4

### **Article 3: Transforming Social Representations of Body Dysmorphic Disorder (BDD) into Social Work Practice: Implications for Intervention and Professional Development**

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#### **4.1 Abstract**

**Background:** The mental health issue known as Body Dysmorphic Disorder (BDD) arises from obsessive attention to perceived physical flaws which are increasingly affected by societal and cultural standards of beauty. SRT serves as an important model for comprehending the impact of collective societal standards on personal mental health beliefs and experiences regarding

disorders such as BDD. While BDD gains importance in mental health treatment the use of SRT within social work practice has not been discussed. The current study explores how social representations of body impact behaviors and mental health of youth and examine the implications for social work interventions and professional development.

**Methods:** This research uses a mixed-methods strategy that includes thematic analysis of qualitative interviews with quantitative survey data. Youth aged 16–21 living in Canada were the participants of this study, concentrating on those with and without BDD-like symptoms. The research deployed NVivo for coding qualitative data and SPSS for statistical investigation while examining social representations using the theoretical concepts of anchoring, objectification, and transforming social representations . Social work implications were investigated through the synthesis of findings and integration of these SRT concepts.

**Results:** People showing BDD-like symptoms displayed strict adherence to societal beauty standards while evaluating their body which led to increased body dissatisfaction and emotional distress. These participants strongly show a tendency toward objectification and they diminish their self-esteem based on their physical appearance. Alternatively, participants without BDD-like symptoms exhibited more flexible anchoring, incorporating health, functionality, and individuality into their body representations. Social work programs focusing on media literacy and body positivity combined with community support prove essential for changing harmful representations into frameworks that promote health and adaptation.

**Conclusion:** The research highlights the need to incorporate SRT into social work practice as a solution to body dissatisfaction and BDD. Social workers who comprehend anchoring and objectification processes can create strategies to counter societal beauty standards while building

resilience in young people. Media literacy programs combined with family education and peer support interventions help change societal body image norms which in turn enhance mental health and well-being. The research demonstrates social workers' capacity to drive change through systemic advocacy to lessen both the occurrence and effects of BDD.

**Keywords:** body dysmorphic disorder, social representation theory, social work, mental health, body, youth, societal beauty standards, anchoring, objectification, media literacy.

## 4.2 Introduction

Body Dysmorphic Disorder (BDD) is defined as a severe mental health condition that manifests as an obsessive preoccupation with perceived physical flaws. These concerns are often minor or entirely imperceptible to others, yet they cause substantial emotional distress and can significantly impair an individual's daily functioning and quality of life. This distress is frequently translated into maladaptive behaviors, such as excessive grooming, compulsive mirror-checking, or repeated cosmetic procedures. These negative behaviors illustrate the pervasive impact of the disorder (Phillips et al., 2002). Among youth in Canada, the rising prevalence of BDD-like symptoms is cause for alarm, and has been closely associated with the influence of social media and peer dynamics, which perpetuate and normalize unattainable beauty ideals.

The rise of platforms like Instagram and TikTok has amplified these issues by creating a visually dominated environment of curated and digitally enhanced images. These platforms perpetuate idealized beauty standards, of being youthful, slim, and flawless for example, through content that often blurs the line between reality and fiction. For young adults, whose self-

identities are in developmental flux, this exposure contributes to internalizing these ideals, anchoring their self-worth in appearance-driven metrics (López-Guimerà et al., 2010; Perloff, 2014). This increases the risk of body dissatisfaction and BDD-like symptoms, as individuals try and fail to align their physical appearance with the often unattainable standards on these platforms.

### **4.3 Theoretical Lens: Social Representation Theory (SRT)**

Despite the growing prevalence and awareness of BDD, there is a lack of integration between theoretical frameworks such as Social Representation Theory (SRT) into approaches to understand and address the disorder through social work. This is important, as SRT provides a robust framework to analyze how societal norms, collective beliefs, and shared understandings shape individual behaviors and mental health outcomes. Developed by Moscovici (1988), SRT posits that societal representations are co-constructed through social interactions and become embedded in the cognitive and emotional lives of individuals. These representations are not static but evolve through processes such as anchoring and objectification.

Anchoring refers to the process by which abstract societal ideals, such as beauty standards, become familiar and ingrained in an individual's psyche through repeated exposure and normalization (Moscovici, 1988). For example, the ubiquitous portrayal of slim and flawless bodies in media and peer interactions leads individuals to internalize these ideals as benchmarks for self-worth. This process has its most profound effect on individuals with BDD, as their representations of their bodies are rigidly anchored in these unattainable standards.

Another core process within SRT, objectification, explains the process of individuals internalizing societal norms by mainly evaluating themselves and others through the lens of

physical appearance. As a result, they experience a disconnection between their sense of self and their body, and treat their bodies as objects that must conform to external standards of beauty (Fredrickson & Roberts, 1997). This objectification can manifest in compulsive behaviors aimed at achieving societal validation, further perpetuating feelings of inadequacy and dissatisfaction.

#### **4.4 Gaps in Social Work Practice**

Social work and its mission to promote mental health, social justice, and community well-being, is best suited to address the societal and relational dimensions of BDD. However, the integration of SRT into social work practice has been limited, leaving a gap in understanding how social representations influence behaviors and mental health outcomes. Existing literature emphasizes the importance of using theoretical frameworks to guide practice, particularly in addressing complex issues like BDD that are rooted in both individual and societal dynamics (Wagner, 1993; Walmsley, 2004).

Studies have found the transformative potential of SRT in professional practice, demonstrating how a deeper understanding SRs can better inform targeted interventions (Rateau et al., 2012). For example, Camargo and Bousfield (2009) illustrate how SRs of health behaviors can shape individual risk perceptions and actions. Similarly, Wagner et al. (1999) emphasize that SRs are not merely cognitive constructs but are deeply embedded in social practices and professional decision-making. As this indicates, to be more effective social work could adopt an SRT-informed approach to addressing BDD, leveraging its theoretical insight to design interventions that challenge societal norms and promote healthier representations.

#### **4.5 Bridging Theory and Practice**

The goal of this study is to bridge this gap between SRT's theoretical insights and real-world application in social work practice. By analyzing the SRs of body among youth aged 16–21 living in Canada, this research explores how anchoring and objectification processes contribute to the development and perpetuation of BDD-like symptoms. The study integrates qualitative and quantitative data to fully understand the dynamic between societal influences, individual behaviors, and mental health outcomes. In doing so, it offers practical implications for social work interventions, such as the need for media literacy programs, family education initiatives, and community-based support systems.

Social workers can become agents of change, and drive systemic transformations to address societal beauty standards and promote mental health by incorporating SRT into their practice. By offering a framework to mitigate the impact of BDD and related body concerns, this approach aligns with social work's core values of empowerment, social justice, and holistic well-being.

#### **4.6 Methods**

This study utilized a mixed-methods approach to probe SRs of body and their relation to Body Dysmorphic Disorder (BDD)-like symptoms among youth living in Canada. The research used quantitative and qualitative methods together to study social body representations affected by media, peers, and family and their connection to Body Dysmorphic Disorder (BDD)-like symptoms in youth living in Canada as well as the significance of these representations for social work practices. The research focused on SRT processes such as anchoring and objectification to understand their significance for social work practice.

#### 4.6.1 Participants

The participants of this study were high-school, college, and university students aged 16 to 21, who were living and studying in Canada. Inclusion criteria required participants to: **1-Be** enrolled in a Canadian educational institution (high school, college, or university). **2-Reside** and study in Canada. **3-Be** proficient in English **4-Fall** within the age range of 16 to 21 years.

The initial sample consisted of 582 participants. After excluding 43 participants for incomplete responses and another 43 for exceeding the age limit, the final sample included 496 participants ( $M_{age} = 18.81$ ,  $SD = 1.09$ ; 68.29% female). Participants were recruited through various channels, including social media platforms (Facebook, Instagram, Telegram, WhatsApp), and the University of Ottawa's Integrated System of Participation in Research (ISPR), where university students received a 1% course credit for participation. Data collection occurred online using the Qualtrics platform between August 2023 and June 2024. All participants provided informed consent, and the study received ethical approval from the University of Ottawa Research Ethics Board (#S-10-22-8445).

After participants showed their interest by mentioning it in phase 1 at the end of the questionnaire, they were invited via email for phase 2. According to Hennink et al., 2017, recruiting between 16-24 participants could meet the saturation but researcher increased recruitment efforts because phase 2 used quantitative methods to compare themes between participants with BDD-like symptoms and those without. Multiple phase 1 participants showed interest in phase 2 participation but only a small number responded after receiving up to four email reminders. Phase 2 interviews included 31 participants. The researcher increased participation by replacing the gift card draw with a guaranteed \$20 gift card or additional course

credits. The recruitment process extended over four months during which scheduling occurred through email communications. The researcher held Zoom interviews and received verbal consent from participants at the beginning of the interview while showing the consent form in the screen as well. The researcher would have expressed gratitude to the participant before ending the Zoom call if they had verbally declined participation. No interview participant declined to participate during any of the sessions. After all, 31 participants finished the interview session. A debriefing form was emailed after each interview was done.

#### **4.6.2 Materials**

Participants completed the questionnaires via the Qualtrics platform, which included the following:

**1. Socio-Demographics:** The socio-demographic form collected information on gender, sexual orientation, age, race/ethnicity, marital status, residency status, and socioeconomic status.

The variables were categorized as follows:

**Gender:** Recorded based on the Canadian Institutes of Health Research (CIHR) framework, which includes woman, man, pangender, transgender, gender-diverse, etc. (Adisso et al., 2020).

**Sexual Orientation:** Included lesbian, gay, bisexual, transgender, queer/questioning, and Two Spirit.

**Age:** Measured as a continuous variable.

**Marital Status:** Categorized as single, married/common-law, widowed/divorced/separated, and other.

**Socioeconomic Status:** Included education (high school, college, undergraduate), job status (employed, unemployed), and residence area (rural, urban).

To address the diversity of Canadian demographics, such as visible minority groups, Indigenous people, gender diversity (men, women, and LGBTQ2), and immigrants, the following measures were applied:

**Gender Diversity:** A two-step method was used, consisting of questions about birth sex (female, male, intersex, and other) and current gender identity (woman, man, non-binary, and other). This method helps to distinguish biological sex and gender identity when responses are different across steps and is validated across North America (Magliozzi et al., 2016).

**Visible Minorities, Immigrants, and Indigenous Groups:** Questions were included about immigration status and whether participants identified as part of visible minority or Indigenous groups. Recruitment advertisements highlighted the inclusivity of the project, and efforts such as oversampling and targeted distribution within minority communities were used to enhance diversity representation (Sell, 2017; Anderssen & Malterud, 2017).

**2. *Body Dysmorphic Disorder Questionnaire (BDDQ)* :** Developed by Phillips (1995), the BDDQ screens for probable BDD using five items, with most answers being binary (yes/no) except for one question asking about the number of hours spent thinking about appearance (Phillips, 2005). Scores range from 0 to 4, with higher scores indicating a greater likelihood of meeting BDD criteria. The BDDQ has demonstrated sensitivity (94–100%) and specificity (89–93%) in clinical samples (Dey et al., 2015; Grant et al., 2001). The study used the adolescent version, which maintains the same scoring and screening criteria as the adult version but features wording suitable for younger participants (Dyl et al., 2006).

**3. BDD-YBOCS (*Body Dysmorphic Disorder Modification of the Y-BOCS*):** The BDD-YBOCS is a 12-item scale assessing the severity of BDD symptoms over the past week.

**Items 1–5:** Measure obsessive preoccupations with perceived appearance defects.

**Items 6–10:** Assess repetitive behaviors related to BDD.

**Items 11 and 12:** Evaluate insight and avoidance related to appearance.

Responses are evaluated with a 5-point Likert scale ranging from 0 to 4 where 0 signifies no symptoms and 4 represents extreme symptoms and total scores can reach up to 48. Higher scores indicate greater BDD severity. This scale demonstrated high internal consistency in the current study ( $\alpha = .91$ ). The adolescent version, tailored for younger participants, was utilized (Phillips et al., 2014).

**4. *Short-Version of the Verbal Association Technique*:** This method, based on SRT, involves two tasks: free association and hierarchical ranking. Participants were asked to:

List a maximum of eight terms which describe physical appearance.

Participants were required to organize these words or phrases according to importance using a 7-point Likert scale that ranges from not at all important to extremely important.

The frequency and rankings of the words were recorded for analysis (Lo Monaco et al., 2017). This approach allowed for a nuanced exploration of the SRs of body and appearance.

**5. *Semi-directed interviews*:** The interview questions were developed using SRT and body/appearance research to examine socio-cultural influences from social media platforms along with peers, parents and celebrities. The interview questions examined body discussions within family and peer groups alongside social standards of the ideal body and gender construction processes. The study analyzed representational genesis by examining main SRT processes which included both anchoring (naming and emotional anchoring) and objectification

(symbolization and personification). The research approach revealed how different factors interconnect by displaying their representational structure (Eiguren et al., 2021). For full description of the interview questions, see article 2 research tools.

## **4.7 Results**

### **4.7.1 Sociodemographic Characteristics**

The study included a final sample of 496 participants ( $M_{age} = 18.81$ ,  $SD = 1.09$ ; Table 2-1), with 68.29% identifying as female and 93.45% aged between 18 and 21 years. Most participants (84.19%) were Canadian citizens or permanent residents, with 87.58% residing in urban areas. Regarding racial representation, 38.52% identified as White, 19.88% as Black, and 17.62% as South-East Asian.

### **4.7.2 Prevalence of BDD-Like Symptoms**

Around one third of participants screened positive for BDD-like symptoms (Table 2-2). Significant associations were detected between sex and the prevalence of BDD, with females having a significantly higher prevalence than males. Similarly, gender identity was associated with BDD prevalence, as 42.14% of women and 40.00% of non-binary participants reported BDD-like symptoms, compared to 15.38% of men.

### **4.7.3 Body Representation and BDD-Like Symptoms**

Participants with BDD-like symptoms reported notably different body representations in comparison to participants without BDD-like symptoms. A large portion of individuals with

BDD-like symptoms stated negative body representation, while those without BDD-like symptoms mainly showed positive or mixed body representation (Table 3-2). This underscores the rigid and negative body representations among individuals with BDD-like symptoms.

#### **4.7.3.1 Influences on Body**

Social influences considerably shaped body and appearance representations. Sentiment-based responses to peer discussions revealed a predominance of negative sentiment among participants with BDD-like symptoms, compared to among those without symptoms (Table 3-4). Family standards also played a distinct role, where participants with BDD-like symptoms reporting attempts to change their appearance to align with family expectations, compared to none in the non-BDD group (Table 3-3).

#### **4.7.3.2 Social Media and Celebrity Influence**

Social media's role in shaping body was evident, as participants with BDD-like symptoms showed a higher association between BDD severity and peer influence compared to family and social media influences (Table 3-6). Celebrity body also significantly impacted efforts to change personal body, where participants with BDD-like symptoms reporting attempts to emulate celebrity appearances, compared to those without symptoms (Table 3-5).

#### **4.7.4 Rank-Frequency Analysis**

The verbal association task yielded 3336 words, with key terms like "fat", "tall" and "strong" emerging in the central core of body representations (Table 2-4). Among participants with BDD-like symptoms, terms like "fat", "pretty" and "strong" were central, reflecting their heightened focus more on appearance-related attributes (Table 2-5). For participants without

BDD-like symptoms, words like "tall", "healthy", "skinny" and "beautiful" formed the core, emphasizing more adaptive representations (Table 2-6).

#### 4.8 Discussion

The results of this study provide compelling insights into how anchoring and objectification, core concepts of SRT, influence the social construction of body among young individuals. These findings are crucial for understanding what is the relationship between societal influences, including media, peers, and family, and the SRs of the body in shaping BDD-like symptoms among youth living in Canada, and how can these findings inform social work practice.

Participants with BDD-like symptoms displayed a more rigid anchoring to societal ideals of thinness and flawlessness, reinforcing personal preoccupations with unattainable beauty standards. These central elements of their body representations the role of media, family, and peer influences in normalizing such ideals and embedding them into one's cognitive and emotional frameworks. Consistent with Moscovici's (1988) concept of anchoring, these individuals translate abstract societal norms into tangible personal standards, perpetuating cycles of dissatisfaction and self-scrutiny.

P31: *"I've had, like, a bad relationship with my body for a long time. You know, I've always been a bigger person, and I'm very tall, so it's difficult for me to think about my body."*

Conversely, participants without BDD-like symptoms demonstrated more adaptive representations of the body (flexible anchoring). They held more value in health, functionality, and individuality, as opposed to standard beauty ideals. This less rigid, more flexible nature

demonstrated their more balanced navigation of societal pressures, allowing them to integrate personal values into their body representation. These findings align with prior research suggesting that diverse and inclusive representations foster resilience against harmful societal norms (Wagner, 1993; Camargo & Bousfield, 2009).

P4: *“I think my body is super suitable for me, and I like my body from head to toe ... Luckily...”*

Objectification was significantly more pronounced among participants with BDD-like symptoms, as evidenced by their heightened focus on perceived flaws and physical perfection. Emotional anchoring, a complementary process, explains how societal ideals are internalized and linked to personal self-worth, exacerbating distress when these ideals are not met. Fredrickson and Roberts (1997) argued that the process of objectification contributes to a disconnect between one’s self-perception and intrinsic value, as seen in the compulsive behaviors of individuals with BDD-like symptoms.

P31: *“Women’s curves, like their butts and chests, are hypersexualized on social media”*

#### **4.8.1 Implications for Social Work Interventions**

Based on the findings of this study and the processes of anchoring and objectification identified through SRT, the programs to address body dissatisfaction can be conceptualized across three levels: (1) prevention programs, (2) intervention programs, and (3) structural or policy-level actions. Prevention programs are the most appropriate for youth populations show early signs of BDD (BDD-like symptom) and are directly aligned with the study’s findings regarding the influence of social media, peer dynamics, and family expectations.

#### **4.8.1.1 Prevention Programs**

Prevention Programs constitute the primary focus of this framework, as the majority of participants in this study demonstrated BDD-like symptoms without formal diagnosis. These programs seek to counter harmful body representations before they become entrenched. Evidence-based prevention models such as Media Smart (Wilksch & Wade, 2014), the Dove Self-Esteem Project (Aksu, 2023), the Body Project (Stice et al., 2011), SoMe (Gordon et al., 2021), and Expand Your Horizon (Alleva et al., 2015) have demonstrated success in educational and community contexts by fostering appearance-critical thinking, body functionality appreciation, and supportive peer relationships. These programs align closely with the findings of this study, which point to social media, peer comparison, and family expectations as primary vectors of body dissatisfaction among youth. These include evidence-based programs such as Media Smart (Wilksch & Wade, 2014), the Dove Self-Esteem Project (Aksu, 2023), the Body Project (Stice et al., 2011), SoMe (Gordon et al., 2021), and Expand Your Horizon (Alleva et al., 2015). These models align closely with the profile of youth in this study, who show early signs of BDD-like symptoms and describe significant influence from social media, peer comparison, and family expectations.

##### *4.8.1.1.1 Media Smart*

The Media Smart program is a school-based media literacy intervention designed to help adolescents critically analyze media messages about body ideals and appearance pressures (Wilksch & Wade, 2014). Delivered through classroom activities and discussion-based modules, it educates youth on the manipulative nature of advertising, the role of influencers, and the unrealistic body standards promoted across visual and digital media. Research suggests that the program is effective in reducing internalization of beauty ideals and appearance-related anxiety,

particularly among teenage girls (Wilksch & Wade, 2014). This intervention reflects the findings of the current study, where participants consistently reported feeling overwhelmed by constant exposure to "perfect" body images on platforms like TikTok and Instagram, highlighting the importance of early media literacy to prevent these pressures from leading to clinical body dissatisfaction or BDD-like symptoms.

P25: *“I do like remember a few times where we were like talking about like Bella Hadid and like how they're like models and like super tall and like, have what media perceives as, like, the perfect body.”*

#### 4.8.1.1.2 Dove Self-Esteem Project

The Dove Self-Esteem Project is a global body confidence program targeting youth aged 10–17, offering free resources, school workshops, and parent-teacher guides to build resilience against harmful beauty standards (Aksu, 2023). Developed in collaboration with psychologists and body image experts, the program promotes critical thinking about media imagery and teaches self-compassion, body neutrality, and self-acceptance. With over 94 million youth reached in more than 150 countries, it remains one of the largest body image initiatives worldwide. Activities include group discussions, journal reflections, and media analysis exercises where youth deconstruct digitally altered images and discuss their emotional impact. Consistent with the present study's findings where participants expressed distress over comparison and belonging the program aims to shift appearance-related self-worth toward internal qualities and strengths, echoing social work's emphasis on empowerment and prevention.

P1: *“I would say that most of my family, if not all of them, they have sort of a skewed perception of me because I'm from an immigrant family. So, you know, they have the idea that, you should have a perfect body or you should be up to standard compared to what I see, you know, among my peers.”*

#### 4.8.1.1.3 The Body Project

The Body Project is a peer-led, small-group intervention designed to prevent the internalization of thin ideals among adolescent and college-aged women (Stice et al., 2011). Delivered typically in four 1-hour sessions, participants engage in cognitive dissonance-based activities where they critique cultural beauty ideals, discuss their harmful effects, and practice rejecting unrealistic standards through written and verbal exercises. Research shows that

participation significantly reduces body dissatisfaction, thin-ideal internalization, and onset of eating disorders up to three years post-intervention (Stice et al., 2011). Its relevance to this study is clear: participants described peer influences and pressures to conform to appearance norms. The Body Project leverages peer support and dissonance-based techniques to challenge these pressures before they lead to deeper psychological distress or BDD-like symptoms.

P3: *“In my friends... good body ... Like it's pretty lean, but like, not too like, lean to the point where it's like, very skinny and it's like a bad one would be if you're like. Pretty fat. Or maybe like, borderline obese. I think that would be a bad one.”*

#### 4.8.1.1.4 SoMe

SoMe is a school-based social media literacy program designed to enhance youth understanding of how social media content is curated, enhanced, and monetized by influencers and brands (Gordon et al., 2021). Using interactive tools, students learn to critically examine the constructed nature of online imagery and recognize the psychological effects of comparison and validation-seeking behaviors. In randomized trials, SoMe has demonstrated significant reductions in social media-related appearance pressures, negative mood, and anxiety around self-presentation (Gordon et al., 2021). Given that participants in this study explicitly linked their insecurities to Instagram and TikTok content, SoMe aligns with prevention needs by fostering critical awareness of how algorithm-driven content and idealized body imagery contribute to negative self-evaluation and BDD-like symptoms.

P6: *“there's a lot of bad that people would consider bad. Like two skinny, to fat. If you're like flatter. Basically anything people can do especially on TikTok, I've noticed people can be very, criticizing.”*

#### 4.8.1.1.5 *Expand Your Horizon*

Expand Your Horizon is a brief, writing-based intervention aimed at increasing body appreciation by focusing on body functionality rather than appearance (Alleva et al., 2018; Davies et al., 2022). Participants engage in reflective writing exercises where they describe the ways their bodies help them act, move, create, and experience life. This reframing enhances body satisfaction and reduces self-objectification, even after a single session, with effects lasting several weeks. The activity is cost-effective, easy to implement, and highly adaptable for clinical and non-clinical settings. These results illuminate a key finding in this study: participants without BDD-like symptoms already anchored their body representations in health, movement, and individuality. Expand Your Horizon exemplifies this flexible anchoring process and offers a practical tool to reinforce functional body perceptions in youth at risk of developing appearance-based distress.

P4: *“I would say positive because it more like encouraging to, like, eat healthy and go to the gym so that we can be strong rather than, like, negative.”*

#### 4.8.1.2 **Intervention Programs**

Intervention Programs including models such as the Collaborative Care Model for BDD (Phillips, 2017; Ivbijaro et al., 2014), ACT-Based Group Interventions (Rezaeisharif et al., 2021), School-Based Cognitive Behavioral Group Counseling (Larkin & Thyer, 1999), and the Aspire Program (Iachini et al., 2016) are best suited for youth already experiencing emotional distress and difficulties in daily functioning due to appearance-related anxiety. These approaches focus on enhancing insight, reducing compulsive behaviors, and increasing self-acceptance through cognitive, behavioral, and motivational strategies. While most study participants did not meet clinical criteria for BDD, some described behaviors such as fasting, isolation, compulsive

checking, and heightened perfectionism suggesting a need for complementary support beyond prevention.

#### *4.8.1.2.1 Collaborative Care Model*

The Collaborative Model for BDD is an integrated, evidence-based treatment approach that involves interdisciplinary collaboration between psychologists, psychiatrists, social workers, and family therapists (Phillips, 2017). This model includes cognitive-behavioral therapy (CBT) to address body image distortions, medication management for comorbid anxiety or depression, and psychoeducation for both clients and their families to better understand BDD and its impacts. Family involvement and peer support groups are emphasized to reduce isolation and build social support systems. This model aligns with the participants who reported distress and avoidance behaviors like fasting, excessive exercise, or isolation, showing early markers of BDD-like symptoms. The collaborative format ensures that treatment is individualized, addresses both cognitive and functional impairments, and includes systemic resources that align with social work practice principles (Ivbijaro et al., 2014).

#### *4.8.1.2.2 Acceptance and Commitment Therapy (ACT)*

The Acceptance and Commitment Therapy (ACT) group intervention is grounded in mindfulness and cognitive flexibility to help individuals accept difficult thoughts and feelings without over-identifying with them (Rezaeisharif et al., 2021). Delivered in group settings, this program targets body dissatisfaction and perfectionistic tendencies by teaching participants to detach from rigid self-judgments and learn to relate differently to their thoughts about appearance. Core ACT components acceptance, values-based action, and cognitive defusion, help reduce unhealthy self-comparisons and appearance-control behaviors. Participants in the study who demonstrated rigid self-standards, compulsive checking, and perfectionism regarding

their bodies would benefit from ACT, as it fosters psychological flexibility and resilience in coping with appearance-related distress.

#### *4.8.1.2.3 Cognitive-behavioral Group Counseling*

Cognitive-behavioral group counseling for body image concerns typically functions in a school-based format and focuses on challenging maladaptive beliefs and behaviors related to appearance (Larkin & Thyer, 1999). This structured intervention includes cognitive restructuring to challenge distorted body-related thoughts and behavioral techniques to reduce appearance-checking, dieting, and comparison behaviors. Group discussions help normalize feelings of insecurity and reduce shame, while skills training builds coping strategies and self-esteem. This model is especially fitting for the participants in this project who demonstrated obsessive thinking about flaws or persistent comparison behaviors. By intervening early, such programs help disrupt the cognitive-behavioral cycles that can develop into more serious disorders, including BDD.

#### *4.8.1.2.4 Aspire Program*

The Aspire Program is a group-based intervention using motivational interviewing (MI) techniques to promote positive life choices, enhance self-worth, and reduce shame among at-risk youth (Iachini et al., 2016). Through reflective dialogue, values clarification, and peer-supported goal setting, the program fosters autonomy and helps participants connect personal goals to behavior change. Although originally designed for students at risk of school disengagement, the program's emphasis on emotional awareness, self-respect, and removing shame-based barriers makes it well-suited for youth experiencing body dissatisfaction. For this study, Aspire can be adapted to target ambivalence toward changing unhealthy behaviors (e.g., extreme dieting or

over-exercising), particularly for those who feel caught between internal pressures and social influences.

#### *4.8.1.2.5 Structural and Policy-Level Actions*

Lastly, Structural and Policy-Level Actions provide a necessary macro-level complement to individual and group-based approaches. Policies restricting retouched images and cosmetic surgery advertising for minors (as implemented in France and the UK) represent critical structural interventions that reduce exposure to harmful beauty messaging and challenge industries that fuel body dissatisfaction. France and the UK now require labels on digitally retouched photos and restrict cosmetic surgery advertising aimed at minors, to reduce the harmful impact of beauty marketing (Advertising Standards Authority, 2022). These policies reflect what a structural social work approach can promote, holding industries accountable for creating unrealistic body ideals and protecting vulnerable populations from their effects.

The study's findings have critical implications for social work practice, especially in efforts to address and challenge the systemic reinforcement of harmful beauty standards. At the prevention level, school and community-based peer-led programs such as the Body Project or Media Smart can be implemented by social workers to provide spaces where youth critically analyze social media imagery, challenge thin-ideal beliefs, and support one another in developing healthier, more resilient body representations (Stice et al., 2011; Wilksch & Wade, 2014). These peer-based interventions are especially powerful given the influence of peers on appearance-related attitudes identified in the study.

Family-centered prevention efforts using programs like the Dove Self-Esteem Project can further engage parents, caregivers, and siblings in strengthening body-positive communication

and countering intergenerational transmission of rigid beauty norms (Aksu, 2023). For youth already showing distress or early BDD-like symptoms, therapeutic group interventions such as Acceptance and Commitment Therapy groups, Cognitive-Behavioral Group Counseling, or the motivational interviewing-based Aspire Program can target perfectionism, social anxiety, and self-surveillance through facilitated activities that address both cognitive and emotional components (Rezaeisharif et al., 2021; Larkin & Thyer, 1999; Iachini et al., 2016).

Beyond these interpersonal interventions, social workers also play a critical role at the macro level, advocating for policy measures like regulating digitally altered images in advertising or restricting cosmetic surgery marketing to minors. These approaches address systemic causes of appearance pressure and align with SRT principles by shifting harmful social representations through public policy and cultural critique (Perloff, 2014; Rateau et al., 2012). By integrating peer-led, family-centered, and policy-focused strategies, social workers can intervene holistically supporting individuals and reshaping the broader contexts that reinforce body dissatisfaction.

The study also highlights the need for culturally sensitive and intersectional interventions. The fact that BDD-like symptoms are more common among women and racial minorities illustrated the key role of intersecting oppressions, such as racism and sexism, in exacerbating body dissatisfaction. To address these systemic inequities, social workers must design interventions that reflect their clients' diverse cultural contexts. As Castro and Batel (2008) argue, understanding the interaction between cultural norms and SRs is vital for effective practice.

Another approach is driving educational policies that incorporate media literacy and mental health education into school curricula. By equipping young people with the tools to critically engage with societal norms, these programs can address BDD-like symptoms and better promote mental well-being. Collaboration between social workers, educators, and policymakers can ensure these initiatives are both comprehensive and impactful (Gilligan, 2004).

From a practical standpoint, SRT offers valuable tools for social workers to identify and intervene with at-risk youth. Assessments of rigid anchoring, flexible anchoring and objectification processes can serve as early indicators of vulnerability to BDD-like symptoms. Encouraging clients to critically examine the societal origins of their body dissatisfaction fosters reflection and empowers them to challenge harmful norms.

#### **4.8.2 The Social Representations-Focused Intervention (SRFI): A Contextual Approach to Body Dissatisfaction and BDD**

Grounded in Social Representation Theory (SRT) (Joffe, 2003), the SRFI conceptualizes body dissatisfaction and Body Dysmorphic Disorder (BDD) as products of shared cultural meanings rather than solely individual distortions. SRFI at the level of collective consciousness where representations of the physical body are formed and reinforced through Parent expectation, media, peer influence, and social discourse. Unlike intrapsychic or exposure-based interventions, SRFI addresses the origins of these representations themselves. It aims to shift negative body ideals by transforming the peripheral elements of social representations like language, emotions, symbols, and social practices to be more functional, diverse, and inclusive. It emphasizes the importance of mapping existing representations, critically deconstructing harmful narratives, and re-anchoring body ideals around functionality, diversity, and self-

acceptance. Designed for youth and delivered through participatory methods like group discussions, narrative rewriting, and peer ambassadorship, this intervention equips social workers with the tools to foster both individual resilience and representational change at the community level.

### 1- Mapping Representations

SRFI begins by uncovering the existing lay representations of the body among youth through methods such as word association tasks, group reflections, and visual prompts. For instance, exercises like a “Body Word Cloud” invite participants to list and categorize spontaneous associations people have about their bodies. These are then analyzed collaboratively to identify sources social media platforms, peer comments, family feedback that are contributing to the formation of problematic ideals. This stage creates awareness not just of individual beliefs but also their social origins, aligning with SRT’s focus on collectively held meanings.

### 2- Challenging and Reframing the Representation Periphery:

The second stage uses critical media literacy workshops and narrative techniques (e.g., role-play, storytelling circles) to help participants dissect and deconstruct harmful cultural ideals of appearance propagated by influencer culture and commercial beauty trends. SRFI innovatively uses narrative rewriting and dialogic interactions to produce alternative, positive associations: anchoring appearance to health, functionality, individuality, and agency rather than rigid beauty norms. By changing peripheral representations, participants learn to challenge the extreme anchoring mechanisms that reinforce body dissatisfaction.

### 3- Re-Anchoring and Community Diffusion:

SRFI leverages peer-led initiatives such as “Body Representation Ambassadors” and community campaigns to reinforce and spread new, healthy body ideals within their social networks. Drawing from principles of diffusion of innovation, SRFI works not only at the individual but also the community level, inviting families, teachers, and peers to take part in discussions and reinforcing messages. This increases the likelihood of sustained change, building a social support system for resilience against BDD-like symptoms.

Parent play a crucial role in shaping young people’s body representation through comments, modeling behaviors, and reinforcing social norms. Therefore, the SRFI incorporates a targeted component for parental engagement and training, aiming to expand the intervention’s influence beyond youth participants. This includes offering parent-focused workshops that raise awareness of how language, family dynamics, and media practices can reinforce rigid anchoring and body-related anxieties. These workshops equip parents with tools to recognize early signs of body dissatisfaction, foster open communication, and actively promote flexible anchoring through supportive, health-focused conversations. By aligning parental messaging with the goals of the youth-focused activities, SRFI reinforces consistent representational shifts across the child's ecological environment. This multilevel approach strengthens the sustainability of representational change, ensuring that youth are not only internally empowered but also externally supported in their re-anchored understanding of body image.

#### **4.8.2.1 Flexible vs. Rigid Anchoring: Why SRFI Works**

Anchoring is a key SRT process: it refers to how unfamiliar or complex ideas are rooted in familiar social knowledge. Rigid anchoring occurs when body ideals are anchored to narrow, inflexible beauty standards (e.g., thinness, muscularity, clear skin) leaving little room for

diversity. Individuals internalizing such rigid anchors are more vulnerable to BDD symptoms, especially when exposed to idealized media. Flexible anchoring, by contrast, involves linking body perceptions to multifaceted concepts like strength, uniqueness, health, and functionality. SRFI intentionally promotes flexible anchoring by offering new reference points for self-evaluation, grounded in social dialogue and mutual validation.

#### **4.8.2.2 Why SRFI Supports Social Work Practice**

The research emphasizes that body dissatisfaction and BDD-like symptoms are socially constructed and reinforced through socio-cultural pressures. SRFI is uniquely positioned to intervene at this systemic level allowing social workers to engage individuals and their contexts. It goes beyond symptom reduction: it aims to transform how youth collectively perceive and value their bodies. Furthermore, this supports early identification in at-risk youth, as assessments of rigid and flexible anchoring serve as indicators of vulnerability and can be integrated into school or community assessments.

By factoring in gender differences, SRFI recognizes that boys and girls do not internalize the same ideals nor face the same pressures. Boys may be pressured toward muscularity or height, while girls often anchor body ideals around thinness, flawless skin, and sexually appealing. SRFI allows tailored discussions and representational shifts depending on gendered experience, creating spaces where diverse expressions of body identity are affirmed.

SRFI, as framed here, is expected to reduce body comparison, self-objectification, and internalization of narrow beauty ideals while fostering body appreciation and a supportive peer and family culture. The intervention also aligns with evidence that collective re-anchoring of representation can drive sustainable behavior change (Joff, 2003). It is especially promising for

school and community-based social work settings looking to promote long-term resilience and advocate for systemic shifts like media diversity and body literacy policies. By collaborating with community organizations that serve marginalized groups, they can amplify the reach and effectiveness of these efforts. Intersectionality-informed practices enhance the cultural relevance and efficacy of the interventions, fostering greater equity in mental health outcomes.

This study highlights the critical role of social work in addressing the pervasive influence of body dissatisfaction and Body Dysmorphic Disorder-like symptoms among youth in Canada. By examining body concerns through the lens of SRT, it becomes evident that youth are continually negotiating their identities within a complex web of cultural messages, peer feedback, family norms, and media expectations. Social work, with its foundational commitment to mental health, social justice, and community well-being, is strategically positioned to offer prevention, intervention, and advocacy efforts that disrupt the reproduction of harmful body ideals. Through responsible engagement with social media, fostering family dialogue, and challenging dominant narratives that perpetuate rigid beauty standards, social work can intervene at multiple levels of influence, empowering youth toward healthier, more holistic self-concepts.

The study's findings underscore the importance of educational strategies focused on enhancing media literacy, fostering critical thinking, and building resilience among youth. Social workers can lead school- and community-based programs that address the psychological and social roots of body dissatisfaction, supporting youth to resist internalizing narrow beauty standards and instead develop a more empowering sense of self-worth. SRT-informed interventions such as reflective group discussions, peer-led dialogues, and culturally responsive family engagement can encourage young people and their caregivers alike to examine the origins of their beliefs and shift toward flexible anchoring based on health and intrinsic values.

Importantly, this must include a gender-sensitive and intersectional approach that recognizes the heightened vulnerability of girls, LGBTQ+ youth, and other marginalized groups who face distinct pressures regarding appearance.

Beyond direct practice, this study also calls for greater advocacy and policy engagement from social workers. As media continues to shape body norms at an alarming pace, social workers can push for regulations that promote transparency around digitally altered images and greater diversity in media representations. They can partner with schools, mental health organizations, and policymaking bodies to embed body literacy and mental health curricula into institutions that shape youth identity. Ultimately, by bridging micro-level interventions with macro-level advocacy, the social work field can take a leading role in reshaping societal narratives around body representation. This aligns with the field's core mission to challenge oppressive norms, promote equality, and strengthen community resilience ensuring that youth are supported not only in overcoming body concerns but in thriving beyond the confines of appearance-based value systems.

#### **4.8.3 AI Program to Detect Edited Image**

A further structural implication of this research concerns the regulation of digitally manipulated body imagery. Given that young people engage daily with online spaces saturated by filters, retouching apps, and AI-generated appearance modifications, policy frameworks can leverage technology as a protective mechanism. Emerging AI-based image authentication tools are now capable of identifying when an image has been significantly altered; for example, through body reshaping, skin perfecting, or full AI synthesis. Governments and regulatory bodies could require social media platforms to integrate such technologies and automatically flag

manipulated images with clear, standardized notices. By making the production of unrealistic bodies visible rather than seamless, these policies disrupt the anchoring of beauty ideals in hyper-edited representations and weaken their influence on youth. From an SRT, such mandated transparency alters the social field in which body representations circulate, allowing more flexible and realistic anchors to take hold. Although technological solutions cannot replace education, prevention, or intervention support, they function as essential macro-level safeguards that reshape the environment in which harmful norms are produced, circulated, and consumed.

#### **4.9 Strengths and Limitations**

This study demonstrates several strengths that make it a significant contribution to both academic literature and social work practice. Its integration of SRT into the context of Body Dysmorphic Disorder (BDD) is a key highlight, offering a nuanced lens to connect individual experiences of body dissatisfaction with broader societal and cultural influences (Moscovici, 1988; Jodelet, 2008). By applying SRT processes such as anchoring and objectification, the study bridges theory and practice, providing a robust framework for understanding how societal norms shape mental health outcomes. Combined with an emphasis on practical social work interventions, this research provides a valuable tool for addressing systemic beauty standards and promoting mental well-being (Camargo & Bousfield, 2009; Rateau et al., 2012).

The study's mixed-methods approach serves to strengthen its contributions. By incorporating both qualitative thematic analysis and quantitative survey data, this study captures both the lived experiences of participants as well as their generalizable broader patterns. This method establishes a comprehensive understanding of body representations, which is supported by analytical tools such as NVivo and SPSS (Bazeley & Jackson, 2013). Further, the inclusion of

multiple dimensions of data, such as gender, race, and sexual orientation, adds an intersectionality component to this approach and examines how systemic oppressions like sexism and racism exacerbate body concerns. This makes the findings particularly relevant for developing culturally sensitive social work practices which are tailored to diverse populations (Burr et al., 2016).

A major obstacle exists between academic theoretical constructs and practical interventions. The study shows how anchoring and objectification processes affect body representations but requires additional adjustments to develop practical social work strategies. Social workers handle intricate cases where body dissatisfaction stems from multiple social, cultural, and economic factors which challenges the implementation of uniform SRT-based interventions.

Social work practice encounters structural barriers when trying to implement the study's key recommendations of media literacy alongside peer support and family-centered interventions. The integration of theoretical insights into everyday practice proves difficult for social workers who operate within environments with limited resources because funding limitations and institutional priorities restrict their time. The research proposes media literacy as an essential intervention yet social workers' lack of specific training demands partnerships with both educators and media experts for effective program leadership.

Systemically modifying established societal beauty standards remains a significant obstacle. Social work focuses on advocacy and policy change but altering cultural stories about beauty standards and self-esteem requires long-term interdisciplinary collaboration. While social workers have the potential to significantly influence transformative efforts according to this

study, systemic resistance exemplified by corporate beauty industries and social media algorithms may prevent rapid change.

The research underscores the significance of intersectionality to combat body dissatisfaction but points out that social work practices face challenges when implementing culturally competent, gender-sensitive and trauma-informed approaches. Social workers need to customize their interventions for different populations because SRT-based strategies can produce different results depending on cultural backgrounds and individual experiences. Studies should continue to develop these findings so they can be customized for various social work scenarios to maintain intervention more effective and inclusivity.

Finally, there is a need for longitudinal studies to better examine the evolution of SRs of the body over time, particularly in response to interventions or societal shifts. Such research would shed light on the stability and adaptability of body-related representations across the lifespan and in varying sociocultural contexts. By integrating SRT with other theoretical frameworks, such as Objectification Theory or Intersectionality Theory, this approach can improve the understanding of body concerns, incorporating both individual and systemic factors influencing body dissatisfaction and BDD-like symptoms. These future directions aim to advance both theoretical understanding and practical applications, ensuring that interventions remain relevant and impactful in diverse contexts.

#### **4.9.2 Contributions of the Study**

This study makes significant contributions to the understanding and application of SRT in the context of mental health and social work practice, particularly in addressing Body Dysmorphic Disorder (BDD)-like symptoms. While SRT has been widely used to explore

societal norms and collective beliefs, this study uniquely applies its concepts such as anchoring and objectification to the experiences of young individuals struggling with body dissatisfaction and BDD-like symptoms. By analyzing how societal beauty standards are internalized and transformed into rigid and often distressing body representations, the research extends the theoretical application of SRT to a domain that bridges mental health and social work practice (Moscovici, 1988; Jodelet, 2008).

A key contribution of this study is the development of the Social Representations-Focused Intervention (SRFI), a novel, practice-oriented model grounded in the principles of SRT. The SRFI translates theoretical insights into a structured intervention that seeks to transform body-related representations through youth-led, community-based, and family-engaged practices. It strategically targets the peripheral elements of harmful body representations such as language, emotion, and social interaction to promote re-anchoring around health, functionality, and inclusivity. More importantly, the model addresses the rigid anchoring among youth exhibiting BDD-like symptoms and fosters flexible anchoring by encouraging youth to critically reflect on, deconstruct, and reframe their own and their community's body ideals. This intervention model not only advances SRT's application in mental health-focused social work but also offers an evidence-based, culturally responsive framework that can be further tested and adapted in diverse educational and social service settings, thereby making it a significant contribution to both theory and practice.

Methodologically, the study integrates qualitative and quantitative approaches to improve analyses of SRs of the body. This includes employing thematic analysis and survey data to create a comprehensive understanding of how body representations are formed and differ between individuals with and without BDD-like symptoms. Finding a flexibility and adaptability in body

representations among individuals without BDD-like symptoms, this study demonstrated the importance of health-oriented and functional perspectives. This methodological rigor ensured that this study provided not only useful theoretical insights, but also evidence-based recommendations for intervention (Camargo & Bousfield, 2009; Rateau et al., 2012).

Through education, advocacy, and systemic intervention the study demonstrates how social work interventions can transform negative body-related representations. The research delivers a roadmap for social workers to confront strict beauty standards and foster positive body depictions by connecting SRT with media literacy alongside peer and family-focused methods.

The study demonstrates its intersectional framework by examining how body dissatisfaction results from interconnected social identities including gender, race, and socioeconomic status. This strategy enhances SRT's relevance by showing how body representations emerge through cultural construction while being socially divided which affects BDD-like symptom vulnerability among various demographic populations.

### **4.9.3 Conclusion**

This study provides significant insights into how societal norms and cultural beauty standards shape body representation and mental health outcomes, especially for youth living in Canada with Body Dysmorphic Disorder (BDD)-like symptoms. By employing SRT, the research highlights how anchoring and objectification processes contribute to the internalization of unrealistic beauty ideals, resulting in rigid and maladaptive body representations for individuals with BDD-like symptoms. Conversely, those without BDD-like symptoms demonstrated more adaptive and flexible body representations, which focused more on individuality, health, and functionality.

As these findings reveal, there is a need for social work to integrate SRT into both theoretical frameworks and its practical interventions. Social workers hold an optimal position to address the systemic and interpersonal dimensions of BDD by leading initiatives to challenge harmful societal norms, foster resilience, and promote inclusive and positive representations of body. These initiatives, including literacy programs, family-centered interventions, and peer-led support programs, are crucial for transforming negative representations into adaptive, health-oriented frameworks.

It is essential that these initiatives are culturally sensitive and intersectional, allowing them to address the compounded vulnerabilities faced by women and racial minorities. By acknowledging systemic oppressions such as racism and sexism, social workers can understand these broader issues and create interventions that are both equitable and effective. Additionally, advocacy for structural reforms, such as the regulation of social media content and promoting diverse representations of beauty, aligns with the profession's commitment to social justice and holistic well-being.

Theoretically, this research contributes to the understanding of SRT by demonstrating the theory's applicability to mental health and body concerns. The fluid nature of SRs and their ability to be transformed through collective discourse and systemic advocacy illustrates the dynamic relationship between societal norms and individual behaviors. This is further evidenced by the development and proposed application of the Social Representations-Focused Intervention (SRFI), which operationalizes SRT's principles into actionable strategies designed to reshape harmful body-related representations. The SRFI addresses rigid anchoring and objectification by fostering flexible, health-oriented ways of interpreting and relating to the body through media literacy, peer collaboration, and community-based initiatives. This intervention demonstrates

how theoretical constructs can be translated into practical, prevention-focused tools that not only support individual resilience but also promote representational change at the collective level.

In conclusion, to fully address BDD and related body dissatisfaction, it is necessary to use a multifaceted approach, combining individual, familial, and systemic interventions. Social workers are agents of change in this case, and can play a transformative role in fostering positive body representations and reducing the prevalence and impact of BDD. By bridging the gap between SRT's theoretical insights and social work practice, this study provides a framework for achieving meaningful and sustainable improvements in mental health outcomes for youth. As described here, future research should continue to explore new ways to apply SRT in addressing body and other mental health challenges, and ensuring that interventions remain relevant and effective across diverse sociocultural contexts.

## **Chapter 5**

### **General Discussion**

This chapter synthesizes the findings from both Phase 1 and Phase 2 of the study to explore the complex ways in which social media, peers, and family influence the SRs of body and appearance among youth in Canada, particularly those with BDD-like symptoms. The SRT provides practical insights into how individuals with and without Body Dysmorphic Disorder (BDD)-like symptoms perceive their bodies. Employing this theoretical framework allows for a comprehensive exploration of not only the cognitive processes, but also the social influences that shape these representations. This approach leads to a more nuanced understanding of the variations between the two groups, and helps uncover the underlying mechanisms that influence body representations. This more holistic analysis provides valuable implications for both theory and practice. Through mixed-methods analysis, the study demonstrates that representations of the body are not static personal beliefs, but socially embedded constructs that influence how youth evaluate themselves, compare themselves to others, and determine their self-worth. These insights underscore the importance of moving beyond individualized frameworks of mental health to consider the broader cultural environments in which body concerns emerge.

Central to this analysis is the distinction between central and peripheral elements of Social Representations (Moscovici, 1988; Jodelet, 2008). The central core of body representations was dominated by appearance-oriented ideals that remain relatively stable across participants. However, the peripheral system revealed rich variations that distinguished youth with BDD-like symptoms from those without. While all participants were aware of societal beauty pressures, those with BDD-like symptoms internalized these ideals more rigidly and

emotionally, demonstrating deeper entrenchment of objectification, perfectionism, and comparative thinking.

The central core zone for participants with BDD-like symptoms, characterized by terms such as "fat", "pretty" and "strong", reveals a complex but narrowly focused SR of body, deeply rooted in societal ideals of physical appearance. These terms suggest a preoccupation with both negative and aspirational body attributes, where "fat" represents a feared or undesirable characteristic, and "pretty" and "strong" represent an idealized or socially acceptable standard. The prominence of these terms reflects how participants with BDD-like symptoms anchor their self-worth in physical appearance. In doing so, their self-perception is shaped by external validation and beauty ideals, which are often unrealistic and culturally enforced. This central focus on physical traits, particularly weight, indicates that societal pressures to meet certain body standards have been internalized by the individual, which likely exacerbates their symptoms and body dissatisfaction. On the other hand, individuals without BDD-like symptoms exhibited a more diverse central core, including terms like "tall", "healthy", "skinny" and "beautiful", suggesting a more balanced and holistic view of the body that incorporates both aesthetic and functional qualities. This broader representation allows for greater flexibility in body representation, as the value of appearance coexists with health and functionality, helping to avoid narrow a fixation on flaws or negative body attributes. The diversity of terms in the central core of participants without BDD-like symptoms suggests that their body representations were not as constrained by societal pressures, and instead more influenced by personal values and individual experiences.

The presence of these terms in the central core highlights the practical importance of understanding the formation of SRs. For individuals with BDD-like symptoms, the central core

of their SR of body is inflexible and dominated by negative, appearance-based concepts. This rigidity may make it more difficult for them to adopt a broader, more positive view of their bodies. In practical terms, targeted interventions to adjust the central core of these individuals' SRs could focus on introducing more diverse and health-oriented body related concepts into individuals' belief systems.

Participants without BDD-like symptoms held a more positive and diverse SR of body as their central core, including terms such as "healthy", and "beautiful". These terms suggest that participants without BDD-like symptoms view their bodies in a more holistic way, with an emphasis on health and functionality. The peripheral elements in this group, such as "athletic" and "strong", indicate that while appearance still plays a role in their SR of body, it is not the sole focus. This flexibility in the central core and peripheral elements for individuals without BDD-like symptoms suggests that they are more adaptable in their SR of body, therefore less vulnerable to body dissatisfaction.

The concept of **rigid anchoring** emerged as a key mechanism explaining this entrenchment. It describes the way in which youth with BDD-like symptoms fix their self-worth to narrow appearance-based standards, emotionally sticking to perceived flaws such as weight, skin, or facial features. **Flexible anchoring**, in contrast, characterizes participants without BDD-like symptoms, who were able to relate to their bodies through multiple frames, health, strength, functionality rather than appearance alone. Recognizing this distinction is crucial, as it shows that vulnerability to BDD-like symptoms is not only a matter of what ideals are internalized, but also how emotionally rigid or flexible those anchors become in everyday self-evaluation.

Gender emerged as a powerful lens through which these anchoring processes are shaped. The findings reveal that men and women do not simply experience different beauty pressures; they inhabit different representational worlds. Men's bodies were anchored to functionality, athletic performance, and strength, yet symbolized through hyper-muscular influencers and fitness culture. Their ideal body was described as tall, V-shaped, and muscular, representing social respect and status rather than emotional self-worth. In SRT terms, the male body occupied a wider zone of acceptability: muscularity was admired, but deviations were less likely to be socially penalized. Women, however, confronted a representation system that was far more rigid and high-stakes. Their ideal body was anchored to sexualized beauty, thinness combined with curves, smooth skin, largely shaped by celebrity aesthetics such as the Kardashian hourglass standard. These representations were emotionally internalized, making even small deviations (weight gain, shape, skin texture) feel deeply consequential. While men judged beauty from a socially evaluative distance, women lived inside these norms, navigating them as measures of their worth, desirability, and belonging. This asymmetry reflects how patriarchal beauty culture positions men as viewers and women as viewed, creating gendered pathways into self-objectification and BDD-like vulnerabilities.

These gendered differences also reflect broader social inequalities that shape whose bodies are valued and how. Women's anchoring of the ideal body in sexiness and desirability underscores how femininity continues to be tied to appearance under Westernized, heteronormative representations. Men's anchoring in cleanliness and naturalness reveals how they reproduce rules of respectable femininity; beauty that is attractive but controlled, fit but not muscular, perfected but not too much. Thus, women internalize norms as self-evaluation, whereas men reproduce them as social judgment, reinforcing a gendered representational divide:

women feel beauty norms; men police them. These dynamics were further amplified for LGBTQ+ participants, who described navigating gendered appearance scripts that positioned their bodies as socially incorrect. From an SRT, these findings illustrate how gender operates as a powerful organizing principle in the central core of body representations, while intersecting identities shape the peripheral variations that determine vulnerability to rigid or flexible anchoring. This reinforces the idea that BDD-like experiences are not merely psychological conditions, but culturally patterned responses emerging within unequal social structures that define whose bodies are celebrated, scrutinized, or stigmatized.

Family dynamics significantly shaped body representations. Parents contributed to youth's anchoring processes both intentionally and unintentionally. Most of the participants experienced pressures related to weight and then grooming through comments or modelling, increasing vulnerability to BDD-like symptoms. Others expressed gratitude for parents who focused on health, strengths, or intrinsic qualities, helping them build more adaptive, flexible self-representations. This highlights the role of families in shaping early SRs of the body and underscores the importance of parent involvement in preventive interventions.

Social media played a crucial role in shaping the emotional tone of body representations. Participants highlighted cycles of comparison, self-doubt, and validation seeking that intensified with curated images. For youth with BDD-like symptoms, exposure to unrealistic images often digitally altered reinforced rigid anchoring and objectification. Even participants without symptoms reported moments of insecurity and pressure. The omnipresence of manipulated images blurred the boundary between natural and artificial bodies, making self-acceptance more

difficult. These findings align with existing research linking social media navigation to internalization of appearance ideals and body dissatisfaction.

Peer influence also emerged as a major factor. Adolescents rely heavily on peer feedback, and comments whether supportive or critical, had significant emotional impact. Appearance-based teasing, exclusion, or comparison amplified distress, particularly for girls and LGBTQ+ youth. Conversely, supportive peer groups provided protective environments where diverse bodies were normalized and flexible anchoring was reinforced. Peer hierarchies around beauty and fitness were shown to reproduce societal norms, indicating that social work interventions must pay close attention to the peer ecology in which young people are embedded.

In light of these findings, SRT offers a particularly useful framework for understanding how BDD-like symptoms develop and how they can be addressed. Because SRT emphasizes that collective meanings shape people's interpretations, it provides a foundation for interventions that move beyond symptom reduction to deeper cultural and representational change. Anchoring, objectification, and re-anchoring processes become not only theoretical constructs but practical tools for social workers aiming to shift harmful body norms.

This study introduces the **Social Representations–Focused Intervention (SRFI)**, an SRT-based model that operationalizes these processes for clinical, educational, and community settings. SRFI begins by mapping young people's existing body representations through word association tasks, reflective dialogues, and journaling. This allows social workers to identify rigid and flexible anchors, objectification patterns, and emotionally charged meanings. The next phase, challenging and reframing, uses media literacy workshops, role-play, narrative rewriting, and small-group dialogues to destabilize harmful peripheral elements and encourage critical

evaluation of societal pressures. The final phase, re-anchoring and diffusion, focuses on cultivating new anchors centered on health, functionality, individuality, and diversity, which are reinforced through peer ambassadors, community campaigns, and family engagement.

Integrating parents into SRFI strengthens its preventive potential. Parent workshops help caregivers identify how their language and modeling can unintentionally reinforce rigid anchoring and appearance-based judgment. Sessions promote supportive communication styles that highlight strengths, abilities, and health rather than perfection or thinness. This multilevel approach ensures that representational change is reinforced in the home environment, making interventions more sustainable.

SRFI is also adaptable for gender-specific and intersectional needs. Given that girls, boys, and non-binary youth experience different body pressures, SRFI incorporates tailored activities that address each group's specific vulnerabilities. For example, girls may focus on dismantling thinness and beauty norms, whereas boys may explore alternatives to muscularity-centered masculinities. For racialized and LGBTQ+ youth, SRFI foregrounds cultural identity, resistance to stigmatized beauty norms, and the development of body-positive community narratives. This flexibility makes SRFI uniquely suited for diverse school and community settings.

Beyond interpersonal interventions, this study emphasizes the importance of structural and policy-level actions. Because youth operate in digital environments saturated with edited images, AI-based image forensics can play a protective role. AI systems capable of detecting retouched or AI-generated bodies could be mandated on social media platforms, requiring visible disclaimers or warnings. Such transparency reduces the power of manipulated images to shape

central representations of ideal bodies and supports youth in challenging unrealistic standards. While technological tools alone cannot solve body dissatisfaction, they serve as valuable macro-level complements to education and therapeutic services.

The prevention models such as Media Smart, the Dove Self-Esteem Project, the Body Project, SoMe, and Expand Your Horizon, collectively target the early formation of harmful body representations, making them particularly relevant given that most participants exhibited BDD-like symptoms without clinical diagnosis. These programs intervene precisely where this study found the strongest influence: social media exposure, peer comparison, and family expectations. By fostering media literacy, promoting functionality-based self-appraisals, and strengthening peer support, these programs directly soften the central appearance-focused anchors that dominate the SRs of participants with BDD-like symptoms. They promote flexible anchoring and broaden peripheral elements, reinforcing more diverse and health-oriented representations. Importantly, these prevention programs align with what this thesis demonstrates: that early intervention before negative representations become rigid is crucial to reducing vulnerability to BDD-like symptoms and interrupting the cycle of comparison, emotional anchoring, and self-objectification.

Intervention programs such as the Collaborative Care Model, ACT-based group interventions, school-based cognitive-behavioral counseling, and the Aspire Program deepen this work by addressing the emotional distress, perfectionism, and compulsive behaviors described by some participants. These models reflect SRT's emphasis on the dynamic relationship between internal bodies and social environments: they challenge distortions in self-representation while also reshaping the relational and systemic contexts that reinforce those distortions.

Finally, the structural and policy-level actions proposed including restrictions on retouched imagery and regulation of cosmetic advertising for minors represent critical macro-level strategies that realign the social field in which youth develop their body representations. Policies that require transparency around digitally altered images, for example, reduce the authority of unrealistic ideals as central societal anchors. Together, these programs create a comprehensive scaffold of support that mirrors the multilevel forces shaping SRs of the body in this study. By combining youth-focused prevention, intervention programs, and systemic reform, these approaches reflect a holistic and SRT-informed pathway for reducing the burden of body dissatisfaction and preventing the progression toward BDD-like symptoms among youth.

This study contributes theoretically by demonstrating the applicability of SRT to mental health, specifically to body dissatisfaction and BDD-like symptoms. The findings reveal how social representations are emotionally lived, culturally embedded, and collectively reinforced. They show that SRs are not rigid but fluid, capable of transformation through dialogue, critical reflection, and supportive environments. The introduction of SRFI illustrates how representational change can be mobilized in practice, providing a bridge between theory and real-world intervention.

Overall, the study highlights that improving youth mental health requires integrated approaches across micro, mezzo, and macro levels. Addressing individual symptoms is important, but transformative change emerges when societal norms, social interactions, and digital environments are also reshaped. Through the application of SRT and the development of SRFI, this study provides a roadmap for social workers, educators, families, and policymakers to

create healthier, more inclusive representations of the body representations that emphasize diversity, functionality, and well-being rather than unattainable ideals.

## **5.1 Research and Practical Implications**

The application of SRT in this study provides valuable insights into how SR of body is structured and offers practical guidance for developing targeted interventions. The key challenge for interventions aimed at individuals with BDD-like symptoms is to alter the central core of their SRs by introducing more positive and diverse body-related concepts. By expanding the central core to include terms like "health", "strength" and "well-being," individual interventions could help these individuals develop a more balanced view of their bodies.

Another practical implication of this study is the importance of addressing the role of external influences, particularly social media, family, and peers, in shaping SR of body. Media literacy programs that teach individuals to critically analyze and resist unrealistic beauty ideals could be effective in reducing the negative impact of social media on body representations. Through the education of parents about how their comments and behaviors impact their children's body representations, family-based interventions can also support the prevention of developing of BDD-like symptoms. Additionally, peer-led initiatives that promote body positivity and self-acceptance within social groups could help mitigate the negative effects of peer criticism and social comparison.

Finally, this study is representative of the importance of a holistic approach to understanding body representations interventions that addresses both the cognitive and social factors contributing to body dissatisfaction. By incorporating SRT concepts such as anchoring, objectification, central core, and peripheral elements into intervention strategies, mental health

professionals can better understand the underlying mechanisms that drive body concerns and develop more effective treatments for individuals with BDD-like symptoms.

Beyond individual interventions, this study's findings provide broader implications for social work initiatives aimed at promoting positive body representation. The role of social media in shaping SR of body illustrates a distinct need for stricter regulations on how digital platforms portray beauty standards. Policymakers and platform developers could use the findings of this study to design guidelines and tools that promote body positivity and reduce the emphasis on appearance. For example, social media platforms could implement features that allow users to filter content that promotes unrealistic body ideals or provide educational resources about media literacy and mental health.

Educational institutions also have a role to play in promoting positive body representations among young people. School-based programs that teach critical thinking about beauty standards and social comparison could help students develop healthier SR of body by challenging societal norms and fostering a culture of body acceptance. By integrating media literacy into the curriculum, students can learn how to critically analyze advertisements, social media posts, and celebrity culture, and develop tools to resist the internalization of unrealistic beauty ideals. These types of programs can be effective by promoting the idea that body diversity should be celebrated, and that health and well-being are more valuable than appearance in determining one's self worth.

Additionally, there is a potential for collaboration between schools and mental health professionals to create workshops addressing body representation, self-esteem, and resilience-building. These workshops would provide a key opportunity for students to learn how to cope

with peer pressure, bullying, and negative self-perception. By fostering a supportive, safe environment for students to discuss body representation issues, schools can play an essential role in identifying and preventing issues of body dissatisfaction and related mental health disorders, such as BDD.

Integrating Social Representation Focused Interventions (SRFI) into these workshops would further strengthen their impact by helping students recognize how societal narratives, cultural norms, and media imagery shape their understanding of the body. SRFI encourages youth to actively question and reconstruct these representations, promoting flexible anchoring and reducing the internalization of rigid or harmful ideals. In doing so, SRFI provides a structured, theory-driven method for transforming both individual perceptions and collective school environments toward healthier, more resilient body narratives.

Another practical implication of this research is its proposal for *parenting programs*. Since family influences are critical in shaping young people's SRs of body, parents should be made aware of the significant role their attitudes and behaviors play. Parenting workshops that focus on promoting positive discussions about body representations, encouraging healthy lifestyle habits, and reducing the emphasis on physical appearance could help prevent the development of BDD-like symptoms. Through this education, parents can learn why and how to avoid making critical comments on their children's appearance, and methods to positively reinforce behaviors related to health and self-care. In doing so, these programs would help parents foster a more nurturing environment for body positivity.

Mental health professionals could also benefit from the findings of this study by integrating SRT-based approaches into therapy for individuals struggling with body concerns.

The concepts such as anchoring and objectification used in intervention programs could help clients recognize how societal and familial influences have shaped their negative body representation. In cognitive-behavioral therapy (CBT), for example, therapists could work with clients to re-anchor their SR of body in values that emphasize health, strength, and self-worth, rather than appearance. By deconstructing and undoing the objectification of their bodies, and building more holistic views, therapists can help reduce the psychological distress associated with BDD and other body disorders for clients.

Moreover, social comparison theory, which this study has previously engaged, provides further insight into how interventions could be tailored to better help individuals with BDD-like symptoms, who tend to compare themselves unfavorably with others. Therapeutic approaches can be effective by targeting these social comparison behaviors, and helping clients shift their focus from appearance-based to ability-based or achievement-based comparisons. Encouraging clients to engage in activities that promote body functionality, such as sports or physical hobbies, could also help shift their attention away from appearance and toward what their bodies can do.

In order to enact broader societal changes, by driving *public health campaigns* promoting diverse representations of body types, they can counteract the narrow beauty standards in media and popular culture. Similar to the campaigns of the body positivity movement, which celebrated all body shapes, sizes, and appearances, these can be expanded to reach a wider audience. By highlighting real-life stories of individuals who have overcome body dissatisfaction or BDD-like symptoms, these campaigns can provide role models for individuals currently struggling with body issues, helping them find a path towards recovery.

At the policy level, stricter regulations on digital content that promotes unrealistic beauty standards could help reduce the prevalence of body dissatisfaction among young people. For instance, mandatory disclaimers on images that have been digitally altered to change appearance, similar to those required in some countries, could help consumers recognize when they are being presented with unattainable ideals. Additionally, policies that encourage transparency in advertising, such as showing models of various body types, could foster a more inclusive representation of beauty in the media.

This study also has implications for gender-focused interventions, as it highlights the gendered nature of body concerns. As women are more susceptible to BDD-like symptoms due to societal expectations of thinness and femininity, this gendered approach is necessary. Therefore, by employing gender-sensitive interventions that address the unique pressures faced by women and non-binary individuals, these efforts could help reduce the impact of societal standards. For example, these interventions can include programs that promote feminist perspectives on body representations, emphasizing empowerment and self-acceptance. These new perspectives can then help women and non-binary individuals resist societal pressures to conform to unrealistic beauty ideals.

Additional research is required to further explore the intersection of cultural identity and body representations, particularly in multicultural societies like Canada. As seen in this study, participants from various cultural backgrounds had differing experiences in their body concerns, especially while navigating Western beauty ideals and their own cultural values. Future studies could investigate how cultural heritage influences the anchoring process in SRs of body, and how individuals from diverse backgrounds resist or internalize Western beauty standards.

Understanding these dynamics could lead to culturally tailored interventions that address the specific needs of different cultural groups.

In addition to cultural diversity, sexual orientation emerged as an important factor in SR of body, with sexual minorities reporting a higher prevalence of BDD-like symptoms. This suggests a need for targeted interventions that address the unique challenges faced by LGBTQ+ individuals in relation to body representations and societal expectations. Inclusive mental health services that provide support for navigating identity and appearance concerns within the LGBTQ+ community could be beneficial. Further research could also explore the ways in which societal norms around gender and sexuality intersect to shape body concerns among sexual minorities.

Another significant contribution of this study is its legislative potential in informing mental health policy. With the concerning rise of body issues and related disorders like BDD, policymakers may be swayed to invest in mental health initiatives to address these body concerns. These initiatives could include funding for research into body disorders, developing educational materials for schools and parents, or creating accessible mental health resources for individuals struggling with body issues.

The findings of this study also suggest that in the development of prevention strategies, early identification of body dissatisfaction in adolescence should be a primary goal. Given the role of peers, family, and social media in shaping SR of body, prevention strategies should aim to educate young people on the dangers of social comparison and objectification. These strategies include programs that encourage mindfulness and self-compassion, which can help

adolescents develop resilience against these external pressures, reducing their risk of developing BDD-like symptoms in the future.

Moreover, this study adds to the growing calls for public dialogue around body representations and mental health. Through this dialogue, more people can understand the societal and psychological factors that contribute to body dissatisfaction, and contribute to creating a more supportive and inclusive society. Encouraging open conversations about body issues in all facets of life, such as in schools, workplaces, or online communities, can help reduce the stigma associated with disorders like BDD, making it easier for individuals to seek help when needed.

Finally, the distinction between the central core and peripheral elements of body representation in SRT offers a framework for understanding the stability and flexibility in SR of body among participants. For those with BDD-like symptoms, the central core of their body representation was dominated by fixed ideals of beauty, such as thinness, perfection, or flawlessness. These participants saw societal ideals as non-negotiable, causing their more rigid and critical self-assessment, with few alternative values or perspectives. On the other hand, participants without BDD-like symptoms held strong peripheral elements such as health, strength, and personal satisfaction, possessing a more dynamic and adaptable central core. This flexibility allowed them to resist the internalization of societal pressure, and have a more balanced and less anxious relationship with their bodies. These central and peripheral elements show not only the different ways participants perceive their bodies, but also potential avenues for targeted interventions, such as encouraging a shift toward more flexible and health-oriented central cores in body representation.

## Conclusion

This thesis explored how youth in Canada form social representations of their bodies through sociocultural influences including social media, peers, and family. The research findings based on Social Representation Theory (SRT) reveal important knowledge about the ways young people both with and without Body Dysmorphic Disorder (BDD)-like symptoms develop internalized representation of beauty standards. The study expands theoretical and practical knowledge about body dissatisfaction while establishing a basis for developing future interventions underlying social representation of body in the social work framework.

This study applied SRT processes to interpret the results related to social representation of body which proves that common societal standards of beauty embed themselves within people's cognitive frameworks. Research reveals through an analysis of anchoring and objectification processes how abstract standards of beauty transform into concrete beliefs that individuals internalize to shape their self-identity regarding body. People with BDD-like symptoms hold inflexible appearance-based representations that strengthen their adverse emotional and psychological states. Individuals without BDD-like symptoms maintain body representations that show higher adaptability by integrating health and functionality into their self-concept. The differentiation between these cognitive processes highlights how mental flexibility helps reduce dissatisfaction with one's body and lessens related emotional distress.

The findings highlight how family, social media and peer influences work together to strengthen societal standards of beauty. Social media stands out as a significant factor since participants experienced more body dissatisfaction after viewing idealized images portrayed in social media. The study supports previous findings that digital platforms enhance unrealistic

beauty standards by showing carefully selected and altered appearances (Perloff, 2014). BDD-like individuals face amplified effects from family and peer influences because they display an increased sensitivity towards external evaluations and societal expectations. Addressing body concerns requires multi-layered interventions that focus on both individual cognitive processes and wide-reaching social influences.

According to social work research, the study highlights the importance of creating multi-level interventions to transform harmful body representations among youth at risk for BDD-like symptoms. Evidence-based prevention programs such as Media Smart, SoMe, the Dove Self-Esteem Project, the Body Project, and Expand Your Horizon equip young people with critical thinking skills to analyze idealized beauty portrayals, challenge social media pressures, appreciate body functionality, and reduce comparison-based distress. At the intervention level, approaches including the Collaborative Care Model, ACT-based group interventions, cognitive-behavioral group counseling, and the Aspire Program provide structured therapeutic support for those already experiencing emotional or behavioral impacts of appearance concerns. Family-based components help parents build body-positive home environments, while peer-led dialogues foster solidarity and normalize diverse body types. Integrating Social Representation Focused Interventions (SRFI) across these models strengthens their impact by encouraging youth to examine how societal norms, digital media, and interpersonal feedback shape their body beliefs, challenge rigid anchoring processes, and reconstruct more flexible and empowering representations. Together, these prevention, intervention, and policy-oriented strategies work holistically to reduce appearance-based distress and protect youth from escalating into BDD-like symptoms.

These results extend beyond immediate solutions and affect public health, education sectors and policy-making processes. To address body dissatisfaction, it is essential that society alters its beauty narratives to focus less on physical appearance and more on inclusive health-based body representations. Public awareness campaigns combined with educational curriculum reforms and advocacy against commercial beauty standards facilitate this necessary societal shift.

The research establishes a comprehensive understanding of body dissatisfaction and BDD issues by merging SRT with psychological and sociocultural viewpoints. Subsequent research needs to investigate how cultural variations impact body representations and evaluate the sustained impact of interventions that modify these body representations. The ongoing research application of these findings will provide guidance for building positive body image and enhancing mental health in young populations.

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## **Appendix**

### **Questionnaires (Phase 1)**

#### **Online survey**

**Please provide your email address: ....**

**Please provide your phone number (XXX-XXX-XXXX): ....**

**In which city do you live?**

**In which province do you live?**

**What is your current age (in year)?**

**What was your sex assigned at birth?**

Female

Male

Intersex

You don't have an option that applies to me, I identify as:..

Decline to answer

**What is your current gender identity?**

Woman

Man

Not-binary

You don't have an option that applies to me, I identify as:..

Decline to Answer

**What is your sexual orientation?**

lesbian, gay

bisexual

transgender

queer/questioning

Two Spirit

You don't have an option that applies to me, I identify as:..

Decline to Answer

**What is your marital status?**

Single

Married/common-law

widowed/divorced/separated

Other; please specify...

Decline to Answer

**What is your education?**

High school

College

Undergraduate

Other; please specify...

Decline to Answer

**What is your residence area?**

Urban

Rural

Decline to Answer

**What is your job status?**

Employed

Unemployed

Student

Decline to Answer

**What is your residency status in Canada?**

Canadian/Permanent Resident

International Student

Other (Please specify)

Decline to Answer

**Which racial group do you belong to?**

White

Visible minority (e.g., South Asian, Chinese, Black, Filipino, Arab, Latin American, Southeast Asian, West Asian, Korean and Japanese)

Indigenous

You don't have an option that applies to me, I identify as:..

Decline to Answer

## BDDQ

---

**This questionnaire asks about concerns with physical appearance. Please read each question carefully and circle the answer that is true for you. Also please write out your answers where asked.**

- 1) Are you very worried about how you look? Yes   No  
• If yes: Do you think about your appearance problems a lot and wish you could think about them less? Yes   No  
• If yes: Please list the body areas you don't like: \_\_\_\_\_

*Examples of disliked body areas include: your skin (for example, acne, scars, wrinkles, paleness, redness); hair; the shape or size of your nose, mouth, jaw, lips, stomach, hips, etc.; or defects of your hands, genitals, breasts, or any other body part.*

**(NOTE: If you answered "No" to either of the above questions, you are finished with this questionnaire.)**

- 2) Is your **main** concern with how you look that you aren't thin enough or that you might get too fat? Yes   No
- 3) How has this problem with how you look affected your life? Yes   No
- Has it often upset you a lot?
  - Has it often gotten in the way of doing things with friends or dating? Yes   No
    - If yes: Describe how: \_\_\_\_\_
  - Has it caused you any problems with school or work? Yes   No
    - If yes: What are they? \_\_\_\_\_
  - Are there things you avoid because of how you look? Yes   No
    - If yes: What are they? \_\_\_\_\_

4) How much time a day do you usually spend thinking about how you look? (Add up all the time you spend, then circle one)

- a) Less than 1 hour a day   b) 1–3 hours a day   c) More than 3 hours a day

## Y-BOCS

For each item circle the number identifying the response which best characterizes the patient during the **past week**.

---

**1. TIME OCCUPIED BY THOUGHTS  
ABOUT BODY DEFECT**

How much time do you spend thinking about this problem with how you look?

- 0 - None
  - 1 - Mild (less than 1 hr/day)
  - 2 - Moderate (1-3 hrs/day)
  - 3 - Severe (greater than 3 and up to 8 hrs/day)
  - 4 - Extreme (greater than 8 hrs/day)
- 

**2. INTERFERENCE DUE TO THOUGHTS  
ABOUT BODY DEFECT**

How much do these THOUGHTS about how you look get in the way of school, work, or doing things with family or friends? (Is there anything you don't do because of them?)

- 0 - None
  - 1 - Mild, slight interference with social, occupational, or role activities, but overall performance not impaired.
  - 2 - Moderate, definite interference with social, occupational, or role performance, but still manageable.
  - 3 - Severe, causes substantial impairment in social, occupational, or role performance.
  - 4 - Extreme, incapacitating.
- 

**3. DISTRESS ASSOCIATED WITH THOUGHTS  
ABOUT BODY DEFECT**

How much do these THOUGHTS about how you look bother or upset you?

- 0 - None
  - 1 - Mild, and not too disturbing.
  - 2 - Moderate, and disturbing.
  - 3 - Severe, and very disturbing.
  - 4 - Extreme, and disabling distress
-

**4. RESISTANCE AGAINST THOUGHTS OF BODY DEFECT**

How hard do you try to stop these thoughts or ignore them?

- 0 - Makes an effort to always resist, or symptoms so minimal doesn't need to actively resist.
- 1 - Tries to resist most of time.
- 2 - Makes some effort to resist.
- 3 - Yields to all such thoughts without attempting to control them but yields with some reluctance.
- 4 - Completely and willingly yields to all such thoughts.

---

**5. DEGREE OF CONTROL OVER THOUGHTS ABOUT BODY DEFECT**

When you try to fight the thoughts about how you look, can you beat them?

How much control do you have over your thoughts?

- 0 - Complete control, or no need for control because thoughts are so minimal.
- 1 - Much control, usually able to stop or divert these thoughts with some effort and concentration.
- 2 - Moderate control, sometimes able to stop or divert these thoughts.
- 3 - Little control, rarely successful in stopping thoughts, can only divert attention with difficulty.
- 4 - No control, experienced as completely involuntary, rarely able to even momentarily divert attention.

---

**6. TIME SPENT DOING COMPULSIVE BEHAVIORS RELATED TO BODY DEFECT**

Now I'm going to ask you about the activities/habits you do related to your appearance problem.

- 0 - None
- 1 - Mild (spends less than 1 hr/day)
- 2 - Moderate (1-3 hrs/day)
- 3 - Severe (spends more than 3 and up to 8 hours/day)
- 4 - Extreme (spends more than 8 hrs/day in these activities)

How much time do you spend doing these things?  
*Include all behaviors.*

**READ LIST OF BEHAVIORS**

**(check all that apply)**

- Checking mirrors/other surfaces
- Checking the appearance of the disliked body areas directly
- Grooming activities (c.g., hair combing, styling, shaving)
- Applying makeup
- Excessive exercise (time beyond 1 hr. per day)
- Selecting/changing clothing or other cover-up (rate time spent selecting, changing or fixing clothes or cover-up, not time wearing them)
- Comparing disliked body areas with those body areas on other people
- Questioning others about/discussing your appearance

- \_\_\_ Picking at skin because it doesn't look right
- \_\_\_ Skin cleansing routines
- \_\_\_ Pulling out hair because it doesn't look right
- \_\_\_ Touching the body areas
- \_\_\_ Tanning
- \_\_\_ Other \_\_\_\_\_

**7. INTERFERENCE DUE TO ACTIVITIES  
RELATED TO BODY DEFECT**

How much do these activities/habits get in the way of school, work, or doing things with family or friends? (Is there anything you don't do because of them?)

- 0 - None
- 1 - Mild, slight interference with social, occupational, or role activities, but overall performance not impaired.
- 2 - Moderate, definite interference with social, occupational, or role performance, but still manageable.
- 3 - Severe, causes substantial impairment in social, occupational, or role performance.
- 4 - Extreme, incapacitating.

**8. DISTRESS ASSOCIATED WITH ACTIVITIES  
RELATED TO BODY DEFECT**

How would you feel if you were prevented from doing these activities/habits?

How upset would you become?

- 0 - None
- 1 - Mild, only slightly anxious if behavior prevented.
- 2 - Moderate, reports that anxiety would mount but remain manageable if behavior is prevented.
- 3 - Severe, prominent and very disturbing increase in anxiety if behavior is interrupted.
- 4 - Extreme, incapacitating anxiety from any intervention aimed at modifying activity.

**9. RESISTANCE AGAINST COMPULSIONS**

How much do you try to fight doing these activities/habits?

- 0 - Makes an effort to always resist, or symptoms so minimal doesn't need to actively resist.
- 1 - Tries to resist most of the time.
- 2 - Makes some effort to resist.
- 3 - Yields to almost all of these behaviors without attempting to control them, but does so with some reluctance.
- 4 - Completely and willingly yields to all behaviors related to body defect.

**10. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR**

How strong is the feeling that you have to carry out these activities/habits?  
When you try to fight them, what happens?

- 0 - Complete control, or control is unnecessary because symptoms are mild.
- 1 - Much control, experiences pressure to perform the behavior, but usually able to exercise voluntary control over it.
- 2 - Moderate control, strong pressure to perform behavior, can control it only with difficulty.
- 3 - Little control, very strong drive to perform behavior, must be carried to completion, can delay only with difficulty.
- 4 - No control, drive to perform behavior

experienced as completely involuntary and overpowering, rarely able to even momentarily delay activity.

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**11. INSIGHT**

What word would you use to describe how bad your appearance flaws look?

How certain are you that these body areas look [fill in patient's word(s)]? Are you certain your belief is accurate?

- 0 = Excellent insight: Completely certain belief is false
  - 1 = Good insight. Realizes belief is probably not true, or substantial doubt exists
  - 2 = Fair insight: Belief may or may not be true, or unable to decide if belief is true or not
  - 3 = Poor insight: Fairly convinced that belief is but an element of doubt exists.
  - 4 = Lacks insight; delusional. Completely convinced that belief is true (100% certainty)
- 

**12. AVOIDANCE**

Have you been avoiding doing anything, going any place, or being with anyone because of your thoughts or activities/habits related to your problem with how you look?

- 0 - No deliberate avoidance.
- 1 - Mild, minimal avoidance.
- 2 - Moderate, some avoidance clearly present.
- 3 - Severe, much avoidance; avoidance prominent.
- 4 - Extreme, very extensive avoidance; patient avoids almost all activities.

### Verbal Association

When you think about your body/appearance, what words/phrases come to your mind? Please give us up to 8 words/phrases.

Please rank these words/phrases from 1 to 8 based on their importance in representing the body.

Words\phrases	Rank (1 to 8)
1-	
2-	
3-	
4-	
5-	
6-	
7-	
8-	

### **Interesting to participate in Phase 2?**

There will be Phase 2 for the current research which will involve a series of questions regarding the effects of peers, parents and media on body/appearance. If you are interested in participating in Phase 2, please provide your contact information below; otherwise, if you are not interested in, you do not need to fill it out.

Email:

Phone number:

## **Interviews (Phase 2)**

Thank you for participating in our project about social representation of body. The purpose of the study is to explore social representations of body/appearance in young individuals who reside in Canada to answer the question of how body related problems are shaped by the social representations of the body as conveyed in the media by young people's reference groups (peers, parents, and celebrities). In other words, the present study intends to investigate how the social representations of body are presented through social media as well as within peers and parents' interactions. The interview takes around 60-90 minutes. Your participation is voluntary and there are no consequences if you decide not to participate. All information will be kept confidential, and personal information will be removed from transcription.

Do you consent to audio record the interview?

**START** (start recording if they consent)

What do you think of your body, in general?

Is the body important to you?

How do your relatives see the body? How does society in general?

Is there anyone, for example a celebrity, on social media that you are both following and would like to be in terms of their appearance or body style? Explain.

What do you call the ideal body in social media? What does it look like? Explain.

How do you get close to this ideal body and what are your feelings about it?

What is the best description of a good/bad body in social media? Explain both.

What do you call an ideal body in your friendship groups? How do you get close to this/these ideal(s)?

Have you ever had discussions with your friends about the ideal body?

If yes, during these discussions, how did you feel? Positive or negative? Explain.

What is the best description of a good/bad body in your friendship groups?

Is there any person or celebrity that your friends or people you socialize with have discussed in terms of their appearance/body style? To what extent is it important in your friendship group and how does it impact your thoughts and behaviours regarding your body and appearance?

How do you describe women/men ideal body?

What type of women/men body is more socially acceptable?

What type of women/men body does have more social advantages?

What type of body does give you good feelings while you are in your school/university/college or workplace?

Do you think social power is associated with any type of body/appearance? Explain. To achieve this social power, what practices or behaviors have you done?

Describe your view of being a youth?

Describe you family in terms of their social status? And how are they viewed in the society?

Have you ever received any social advantages/disadvantages due to membership in your family?  
Explain your feeling.

Is there any policy regarding your appearance in your school/college/university which you do not like that? If so, what have you done to deal with that and how?

Are there any standards/specific attitudes in your family regarding appearance related to your age/gender? Are those standards/attitudes consistent/inconsistent with your attitudes? For inconsistencies (if reported), what are / would be your solutions to these inconsistencies?

What is a deserved/undeserved body/appearance in young people in Canada (it can be extended to workplace, family, and community)?

Do you think you have control over your decisions regarding your appearance?

What are the factors that limit you to have independent decisions?

Do you feel you have a negative body image, if so, where do you feel this perception come from?

Do you think your membership in your family and community impact this perception?

**END**

Thank you so much for your participation in our study. You will receive an email that includes a debriefing form, containing information about our study and hotline resources in case you experienced emotional distress during the interviews.

## **Consent Form (Phase 1)**

### Social representations of body

Principal Investigator:

Supervisor:

Shamim Razaghi Kashani.

Lilian Negura

(Social Science, Social Work, uOttawa)

(Social Science, Social Work, uOttawa)

I am invited to participate in the abovementioned research study as a doctoral thesis conducted by Shamim Razaghi Kashani under the supervision of Professor Lilian Negura.

### **Purpose**

The purpose of the study is to explore social representations of body/appearance in young individuals who reside in Canada to answer the question of how body related problems are shaped by the social representations of the body as conveyed in the media by young people's reference groups (peers, parents, and celebrities). In other words, the present study intends to investigate how the social representations of body are presented through social media as well as within peers and parents' interactions.

### **What does a participant do in this study?**

My participation will consist of completing online questionnaires by using Qualtrics platform.

I will be asked to complete a 45-minute online survey. The questionnaires will cover questions about body and appearance and my socio-demographic characteristics. I may need to provide my contact information to the researcher in order enter the e-gift draw.

### **Is it mandatory to participate in?**

My participation is completely voluntary and there are no consequences if I decide not to participate. I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study. After each phase, I will be given a debriefing letter covering the possible questions regarding my participation or if I require counselling information.

### **Risks**

My participation in this study will entail that I *volunteer personal information* and this may cause me to feel *whether emotional or psychological distress during answer the questions*. The questions may remind me of unpleasant experiences that I have had. If I feel any emotional distress, I can use the resources below:

Mental Health Helpline-Ontario: 1-866-531-2600

Canadian Association for Family Services: 1-866-637-7226

Youth Services Bureau-Ontario: 1-877-377-7775

Kids Help Phone: 1-800-668-6868

Info-Social 811-Quebec: 811

Mental Health Helpline-Alberta: 1-877-303-2642

Crisis Line Association of BC: 310-6789 and 1-800-784-2433

Klinic Crisis Line-Manitoba: 1-888-322-3019

Health and Community Services-Newfoundland and Labrador: 811

Nova Scotia Mental Health and Addictions Crisis Line: 1-888-429-8167

Health and Community Services- Saskatchewan: 811

Crisis Services Canada for Suicide Prevention and Support-Canada Wide: 1-833-456-4566

### **Benefits**

By participating in this study, I will have opportunity to understand how social representation of social media, peers, parents and other social groups could shape ideal body/appearance.

### **Compensation**

There will be three e-gift cards valued \$20 that will be given by drawing. If I choose to withdraw from the study, I will still receive this compensation.

### **Confidentiality**

I will be required to provide my email address and phone numbers for a draw entry. In the interview, related personal information such as name will be removed from the transcripts. The information that I will share will remain strictly confidential. I understand that the contents will be used only for the purpose of the study and that my identity will be protected anonymity. To ensure the confidentiality, a six-digit code will be assigned to the responses and all personal information such as name, email, and phone number will be removed from the dataset. The researcher will only keep my personal information to contact me for e-gift draw. The data will be kept in a password protected laptop of the principal investigator. All data will be destroyed after five years.

In order to minimize the risk of security breaches and to help ensure my confidentiality, it is recommended that I use standard safety measures, such as signing out of my account, closing my browser, and locking my device when I am no longer using it/when I have completed the study.

I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study.

If I have any questions about the study, I may contact the researcher or their supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email ([ethics@uottawa.ca](mailto:ethics@uottawa.ca)) or telephone (613-562-5387).

It is recommended that I *save* a copy of this consent form for my records.

**Acceptance:** By selecting the consent statement below, I agree to participate in this research study.

- Yes, I want to participate.

*Email:* \_\_\_\_\_

- No, I do not want to participate.

- 

### **Consent Form (Phase 2)**

#### Social representations of body

Principal Investigator:

Supervisor:

Shamim Razaghi Kashani.

Lilian Negura

(Social Science, Social Work, uOttawa)

(Social Science, Social Work, uOttawa)

I am invited to participate in the abovementioned research study as a doctoral thesis conducted by Shamim Razaghi Kashani under the supervision of Professor Lilian Negura.

### **Purpose**

The purpose of the study is to explore social representations of body/appearance in young individuals who reside in Canada to answer the question of how body related problems are

shaped by the social representations of the body as conveyed in the media by young people's reference groups (peers, parents, and celebrities). In other words, the present study intends to investigate how the social representations of body are presented through social media as well as within peers and parents' interactions.

### **What does a participant do in this study?**

My participation will consist of taking part in an online interview.

The researcher will ask me a series of questions regarding the effects of peers, parents and media on body/appearance. The interview part totally takes around 60-90 minutes.

### **Is it mandatory to participate in?**

My participation is completely voluntary and there are no consequences if I decide not to participate. I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study. After each phase, I will be given a debriefing letter covering the possible questions regarding my participation or if I require counselling information.

### **Risks**

My participation in this study will entail that I *volunteer personal information* and this may cause me to feel *whether emotional or psychological distress during answer the questions*. The questions may remind me of unpleasant experiences that I have had. If I feel any emotional

distress, I can use the resources below:

Mental Health Helpline-Ontario: 1-866-531-2600

Canadian Association for Family Services: 1-866-637-7226

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Nova Scotia Mental Health and Addictions Crisis Line: 1-888-429-8167

Health and Community Services- Saskatchewan: 811

Crisis Services Canada for Suicide Prevention and Support-Canada Wide: 1-833-456-4566

### **Benefits**

By participating in this study, I will have opportunity to understand how social representation of social media, peers, parents and other social groups could shape ideal body/appearance.

## **Compensation**

There will be four e-gift cards valued \$20 that will be given by drawing. If I choose to withdraw from the study, I will still receive this compensation.

## **Confidentiality**

I will be required to provide my email address and phone numbers for a draw entry. In the interview, related personal information such as name will be removed from the transcripts. The information that I will share will remain strictly confidential. I understand that the contents will be used only for the purpose of the study and that my identity will be protected anonymity. To ensure the confidentiality, a six-digit code will be assigned to the responses and all personal information such as name, email, and phone number will be removed from the dataset. The researcher will only keep my personal information to contact me for e-gift draw. The data will be kept in a password protected laptop of the principal investigator. All data will be destroyed after five years.

In order to minimize the risk of security breaches and to help ensure my confidentiality, it is recommended that I use standard safety measures, such as signing out of my account, closing my browser, and locking my device when I am no longer using it/when I have completed the study.

I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study.

If I have any questions about the study, I may contact the researcher or their supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email ([ethics@uottawa.ca](mailto:ethics@uottawa.ca)) or telephone (613-562-5387).

It is recommended that I *save* a copy of this consent form for my records.

**Acceptance:** By selecting the consent statement below, I agree to participate in this research study.

- Yes, I want to participate.

*Email:* \_\_\_\_\_

- No, I do not want to participate.

## **Debriefing Form**

### ***What are we trying to learn in this research?***

You will be familiar with how sociocultural factors such as family, peers, media could shape the representation of body and appearance. More precisely, you will get to know the importance of social messages disseminated by the media in shaping individuals' representation of the body and the role of parents and peers in forming their children's beliefs about ideal bodies is particularly important.

### ***Why is this important to scientists or the general public?***

The results will provide information about how young people with body/appearance problems are impacted by peers and social media. This information would help social workers to get more familiar with the effects of social factors on the ideal body in young people. The results would provide information for individual-based interventions in order to modify young people

expectations. We can formulate better social services in schools as well that we can disseminate this scientific information to the society. As there is no association for this community in Canada, the outcome would help us to create suitable small-community based associations for these individuals to transfer the knowledge of symptoms and to provide consulting services to find a suitable way for dealing with this condition.

***What are the hypotheses and predictions?***

The current research program aims to explore social representations of body/appearance in young who reside in Canada to answer the question of how body/appearance problems are shaped by the social representations of the body as conveyed in the media by young people's reference groups (peers, parents, and celebrities). In other words, the present study intends to investigate how the social representations of body are presented through social media as well as within peers and parents' interactions.

***Where can I learn more?***

If you would like to know more about current research in this area, see the following references.

Phillips, K. A., Didie, E. R., Menard, W., Pagano, M. E., Fay, C., & Weisberg, R. B. (2006). Clinical features of body dysmorphic disorder in adolescents and adults. *Psychiatry research*, 141(3), 305-314. <https://doi.org/10.1016/j.psychres.2005.09.014>

Ricciardelli, L. A., McCabe, M. P., & Banfield, S. (2000). Body image and body change methods in adolescent boys: Role of parents, friends and the media. *Journal of psychosomatic research*, 49(3), 189-197. [https://doi.org/10.1016/S0022-3999\(00\)00159-8](https://doi.org/10.1016/S0022-3999(00)00159-8)

De Rosa, A. S., & Holman, A. (2011). Social representations of female-male beauty and aesthetic surgery: a cross-cultural analysis. *Temas em Psicologia, 19*(1), 75-98.

[http://pepsic.bvsalud.org/scielo.php?script=sci\\_arttext&pid=S1413-389X2011000100007](http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-389X2011000100007)

***What if I have questions later?***

If you have any remaining concerns, questions, or comments about this questionnaire, please feel free to contact:

Shamim Razaghi Kashani. Lilian Negura

(Social Science, Social Work, uOttawa) (Social Science, Social Work, uOttawa)

If I have any questions about the study, I may contact the researcher or their supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email ([ethics@uottawa.ca](mailto:ethics@uottawa.ca)) or telephone (613-562-5387).

***Is there anything that I can do if I found this questionnaire to be emotionally upsetting?***

If you feel any distress or anxiety during/after participating in this study, please feel free to contact the following resources based on your living area:

**Hotline Resources**

The UOttawa Student Health and Wellness Centre: 613-562-5498

The Distress Centre of Ottawa and Region: 613-238-3311

Mental Health Helpline-Ontario: 1-866-531-2600

Canadian Association for Family Services: 1-866-637-7226

Youth Services Bureau-Ontario: 1-877-377-7775

Kids Help Phone: 1-800-668-6868

Info-Social 811-Quebec: 811

Mental Health Helpline-Alberta: 1-877-303-2642

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Nova Scotia Mental Health and Addictions Crisis Line: 1-888-429-8167

Health and Community Services- Saskatchewan: 811

Crisis Services Canada for Suicide Prevention and Support-Canada Wide: 1-833-456-4566

### **Other Resources**

1-www.canped.ca

To support for those caring for a youth with an eating disorder which is located in Ottawa at the Children's Hospital of Eastern Ontario and they are treating children and adolescents with eating disorder. This website provide videos for the adolescents, children and their parents. For seeking

help and get an appointment email them at [canped@cheo.on.ca](mailto:canped@cheo.on.ca), or call at (613) 737-7600 ext 3803.

2-The National Eating Disorder Information Centre (NEDIC, [www.nedic.ca](http://www.nedic.ca))

NEDIC provides information, resources, referrals and support to Canadians affected by eating disorders.

Phone (1-866-NEDIC-20 and 416-340-4156), email ([nedic@uhn.ca](mailto:nedic@uhn.ca)), and live chat services are available:

9am – 9pm Monday – Thursday

9am – 5pm on Friday

12 – 5pm on Saturday and Sunday

Note: all times EST.

3- Operational Stress Injury Resource for Caregivers

<https://www.theroyal.ca/patient-care-information/clinics-services-programs/operational-stress-injury-clinic>

It provides support and care for people with operational stress injury which include posttraumatic stress disorder (PTSD). Also, it cares of people with anxiety, depression, and substance use. It is located in Ottawa. The Operational Stress Injury Resource for Caregivers and The Mind's the matter provides OSI education for family members and friends of people living with OSIs as well as self-care tools to support them in the role as caregiver.

Call at +1 (613) 345-1461 for getting help or appointment.

4- Von Canada, [www.von.ca](http://www.von.ca)

They provide home care and public health over across the Ontario and Nova Scotia.

For joining their programs and getting help, they provided a form in their website and by filling it out, they will reach you out soon. Or you can call them:

VON | National Office

2315 Saint Laurent Blvd Suite 100

Ottawa, Ontario

T: 613-233-5694

E: [communications@von.ca](mailto:communications@von.ca)

5- Mental Health Commission of Canada

[www.mhcc.ca](http://www.mhcc.ca)

6- Early Psychosis Intervention

[www.earlypsychosis.ca](http://www.earlypsychosis.ca)

7- Canadian Mental Health Association (CMHA)

[www.cmha.ca](http://www.cmha.ca)

The ones who are seeking help, will be able to contact the association or by clicking on the link, they will be able to find the Get Help and they can get an appointment or get help online 24 hours.

**Ottawa Branch:** 311 McArthur Avenue 2nd floor Ottawa, K1L 8M3 Ontario, Canada

**Phone:** 613-737-7791. **Fax:** 613-737-7644. **Email:** [general@cmhaottawa.ca](mailto:general@cmhaottawa.ca)

**Champlain East Branch:** 329 Pitt Street Cornwall, K6J 3R1 Ontario, Canada

**Phone:** 613-933-5845. **Fax:** 613-936- **Email:** [office@cmha-east.on.ca](mailto:office@cmha-east.on.ca)

8- Canadian Psychological Association

[www.cpa.ca](http://www.cpa.ca)

9-Kids Help Phone

[www.kidshelpphone.ca](http://www.kidshelpphone.ca)

By click on the issue you have, you will connect to lots of information and videos to how to cope with your problem. Also you will be able to call at any time: 1-800-668-6868

10- Self-Injury Outreach and support

[www.sioutreach.org](http://www.sioutreach.org)

11- Centre for Suicide Prevention, [www.suicideinfo.ca](http://www.suicideinfo.ca)

Is an education centre, a centre of excellence, based in Calgary, Alberta. We are a branch of the Canadian Mental Health Association. You can Sign up for their mailing lists to receive their

weekly news roundup, monthly research roundup, latest resources and organizational news and events. You can contact them in case you are seeking help for yourself or anyone who are in crisis: call 1-833-456-4566 or text 45645 or call 403-245-3900

12- CBT Online, [Moodgym.anu.edu.au](http://Moodgym.anu.edu.au)

is like an interactive self-help book which helps you to learn and practise skills which can help to prevent and manage symptoms of depression and anxiety.

You can email them at: [moodgym@ehubhealth.com](mailto:moodgym@ehubhealth.com)

**THANK YOU FOR YOUR PARTICIPATION!**

# Ethics Approval

01/08/2023

**Université d'Ottawa**  
Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**  
Office of Research Ethics and Integrity

## CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-10-22-8445
Titre du projet / Project Title	Social representation of body in individuals with body dysmorphic disorder like symptoms: The effects of social media and social groups in shaping social representation
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	01/08/2023
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	31/07/2024

### Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Shamim RAZAGHI KASHANI	École de service social / School of Social Work	Chercheur Principal / Principal Investigator
Lilian NEGURA	École de service social / School of Social Work	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

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[www.recherche.uottawa.ca/deontologie](http://www.recherche.uottawa.ca/deontologie) | [www.recherche.uottawa.ca/ethics](http://www.recherche.uottawa.ca/ethics)