Feeling good about your body: The role of self-compassion in supporting body appreciation amongst New Zealand adults

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Abstract

In Aotearoa New Zealand, there are concerning rates of eating disorders and normativity of body discontent (Tantleff-Dunn et al., 2011; Wells et al., 2006). Research has indicated that negative body image is, in part, a consequence of exposure to societal appearance ideals that impede self-worth (e.g., appearance contingent self-worth) and body-related threats (e.g., body comparison) that people are challenged with on a daily basis. While increasing positive body image has been a proposed mechanism for reducing symptoms of eating disorders (Piran & Tylka, 2019), no research has been conducted that examines positive body image and threats to positive body image among New Zealanders. Additionally, there is a research deficit regarding the factors involved in fostering and safeguarding positive body image in New Zealanders. One factor which is shown to be related to protecting positive body image from body-related threats is self-compassion, or the ability to be kind to oneself even amid times of difficulty and suffering.

Homan and Tylka (2015) investigated this phenomenon and found that self-compassion protected participants body appreciation from the threats of body comparison and appearance contingent self-worth. This study aimed to directly replicate Homan and Tylka's (2015) study by investigating whether self-compassion would moderate the relationships between body appreciation and (a) body comparison and (b) appearance contingent self-worth. Additionally, it aimed to examine the associations between self-compassion, body appreciation, body comparison and appearance contingent self-worth in a diverse sample of Aotearoa New Zealand adults. Participants (N = 206; mean age = 34.8, SD = 12.4) completed self-report measures of self-compassion, body appreciation, body comparison and appearance contingent self-worth online via Qualtrics. Pearson's product-moment correlation coefficient and two regression-based moderation analyses were conducted to investigate the relationships between the main study variables and to test self-compassion as a moderator.

Results indicated that body comparison and appearance contingent self-worth were negatively related to body appreciation and that self-compassion was positively associated with body appreciation. However, in contrast to Homan and Tylka's (2015) study, self-compassion did not moderate the negative relationship between body appreciation and body comparison and appearance contingent self-worth, such that self-compassion did not appear to protect participants body appreciation from the threats of body comparison and appearance contingent self-worth. These results underline the need for more research attention on positive body image and highlight self-compassion as an advantageous characteristic supporting positive body image among New Zealanders.

Keywords: body image, self-compassion, body appreciation, appearance contingent self-worth, body comparison, New Zealand.

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Table of Contents

Abstract 2

Acknowledgements 4

Abbreviations List 9

Chapter One: Introduction 11

Chapter Two: Literature Review 16

2.1 The Crisis of Eating Disorders 16
2.1.1 Eating Disorder Definition and Prevalence 16
2.1.2 Biopsychosocial and Financial Impact 17
2.1.3 Current Intervention 20
2.1.4 Current Prevention 24

2.2 Negative Body Image and its Relevance to the Development of Eating Disorders 28
2.2.1 Defining Body Image 28
2.2.2 Body Dissatisfaction 28
2.2.3 Appearance Contingent Self-Worth 30
2.2.4 Body Comparison 31

2.3 Promoting Positive Body Image 32
2.3.1 Defining Positive Body Image 32
2.3.2 Body Appreciation 32
2.3.2 The Potential Role of Self-Compassion 34

2.4 Importance of Replication Studies and the Present Study Hypotheses 38

Chapter Three: Methodology 41

3.1 Research Design 41

3.2 Ethics 41

3.3 Participants 43

3.4 Data Collection Procedure 46

3.5 Measures 47

3.6 Data Analysis Procedure 53

Chapter Four: Results 55

4.1 Data Cleaning 55

4.2 Internal Consistency 55

4.3 Descriptive Statistics 56

4.4 Associations Between Body Comparison, Appearance Contingent Self-Worth, and Body Appreciation (H1) 57

4.5 Association Between Self-Compassion and Body Appreciation (H2) 57

4.6 Moderation Analyses 58

4.7 Moderation Analyses of Self-Compassion on the Relationship Between Body Comparison and Body Appreciation (H3) 58

4.8 Moderation Analyses of Self-Compassion on the Relationship Between Appearance Contingent Self-Worth and Body Appreciation (H4) 60
Chapter Five: Discussion 62
5.1 Levels of Self-Compassion, Body Appreciation, Body Comparison and Appearance Contingent Self-Worth 63
5.2 Main Findings Concerning Positive Body Image and Self-Compassion 65
5.3 Study Limitations and Directions for Future Research 69
Chapter Six: Conclusion 74
References 76
Appendices 121
Appendix A: Information Sheet 121
Appendix B: Survey/Questionnaire 124
Appendix C: Approval of Ethics 129
Appendix D: General Flyer 130
Appendix E: Gender-Diverse Flyer 131
Appendix F: Letter to Organisation 132

List of Tables

Table 1. Demographic Characteristics of the Sample……..45
Table 2. Means, Standard Deviations, Minimum and Maximum Scores of Variables of Interest……..56
Table 3. Inter-Correlations of Variables of Interest…….58
Table 4. Regression Analyses Predicting Body Appreciation from Body Comparison and Appearance Contingent Self-Worth with Self-Compassion as the Moderator……60

List of Figures

Figure 1. Theoretical Display of Body Comparison and Appearance Contingent Self-Worth Predicting Body Appreciation and Self-Compassion as a Moderator and Age as a Covariate……..40

Abbreviations List

ACSW	Appearance Contingent Self-Worth
ACT	Acceptance and Commitment Therapy
AN	Anorexia Nervosa
A/NZ	Aotearoa New Zealand
ARFID	Avoidant/Restrictive Food Intake Disorder
BAS	Body Appreciation Scale
BAS-2	Body Appreciation Scale-2
BCO	Body Comparison Orientation
BD	Body Dissatisfaction
BED	Binge Eating Disorder
BEECOM	Body, Eating, and Exercise Comparison Orientation Measure
BMI	Body Mass Index
BN	Bulimia Nervosa
CBT	Cognitive-Behavioural Therapy
CBT-E	Cognitive Behaviour Therapy-Enhanced
CD	Cognitive Dissonance
CFT	Compassion-Focused Therapy
CSWS	Contingencies of Self-Worth Scale
DBI	Dissonance-Based Intervention
DBT	Dialectical Behavioural Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
ED	Eating Disorder

EDNOS	Eating Disorder Not Otherwise Specified
FBT	Family-Based Therapy
ICD-11	International Classification of Diseases, Revision 11
IPT	Interpersonal Therapy
MBIs	Mindfulness-Based Interventions
ML	Media Literacy
OSFED	Other Specified Feeding and Eating Disorder
RCT	Randomised Controlled Trials
SCS	Self-Compassion Scale
SCS-SF	Self-Compassion-Short Form
SMR	Standardised Mortality Ratio
US	United States
USFED	Unspecified Feeding and Eating Disorder

Chapter One: Introduction

Eating disorders (EDs) are a significant global health problem (Erskine et al., 2016). EDs and their subclinical variants are severe health conditions causing substantial disease burden (Erskine et al., 2016). In addition to their complex array of physical complications and significant comorbidity with other psychiatric disorders, EDs have a considerable negative medical, psychological, social, and financial impact on individuals and their whānau (family) (Butterfly Foundation, 2012; Hay et al., 2014; Treasure et al., 2020). Alarmingly, research indicates that in 2017 the highest burden of eating disorders in the world was observed in Australasia, which had the highest age-standardised prevalence (807.13 per 100,000 population) and disability-adjusted life years rates (a summary health measure combining mortality and morbidity into a single measure to determine global disease burden: Chen et al., 2015) (170.74 per 100,000 population) compared to high-income Asia Pacific, Central Asia, East Asia, South Asia, Southeast Asia, Caribbean, Central Europe, Eastern Europe, Western Europe, Andean Latin America, Central Latin America, Southern Latin America, Tropical Latin America, North Africa and Middle East, High-income North America and Sub-Saharan Africa (Wu et al., 2020). Furthermore, research has highlighted that since the COVID-19 pandemic, the prevalence and severity of eating disorders has increased globally and among the Aotearoa New Zealand (A/NZ) population. Indeed, mainstream media in NZ have dubbed the increased need for clinical services a “crisis” or “tsunami” (Hansen et al., 2021; Leask, 2021; Marsh, 2021; Strongman, 2021; Wilkinson, 2020).

Sociocultural theorists suggest that the development and maintenance of disordered eating and EDs, in part, can be attributed to sociocultural factors, which play a vital role in the generation and elevation of body dissatisfaction (Pennesi & Wade, 2016; Yamamiya et al., 2008). Indeed, body dissatisfaction has been found empirically to be a vital factor in both the development and maintenance of various disordered eating behaviours and clinical diagnoses of EDs (Cafri et al., 2005; Jung & Forbes, 2006; Leit et al., 2002; Litt & Dodge, 2008; McGuinness & Taylor, 2016;

Midlarsky & Nitzburg, 2008; Slevec & Tiggemann, 2011; Stice, 2002; Stice et al., 2011; Tylka, 2011). Additionally, individuals who base their global self-evaluation on whether they match cultural norms for physical attractiveness (dubbed appearance contingent self-worth) and those that engage in social body comparisons tend to be less content with their appearance and are at greater risk of developing an eating or body image disorder (Arigo et al., 2014; Arroyo, 2014; Cattarin et al., 2000; Leahey et al., 2011; Overstreet & Quinn, 2012; Phillips et al., 2011; Sanchez & Kwang, 2007). While there has been significant attention on identifying risk factors for negative body image, there is a gap in research examining factors that may be linked with cultivating and protecting positive body image (Grogan, 2016). Additionally, there is a dearth of literature detailing strength-based psychological prevention interventions for fostering a positive body image. Understanding mechanisms underlying the development of positive body image is critical to being able to shift negative cultural messaging concerning body image.

Over the last decade, researchers have increasingly recognised the value of understanding and endorsing positive body image (Frisén & Holmqvist, 2010; Tylka, 2011; Wood-Barcalow et al., 2010). Body appreciation, one of the most comprehensively studied aspects of positive body image, is defined as (a) positive attitudes toward one's own body irrespective of its appearance, (b) accepting one's body along with its imperfections and discrepancies from societal appearance standards, (c) respecting one's body by taking care of its needs and adopting healthy behaviours, and (d) disregarding unrealistic media appearance standards to protect one's body (Avalos et al., 2005). An expanding corpus of studies have revealed that body appreciation is positively related to self-esteem (Atari, 2016; Avalos et al., 2005; Cotter et al., 2015; Gillen, 2015; Lemoine et al., 2018; Swami et al., 2017; Tylka & Wood-Barcalow, 2015b), life satisfaction (Atari, 2016; Swami et al., 2017), optimism (Avalos et al., 2005), proactive coping[1] (Avalos et al., 2005; Tylka & Wood-

[1] Proactive coping refers to actions taken to develop tools that facilitate promotion toward difficult goals and personal development.

Barcalow, 2015b), appearance satisfaction (Cotter et al., 2015), intuitive eating (Iannantuono & Tylka, 2012; Lemoine et al., 2018; Tylka & Wood-Barcalow, 2015b), psychological well-being (Lemoine et al., 2018), appearance evaluation (Swami et al., 2017; Tylka & Wood-Barcalow, 2015b), body areas satisfaction (Swami et al., 2017) and negatively related to body surveillance (Avalos et al., 2005; Tylka & Wood-Barcalow, 2015b), body shame (Avalos et al., 2005), body preoccupation (Avalos et al., 2005), body dissatisfaction (Avalos et al., 2005; Tylka & Wood-Barcalow, 2015b), eating disorder symptoms (Avalos et al., 2005; Cotter et al., 2015; Tylka & Wood-Barcalow, 2015b), unhealthy eating behaviour (Gillen, 2015), depression (Gillen, 2015; Iannantuono & Tylka, 2012; Rawana et al., 2016), drive for muscularity (Gillen, 2015; Rawana et al., 2016), emotional eating (Rawana et al., 2016, restrained eating (Rawana et al., 2016), internalisation of media appearance ideals (Tylka & Wood-Barcalow, 2015b).

Additionally, experimental studies have demonstrated that body appreciation protects against body dissatisfaction (Andrew et al., 2015; Halliwell, 2013). Other studies detail the protective role of body appreciation toward the development and maintenance of positive body image, even amid the sociocultural threats that men and women so frequently experience (Maher et al., 2021; Tylka & Piran, 2019).

Another factor that has been linked with an increase in positive body image is self-compassion. Self-compassion encompasses expressing compassion and empathy toward oneself during difficult times or instances of suffering and extends to all instances of suffering, even those caused by perceived personal inadequacies, failures, flaws and life events that are emotionally distressing (Neff, 2011). Research has demonstrated self-compassion to be an advantageous characteristic with links to healthier body image, including higher body appreciation (Homan & Tylka, 2015), body image flexibility (Kelly et al., 2014), and body satisfaction (Pullmer et al., 2019) and lower disordered eating (Breines et al., 2014), body shame (Breines et al., 2014), body

surveillance (Daye et al., 2014), social physique anxiety (Magnus et al., 2010; Mosewich et al., 2011), psychological distress (Pullmer et al., 2019), and eating pathology (Pullmer et al., 2019).

Furthermore, self-compassion, as opposed to other intrinsic protective factors, is remarkable as research has found self-compassion can be taught and developed through mindfulness and self-compassion-based training making it a good candidate for intervention (Germer & Neff, 2019). In the literature, self-compassion has repeatedly been acknowledged as a psychological quality that can be strengthened over time to help people respect and appreciate their bodies even during the most trying circumstances. (Kelly et al., 2019; Maher et al., 2021; Vimalakanthan et al., 2018).

Even though self-compassion has emerged as a useful and valuable construct, only a small number of studies have been conducted within the A/NZ population, and those that have focussed exclusively on cisgender women (de Wet et al., 2020; Mifsud et al., 2021). Furthermore, no research has explored New Zealanders' levels of self-compassion, body appreciation, body comparison and appearance contingent self-worth and their relations to one another.

Thus, the primary aim of the present study was to investigate the relationships between self-compassion, body appreciation, body comparison and appearance contingent self-worth in a sample of New Zealanders that is diverse in gender (including all genders). It was hypothesised that (a) body comparison and appearance contingent self-worth would be negatively related to body appreciation, (b) self-compassion would be positively associated with body appreciation, and (c) self-compassion would moderate the negative relationship between body appreciation and (i) body comparison and (ii) appearance contingent self-worth, such that high levels of self-compassion would be linked with high levels of body appreciation and lower levels of body comparison and appearance contingent self-worth.

To assess these hypotheses, 206 New Zealand adults (aged 18 and over) completed an anonymous survey online via Qualtrics, that included demographic questions (i.e., age, gender, sexual orientation, ethnicity) and measures of body appreciation, (measured by the Body

Appreciation Scale-2; Tylka & Wood-Barcalow, 2015b), body comparison (measured by the Body, Eating, and Exercise Comparison Orientation Measure; Fitzsimmons-Craft et al., 2012), self-compassion (measured by the Self-Compassion Scale-Short Form; Raes et al. 2011), and appearance contingent self-worth (measured by the Contingencies of Self-Worth Scale; Crocker et al., 2003).

The remaining portions of the thesis will be organised as follows. Relevant literature and hypotheses for the present study will be reviewed in detail in Chapter 2. Chapter 3 will discuss the methodology that the present study employed, including research design, ethical considerations and process, participants' characteristics, data collection procedure, measures used and data analysis procedure. In Chapter 4, the study's results will be presented, and in Chapter 5, a discussion of the findings will be presented, including contextualising findings in light of previous research, accentuating study limitations, and identifying directions for future research. Lastly, Chapter 6 will conclude by highlighting the central findings and their ramifications for New Zealanders.

Chapter Two: Literature Review

2.1 The Crisis of Eating Disorders

2.1.1 Eating Disorder Definition and Prevalence

Eating disorders (EDs) represent a group of severe complex psychiatric disorders characterised by considerable disturbances in eating or eating-related behaviours (e.g., self-inflicted vomiting, restrictive eating, incorrect use of laxatives and diuretics, binge eating, purging, fasting), as well as disturbances in body image (e.g., fear of gaining weight or becoming fat, body dissatisfaction, overvaluation of shape and weight) that have a profound impact on the quality of life and social functioning of the individual (American Psychiatric Association [APA], 2013; Bulik et al., 2022; Klump et al., 2009). The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) recognises several distinct ED diagnoses, including anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding and eating disorder (APA, 2013). Anorexia nervosa is characterised by a significant fear of gaining weight or becoming fat, as well as the use of highly restrictive eating behaviours to assist in gaining a significantly low body weight (APA, 2013). Bulimia nervosa features numerous episodes of binge eating accompanied by compensatory behaviours, such as fasting, restrictive eating, misuse of laxatives or diuretics, excessive exercise and purging (APA, 2013). Binge eating disorder is similar to bulimia nervosa; however, it does not feature compensatory behaviours, and other specified feeding and eating disorder comprises low-frequency bulimia nervosa and binge eating disorder, atypical anorexia nervosa, night eating syndrome and purging disorder (APA, 2013).

The A/NZ population has similar lifetime and 12-month EDs prevalence rates to other Western high-income countries including Germany, US, and six other European countries, with prevalence rates of 1.7% and 0.5% reported in the A/NZ population and 1.69% and 0.72% reported in the Western high-income countries (Wells et al., 2006; Qian et al., 2021). Importantly, transgender and gender diverse individuals show even higher rates of EDs, with estimates ranging

from 2% to 18% (Coelho et al., 2019). Alarmingly, approximately 80% of individuals with EDs go undetected and never receive treatment (American Psychiatric Nurses Association, 2022).

2.1.2 Biopsychosocial and Financial Impact

EDs and their subclinical variants are severe health conditions causing substantial disease burden (Erskine et al., 2016). In conjunction with the considerable negative medical, psychological, social, and financial impact of EDs on individuals and their whānau (family), EDs are also significantly comorbid with other psychiatric conditions and a complex array of physical complications (Butterfly Foundation, 2012; Hay et al., 2014; Treasure et al., 2020).

EDs are frequently comorbid with other psychiatric conditions, with 83.7% of individuals with an anorexia nervosa diagnosis, 94.4% with a bulimia nervosa diagnosis, and 93.8% with a binge eating disorder diagnosis also meeting DSM-5 criteria for at least one other psychiatric diagnosis (Milos et al., 2003; Udo & Grilo, 2019). Additionally, over half of individuals with an ED diagnosis also meet DSM criteria for two additional psychiatric diagnoses (Spindler & Milos, 2007). EDs are most frequently comorbid with mood disorders such as major depressive disorder, anxiety disorders such as generalised anxiety disorder and social anxiety disorder, impulse control disorders, substance use disorders, and post-traumatic stress disorder (Agras, 2001; Udo & Grilo, 2019). Depression and anxiety have the highest comorbidity rates with EDs, with 40.5-59% of individuals with an ED also meeting criteria for a lifetime mood disorder and 54.2-79.6% meeting criteria for a lifetime anxiety disorder (Hudson et al., 2007; Udo & Grilo, 2019).

In addition to psychiatric comorbidities, EDs cause significant short and long-term physical health consequences, including cardiovascular abnormalities (Sachs et al., 2016), several gastrointestinal disturbances (Sato & Fukudo, 2015), micronutrient deficiencies (Hanachi et al., 2019), issues with bone density (Robinson et al., 2016),fluid and electrolyte abnormalities, dental and dermatological issues, and among females menstrual and fertility problems, osteoporosis and

osteopenia, and vitamin and trace element deficiency (Gravina et al., 2018; Mitchell & Crow, 2006).

Given the several physical health consequences of EDs in combination with their heightened comorbidity with psychiatric conditions like depression, it is unsurprising that mortality among ED patients is a significant area of concern. Mortality, particularly among adult patients treated for anorexia nervosa, is considerably higher than other serious psychiatric disorders, including schizophrenia, depression, and bipolar disorder (Arcelus et al., 2011; Jáuregui-Garrido & Jáuregui-Lobera, 2012). The standardised mortality ratio (SMR) can be determined by dividing the number of deaths observed by the number of expected deaths and is primarily used to indicate whether a specific population are more, less or equally as likely to die than a reference population (Fichter & Quadflieg, 2016; Liddell, 1984). An SMR greater than 1.0 indicates that there were more than expected deaths in the study population (excess mortality) (Fichter & Quadflieg, 2016). The literature indicates that the SMRs are 5.35 for anorexia nervosa, 1.49 for bulimia nervosa, 1.50 for binge eating disorder, 2.39 for narrowly defined eating disorders not otherwise specified[2] and 1.70 for widely defined eating disorders not otherwise specified. This finding highlights and accentuates the severity concerning mortality for all EDs, especially with conditions like anorexia nervosa where mortality is more than five times higher than the mortality in the general population (Fichter & Quadflieg, 2016).

Given the chronic and complex nature of EDs, ED treatment and management can be very expensive for the patient and/or their family (Agras, 2001). Indeed, in Ontario, Canada, in 2012, total direct costs of eating disorders were just under $63 million (approximately NZ$78 million), with annual net costs per patient ranging from $6,340 to $17,961 (approximately NZ$7,477 to $21,184) (de Oliveira et al., 2017). Similarly, in the US in the fiscal year 2018-2019, total economic

[2] Eating disorders not otherwise specified (sometimes referred to as ED-NOS) is the old DSM-IV-TR name for other specified feeding or eating disorder/unspecified feeding or eating disorder.

costs associated with eating disorders were estimated to be $64.7 billion (approximately NZ$102.7 billion), which is equivalent to $11,808 (approximately NZ$18,749) per affected person, much like what has been found in Ontario Canada (Streatfeild et al., 2021). Additionally, the substantial reduction in well-being associated with eating disorders was valued at 326.5 billion (approximately NZ$516.9 billion), which brought the estimated combined costs in the fiscal year 2018-2019 to nearly 400 billion (approximately NZ$634.3 billion) (Streatfeild et al., 2021).

Although there is a scarcity of A/NZ research on the financial burden of EDs, one study investigating the psychosocial and financial impacts on carers of those with EDs in A/NZ found that carers reported a reduction in annual income ranging from NZ$200 to $141,950 (Surgenor et al., 2022). Forty-five percent of participants reported paying for private treatment for their affected individual, with the median cost being NZ$4,000 but going as high as $30,000 (Surgenor et al., 2022). Additionally, 12.4% of respondents reported that they had to access finance or sell assets to pay for treatment for their affected individual, with 9.1% of carers needing to access over NZ$10,000 (Surgenor et al., 2022). These findings elucidate the financial burden and the pervasive burden of care in A/NZ for individuals taking care of those with EDs.

Alongside the financial burden of EDs, the individual and family also experience vast social and occupational consequences. Indeed, both the DSM-5 and the International Classification of Diseases, Revision 11 (ICD-11) describe a link between ED and dysfunction across several domains such as occupation, interpersonal relationships and social and professional activities (APA, 2013; World Health Organisation [WHO], 2019). Indeed, research has indicated links between EDs and dysfunctions in these domains of functioning (Berkman et al., 2007; Clark & Nayar, 2012; Hudson et al., 2007; Jacobi et al., 2004; Kessler et al., 2013; Lee et al., 2021; Quiles-Cestari & Ribeiro, 2012; Streatfeild et al., 2021; Sy et al., 2013; Tchanturia et al., 2013).

Issues with social and occupational performance in EDs are widespread, affecting every aspect of daily life, including meal preparation, shopping, meeting deadlines for work or school,

and controlling challenging emotions when interacting with friends and family (Gardiner & Brown, 2010; Reiss & Johnson-Sabine, 1995).

2.1.3 Current Intervention

Although there are numerous therapies and levels of care available, managing EDs is intricate since patients are sometimes difficult to engage, outcomes are frequently subpar, even in those who do agree to begin treatment and they often involve multiple healthcare disciplines (Mitchell & Peterson, 2020; Monteleone et al., 2019; Treasure et al., 2020). Additionally, the effectiveness of ED treatments in several populations, including men, racial/ethnic minorities, overweight people, and LGBTQ+ people, has been remarkably understudied. Studies on the effectiveness of ED treatment almost always use heterosexual White cisgender women as samples (Burnette et al., 2022). Only a few studies exist on ED treatment for men, and despite evidence indicating that sexual minority populations (e.g., gay and bisexual people) are at disproportionate risk of developing EDs, research on treatment outcomes for this population has been relatively non-existent up until the last 5-6 years (Calzo et al., 2017; Donahue et al., 2020; Mensinger et al., 2020; Quadflieg et al., 2019; Strobel et al., 2019). Therefore current evidence in effective interventions for ED treatment outcomes may not fully apply to these populations.

Outpatient treatment is considered to be the first line of treatment for EDs, as it is less expensive and disruptive compared to more intensive forms of care/treatment (Hay et al., 2014). Outpatient treatment involves individual psychotherapy for adults and family-based psychotherapy for adolescents. Hospitalisation is only considered and recommended for ED patients when they present imminent risk of severe medical complications and/or psychological compromise, while residential and day treatment may be recommended to ED patients that are not responding effectively to well-conducted outpatient treatments (Hay et al., 2014).

There are several empirically supported individual psychotherapies for individuals with EDs (Hay et al., 2014). Among these, cognitive behavioural therapy-enhanced (CBT-E) is the only

treatment that is suitable for all presentations of EDs (Atwood & Friedman, 2020). The goal of CBT-E, a more structured, manual-based variation of cognitive behavioural therapy for eating disorders, is to interfere with the cognitive-behavioural mechanisms that uphold the psychopathology of an eating disorder (Fairburn, 2008; Fairburn et al., 2003). Randomised control trials (RCT) are employed to assess the effectiveness of CBT-E for various EDs. Indeed, 143 patients with a diagnosis of either AN, BN, BED, and OSFED were randomly assigned to receive either CBT-E or treatment and usual (based on CBT principles). Results indicated that at 20 weeks the recovery rate of patients receiving CBT-E was significantly higher (57.7%) than of treatment as usual (36.0%) (Jong et al., 2020). Similarly, another RCT that instead compared CBT-E with interpersonal psychotherapy among a transdiagnostic sample found participants meeting criteria for remission was significantly higher among those receiving CBT-E (65.5%) compared to those receiving interpersonal psychotherapy (33.3%) (Fairburn et al., 2015). Additionally, a systematic review including 20 studies (10 RCTs and 10 uncontrolled trials) examined the efficacy and effectiveness of CBT-E for adults and adolescents with EDs and found support for CBT-E in reducing eating disorder behaviours and core psychopathology for all eating disorders as well as increases in body mass index for those with AN (Atwood & Friedman, 2020). CBT-E may also work to decrease starvation symptoms (Calugi et al., 2018a), reduce body-checking behaviours (Calugi et al., 2017) and body image concerns (Calugi et al., 2018b).

Although CBT-E can be applied transdiagnostically and has a strong empirical backing, treatment can differ based on the age of the patient and their diagnosis. For adults with AN, the psychotherapies with adequate efficacy in treating AN include CBT, focal psychodynamic psychotherapy, interpersonal therapy, Maudsley model of AN treatment for adults, and specialist supportive clinical management (Crone et al., 2023). A RCT comparing specialist supportive clinical management, Maudsley model of AN treatment for adults, and CBT-E among adults with AN found no significant differences between the three psychotherapies. All three psychotherapies

resulted in clinically significant improvements in eating disorder psychopathology, body mass index, and general psychopathology (Byrne et al., 2017). The long-term efficacy of CBT, interpersonal psychotherapy and specialist supportive clinical management among adults with AN was examined in a RCT which found no significant differences in global AN, physical, cognitive and behavioural eating disorder outcome measures, and global psychopathology among the three psychotherapies at the long term follow-up assessment (Carter et al., 2011). However, the authors concluded that one patient died and approximately half the sample had poor outcomes at long-term follow-up assessment and accentuated that there is a continued need to develop treatment approaches that will generate greater outcomes (Carter et al., 2011).

For adolescents and emerging adults with AN the most well-established and first line of treatment is family-based treatment, a manualised therapy derived from the Maudsley family therapy model that emphasises the effects of severe weight loss as being fundamental to the psychology of AN (Crone et al., 2023; Lock & Le Grange, 2013; Lock et al., 2001; Lock, 2015). A randomised clinical trial examining the relative efficacy of family-based treatment and adolescent-focused individual therapy randomly assigned 121 adolescents aged 12-18 years old with a diagnosis of AN to receive 24 outpatients hours of either family-based treatment or adolescent-focused individual therapy across 12 months (Lock et al., 2010). The authors found no differences in full remission between the two treatments at the end of therapy, however, family-based treatment was significantly superior to adolescent-focused individual therapy at the 6 and 12 months follow up in terms of remission (Lock et al., 2010). Additionally, changes in Eating Examination score at post-treatment was greater in family-based treatment participants than adolescent-focused individual therapy at the end of treatment, however, at follow up there were no significant differences (Lock et al., 2010). Compared to another family-based therapy systemic family therapy, FBT is associated with fewer hospitalisations of adolescents with AN (Lock et al., 2016) and has equivalent results in single- and multi-family contexts (Lock et al., 2015; Marzola et al., 2015).

Additionally, consecutive application of CBT-E and FBT with adolescents is linked to increased weight and decreased ED symptoms (Hurst & Zimmer-Gembeck, 2019). Acceptance-based separated family treatment, in which the therapist sees the adolescent and parents separately, has shown improvements in disordered eating symptoms and weight gain from the beginning to the end of treatment, demonstrating the value of offering both family and individual treatment modalities to adolescents with AN (Timko et al., 2015).

For adults with BN and BED, the first line of treatment is individual psychological therapy and among those CBT is the best established treatment, having been assigned a "grade of A" reflecting a strong empirical backing (Hay et al., 2014; National Institute for Clinical Excellence [NICE], 2004). Indeed, after 5 months of receiving 20 sessions of CBT 42% of adult patients with BN had stopped binge eating and purging which was markedly different compared to those patients receiving psychoanalytic psychotherapy where only 6% had stopped binging eating and purging (Poulsen et al., 2014). For BED, obese patients with a diagnosis of BED, after receiving 20 sessions of CBT 69.9% of patients reached clinically significant change at the end of treatment and greater improvements were made in the CBT group compared to the dialectical behaviour therapy (DBT) group in number of objective binge eating episodes, emotional dysregulation and self-esteem as well as 6 months after treatment in global eating disorder pathology and self-esteem (Lammers et al., 2021).

CBT-E (a more structured, manual-based variation of cognitive behavioural therapy) and integrated cognitive-affective therapy have also shown promise among adults with symptoms of BN. Adults with BN symptoms were randomly assigned to received 21 sessions over 19 weeks of either CBT-E or integrated cognitive-affective therapy. Both CBT-E and integrated cognitive-affective therapy were associated with reasonable improvements in BN symptoms, cognitive self-discrepancy, emotional regulation and co-morbid psychiatric symptoms (Wonderlich et al., 2014). For BED among adults, interpersonal therapy has demonstrated comparable results to CBT-E

(Miniati et al., 2018). For individuals that do not respond well to CBT-E, the Stanford model of DBT is efficacious (Ben-Porath et al., 2020). Group DBT has been demonstrated to be linked with reductions in binge eating but not improved mood (Blood et al., 2020). Additionally, acceptance and commitment therapy among individuals with excess weight and binge eating has been indicated to reduce the frequency of binge eating and depression, decrease global eating pathology, and improve quality of life (Juarascio et al., 2017).

For adolescents with BN, FBT is recommended (Crone et al., 2023). Indeed, 39% of adolescent patients aged 12 to 19 years old with a diagnosis of BN receiving twenty sessions of FBT over 6 months, at posttreatment were binge-and-purge abstinent (Le Grange et al., 2007). Additionally, FBT with adolescents, has been linked to lower binge eating and purging behaviours than CBT-E at 6 months (Le Grange et al., 2015). FBT with the incorporation of DBT has been demonstrated to be effective among adolescents in reducing objective binge episodes, self-induced vomiting, and general eating pathology (Murray et al., 2015), a finding that may be linked to DBT's focus on emotional regulation, as shifts in this area have been linked to long-term changes in disordered eating symptoms among an adult population (Brown et al., 2020). Despite BED's clinical importance, there is a scarcity of treatment studies (Hilbert et al., 2019; Marzilli et al., 2018). Preliminary studies provide support for IPT (Tanofsky-Kraff et al., 2007; Tanofsky-Kraff et al., 2010), and internet-facilitated CBT-Self-Help (Jones et al., 2008).

To summarise, although a number of psychological therapies/interventions have proven effective there are still lots of people with EDs that still don't get better, therefore, we need to think creatively about how to improve our interventions.

2.1.4 Current Prevention

Treatment for EDs — especially expert-facilitated, multifaceted treatment — is expensive (Lee & Hoodbhoy, 2013; Treasure et al., 2020) and unavailable/inaccessible for a lot of people (Moreno et al., 2023). Furthermore, it is improbable that there will be enough professionals with the

necessary advanced training to halt the significant flow of EDs with a detect-it/treat-it approach (Cooper & Bailey-Straebler, 2015). Because the peak period for the onset of EDs occurs between the ages of 16 and 19, prevention programmes that are delivered during early and mid-adolescence may be particularly effective for preventing eating disorders. If effective prevention programmes were widely implemented during this critical developmental period, it may be possible to lower the incidence of EDs in the general population (Hudson et al., 2007; Stice et al., 2013b).

ED prevention programs aim to lower ED risk factors in those with ED symptoms below the clinical threshold (i.e., so that individuals no longer meet diagnostic criteria for an ED; Stice et al., 2013a). Preventive programmes often attempt to either: (a) universally prevent symptoms from developing in healthy people (universal prevention), (b) selectively prevent symptoms from developing in people at risk (selective prevention), or (c) alleviate symptoms in people already exhibiting the signs of the targeted disease or behaviour (indicated prevention) (Gordon, 1983). According to meta-analytic research, selective ED prevention programmes produce superior post-intervention outcomes compared to universal prevention for reducing eating pathology, dieting, and negative affect, (Fingeret et al., 2006; Stice & Shaw, 2004).

The most empirically supported ED prevention programs are those that adopt dissonance-based interventions (DBI) and cognitive-behavioural therapy (CBT) (Beintner et al., 2012; Stice et al., 2013a). DBIs involve encouraging participants to actively argue against the media's "thin ideal" propagation (Stice et al., 2000). DBIs are informed by cognitive-dissonance theory, which suggests that individuals are believed to feel psychological discomfort due to the discrepancy between their pre-existing pro-thin-ideal beliefs and attitudes and the anti-thin-ideal behaviour displayed during the intervention. Participants shift away from the thin ideal to resolve this conflict, reducing distress associated with their body image and maladaptive eating behaviours (Stice et al., 2007). Reduced body dissatisfaction and less restrictive eating are linked to this shift in attitudes and beliefs (Stice et al., 2009).

The Body Project program, a dissonance-based prevention intervention, aims to reduce belief in and subscription to the thin-ideal and has been found over a 3-year follow-up to produce a statistically significant 60% reduction in DSM-5 ED onset when compared to an assessment-only control (Stice et al., 2008). However, a subsequent high school/college efficacy trial could not replicate this effect (Stice et al., 2015; Stice et al., 2011).

As previously discussed with regard to CBT/CBT-E for EDs, prevention programs based on CBT aim to restructure distorted thoughts concerning body shape and weight and break associations among maladaptive eating behaviours, negative emotions and distorted thoughts (Wilson et al., 2002). Indeed, a computer-based CBT prevention intervention, Student Bodies programme, has been demonstrated to reduce ED risk factors (such as concerns about weight and shape), the risk of ED onset in some high-risk groups, and ED symptoms (such as frequency of bingeing and purging) in females with subthreshold EDs (Beintner et al., 2012; Jacobi et al., 2012; Taylor et al., 2006).

A randomised controlled trial comparing internet dissonance-based intervention (DBI-I), internet cognitive-behavioural intervention (CBI-I), and no intervention (NI) among women found that DBI-I and CBI-I compared to NI were more effective in reducing body dissatisfaction, depression and thin-ideal internalisation, and CBI-I compared to NI was more effective in reducing eating pathology and dieting (Chithambo & Huey, 2017). Additionally, it was concluded that DBI-I and CBI-I were both effective in reducing eating disorder risk factors (Chithambo & Huey, 2017).

A recent systematic review and meta-analysis examined the effectiveness of ED universal, selective and indicated prevention interventions (Le et al., 2017). For universal prevention interventions, media literacy (helps individuals engaged in media to become active, diligent consumers as opposed to staying passive and obedient to the values and images that prevail the media; Brown, 1998; Potter, 2004) at post-interventions and 30-month follow up was found to be most effective in reducing shape and weight concerns and media internalisation for both females and males. This finding is congruous with earlier systematic reviews (Pratt & Woolfenden, 2002;

Watson et al., 2016). For selective prevention interventions, cognitive dissonance interventions were found to be more effective than controls in reducing ED behaviours and symptoms up to 3 years after the intervention, and more effective than other preventative interventions in reducing the thin-ideal internalisation post-test. Additionally, for selective prevention interventions, CBT interventions were found to be effective at post intervention and 9-month follow up in reducing ED risk factors including bulimic symptoms, dieting and body dissatisfaction. For indicated prevention interventions, no interventions were found to be effective in reducing ED risk factors (Le et al., 2017).

As reviewed above, the literature identifies several promising prevention interventions for ED risk factors, such as DBI, CD, CBT, and ML. However, the evidence for whether these genuinely reduce the incidence of diagnosable EDs is mixed. A meta-analytic review orchestrated by Stice et al. (2021) found that lifestyle modification and dissonance-based prevention programmes significantly decreased the future onset of EDs in several trials, resulting in a 54% to 77% reduction in future ED onset. This finding implies that if these prevention programs were implemented, they could reduce the population prevalence of EDs. Surprisingly, the meta-analytic review found no significant reduction in the future onset of EDs when prevention programs were psychoeducational, cognitive behavioural, behavioural weight gain, interpersonal, and family therapy based. These results suggest that all prevention programmes for EDs are not equal, and a substantial amount of research is needed to elucidate the mechanisms underlying the effectiveness of some programmes over others in reducing ED onset.

More research is also needed on whether preventative programmes for various sub-groups, such as various ethnic groups, different genders and individuals with varying sexual orientations, are equally helpful in preventing the onset of EDs in the future. Additionally, no prevention intervention included self-compassion and its principles, which could be an interesting component and addition to future research in this area.

2.2 Negative Body Image and its Relevance to the Development of Eating Disorders

2.2.1 Defining Body Image

Body image is a multidimensional construct that refers to how people experience their bodies, including thoughts, emotions and beliefs related to body function, appearance and integrity (Bucchianeri & Neumark-Sztainer, 2014). Body image research in psychology stemmed from clinical psychology and psychiatric work that had a prominent focus on eating disorders (Grogan, 2022). As a result, young women were the primary focus of a considerable amount of body image research until the 1980s (Grogan, 2022). Unfortunately, this created a narrative that body image research was only relevant to young females and that the construct itself only comprised weight and shape concerns. Today it is widely understood that body image is relevant to all ages and genders, and that the body image construct encapsulates more than just concern about one's shape or weight (Grogan, 2022). In the following paragraphs, I will review the current literature on positive and negative body image and their implication for health (Grogan, 2022).

2.2.2 Body Dissatisfaction

Body dissatisfaction (BD), an aspect of negative body image, is one of the most consistent and robust causal risk factors for disordered eating and, consequently, eating disorders (Agras, 2010; Dakanalis et al., 2014; Stice, 2002). BD can be defined as an individual's negative emotions and thoughts about their body, often involving a discrepancy between the individual's assessment of their actual/current body and their ideal body (Albertson et al., 2015; Grogan, 2022; Mayo & George, 2014).

BD has been recognised as a significant public health concern (Bucchianeri & Neumark-Sztainer, 2014), as it has been theoretically and empirically shown to be a vital factor in both the development and maintenance of various disordered eating behaviours (including fasting, dieting, restricting food intake, purging, binge eating and dieting) and clinical diagnoses of EDs such as AN and BN, and obsessive-compulsive and related disorders such as body dysmorphic disorder (muscle

dysmorphia) (Cafri et al., 2005; Jung & Forbes, 2006; Leit et al., 2002; Litt & Dodge, 2008; McGuinness & Taylor, 2016; Midlarsky & Nitzburg, 2008; Slevec & Tiggemann, 2011; Stice, 2002; Stice et al., 2011; Tylka, 2011). BD is also associated with high levels of anxiety and depression, poor and low self-esteem, lower quality of life, impairment in subjective and health-related quality of life, low levels of physical activity, obesity, smoking, and functional impairment in areas of the home, social relationships and occupation (Ganem et al., 2009; Grossbard et al., 2009; King et al., 2005; Loth et al., 2015; Mond & Hay, 2007; Mond et al., 2013; Szymanski & Henning, 2007: van den Berg et al., 2007).

Individuals of all ages can be dissatisfied with their bodies, indeed body dissatisfaction can begin to occur at ages before puberty (Tatangelo et al., 2016). According to the Tripartite Impact Model (Thompson et al., 1999), media, peers, and parents are the three sociocultural factors that have the biggest impact on how children develop body dissatisfaction. Indeed, parents verbal messages and modelling of body-related attitudes and behaviours have been found to be influential in constructing children's body image (Phares et al., 2004). The relationship between peer influence (Phares et al., 2004) and media images displaying body ideals (Groesz et al., 2002) and children's body dissatisfaction has also been demonstrated. Unfortunately, the presence of some extent of body discontent has become so prevalent that it is now normative among people in society (Frederick et al., 2007; Jones et al., 2016; Kaye et al., 2018; Ricciardelli & McCabe, 2011; Runfola et al., 2013; Tabaac et al., 2019; Tantleff-Dunn et al., 2011). Sociocultural theorists propose that the widespread presence of BD can be partially explained by a longing to conform to societally-imposed appearance ideals. These societal appearance standards are projected widely by the media, in which the ideal image of what people should look like or the majority look like is consistently displayed. Although societal appearance standards are constantly evolving, most are unattainable and unrealistic for the vast majority of people. Having said that, the pursuit of these societal ideals is still a common feature in many people's lives and thus can result in intense dissatisfaction with

one's body (Burch & Johnsen, 2020; Dahlenburg et al., 2020; Frederick et al., 2005; Federick et al., 2017; Grogan, 2022; Roberts & Muta, 2017; Seifert, 2005; Thompson et al., 1999).

2.2.3 Appearance Contingent Self-Worth

Those who base their global self-evaluation on whether they match cultural norms for physical attractiveness (sometimes termed 'appearance-contingent self-worth') spend a lot of time and effort trying to make themselves more physically attractive (Crocker et al., 2003). However, they are still less content with their appearance and may be more susceptible to developing an eating or body image disorder (Overstreet & Quinn, 2012; Phillips et al., 2011; Sanchez & Kwang, 2007). Overall, centring one's self-worth on one's physical appearance has detrimental effects on how people perceive and are satisfied with their appearance and how they perceive themselves as a whole (Crocker et al., 2004). Although many contingency domains are adversely related to self-esteem (Crocker & Luhtanen, 2003), an appearance-based contingency is one where this is particularly true. For example, research has indicated that appearance contingent self-worth is associated with low psychological well-being, fluctuating self-esteem, depression, and anxiety (Ching et al., 2021; Clabaugh et al., 2008; Breines et al., 2008).

In a community sample of adult women, appearance contingent self-worth was found to be linked to more body comparison and less body acceptance (Homan & Tylka, 2015). Several studies have also indicated that appearance contingent self-worth is positively correlated with body surveillance and body shame and negatively correlated with appearance esteem (Manago et al., 2015; Noser & Zeigler-Hill, 2014; Overstreet & Quinn, 2012). In addition to the direct relationships, there is evidence that in young adult women, appearance contingent self-worth moderates the links between anxiety and disordered eating and anxiety and dietary constraint (Bardone-Cone et al., 2013). More recently, researchers found that in young adult women, appearance-contingent self-worth impacted the relationship between perfectionism and disordered eating. According to their findings, the association between perfectionism and disordered eating

was much stronger when appearance-contingent self-worth was high than when it was low (Bardone-Cone et al., 2017). Furthermore, evidence has found appearance contingent self-worth to be one of the most salient predictors of negative body image and is associated with higher body dissatisfaction, eating disturbance and body surveillance (Bailey & Ricciardelli, 2010; Menon & Pant, 2015; Overstreet & Quinn, 2012). Although the literature is scarce on experimental studies relative to appearance contingent self-worth, one study found that across two experimental conditions, individuals with higher body weight-contingent self-worth demonstrated lower appearance self-esteem and body satisfaction than individuals with lower body weight-contingent self-worth (O'Driscoll & Jarry, 2015). All of these highlight why appearance contingent self-worth is a vital construct to target in interventions aimed at reducing negative body image.

2.2.4 Body Comparison

People frequently compare the appearance of their body with that of their peers and images in the media (Groesz et al., 2002; Jones, 2001; Karazsia & Crowther, 2009; Leahey & Crowther, 2008; Leahey et al., 2007a; Trottier et al., 2007). Body comparison entails evaluating one's appearance in relation to others' appearance and related characteristics and consists of two forms (Laker & Waller, 2020). Comparing oneself to someone perceived as less favourable is a downward comparison (typically enhancing self-esteem; Major et al., 1993) while an upward comparison happens when the object of comparison is thought to be better than oneself (providing the individual with a figure to aspire to, and lowering self-esteem over the long and short terms; Major et al., 1993; Schmuck et al., 2019) (Laker & Waller, 2020). Individuals are more likely to engage in upward comparison, typically associated with more adverse effects (Major et al., 1991) like eating pathology (Arigo et al., 2014) and body dissatisfaction (Arroyo, 2014; Cattarin et al., 2000; Leahey et al., 2011).

Experimental research on body comparison supports the idea that downward comparison produces positive outcomes, whereas upward comparison produces negative ones (Leahey et al.,

2007b; Van den Berg & Thompson, 2007). Consistent with the social comparison theory, an experimental study by Laker and Waller (2022) investigated the hypothesis that upward and downward appearance comparison will have negative and positive impacts on body image and self-esteem (Festinger, 1954). They found that upward comparison resulted in poorer body satisfaction and self-esteem, which helped provide causal evidence/conclusions about body comparison's effect, making body comparison another area for exploration.

2.3 Promoting Positive Body Image

2.3.1 Defining Positive Body Image

The concept of body image is commonly acknowledged to have many facets (Pruzinsky & Cash, 2002). However, negative body image has historically been the emphasis of body image research, with little attention paid to detecting, forecasting, and fostering a positive body image (Grogan, 2016). Recent conceptualizations that positive body image is multidimensional, protective, and disparate from negative body image have contributed to the study of positive body image gaining substantial traction (Tylka & Wood-Barcalow, 2015a). Positive body image is often understood to mean having love, confidence, respect, appreciation, and acceptance of one's abilities and physical appearance (Wood-Barcalow et al., 2010). There is a growing corpus of research supporting the notion that each aspect of positive body image (e.g., body appreciation) is interdependently associated to greater well-being and lower distress (Webb et al., 2015).

2.3.2 Body Appreciation

Body appreciation, one of the most comprehensively examined aspects of positive body image, is defined as encompassing: (a) positive/good opinions toward the body irrespective of its appearance, (b) accepting the body along with its imperfections and discrepancies from societal appearance standards, (c) respecting the body by taking care of its needs and adopting healthy behaviours, and (d) disregarding unrealistic media appearance standards in order to protect the body (Avalos et al., 2005). An expanding corpus of studies has revealed that body appreciation is

positively related to self-esteem (Atari, 2016; Avalos et al., 2005; Cotter et al., 2015; Gillen, 2015; Lemoine et al., 2018; Swami et al., 2017; Tylka & Wood-Barcalow, 2015b), life satisfaction (Atari, 2016; Swami et al., 2017), optimism (Avalos et al., 2005), proactive coping[3] (Avalos et al., 2005; Tylka & Wood-Barcalow, 2015b), appearance satisfaction (Cotter et al., 2015), intuitive eating (Iannantuono & Tylka, 2012; Lemoine et al., 2018; Tylka & Wood-Barcalow, 2015b), psychological well-being (Lemoine et al., 2018), appearance evaluation (Swami et al., 2017; Tylka & Wood-Barcalow, 2015b), body areas satisfaction (Swami et al., 2017) and negatively related to body surveillance (Avalos et al., 2005; Tylka & Wood-Barcalow, 2015b), body Shame (Avalos et al., 2005), body preoccupation (Avalos et al., 2005), body dissatisfaction (Avalos et al., 2005; Tylka & Wood-Barcalow, 2015b), eating disorder symptoms (Avalos et al., 2005; Cotter et al., 2015; Tylka & Wood-Barcalow, 2015b), unhealthy eating behaviour (Gillen, 2015), depression (Gillen, 2015; Iannantuono & Tylka, 2012; Rawana et al., 2016), drive for muscularity (Gillen, 2015; Rawana et al., 2016), emotional eating (Rawana et al., 2016, restrained eating (Rawana et al., 2016), internalisation of media appearance ideals (Tylka & Wood-Barcalow, 2015b).

The protective effect of body appreciation against body dissatisfaction has also been demonstrated in experimental studies. Indeed, an experimental study investigating the protective role of body appreciation among women from the effects of negative media exposure found that women who internalise the thin-ideal but also appreciate their bodies, after viewing models and control images placed little importance on appearance-discrepancies (Halliwell, 2013). Additionally, Andrew et al. (2015) similarly investigated the protective role of body appreciation among university women and found that women who were lower in body appreciation, after thin ideal exposure reported increased body dissatisfaction whereas women who were higher in body appreciation, after thin ideal exposure reported no change in body dissatisfaction.

[3] Proactive coping refers to actions taken to develop tools that facilitate promotion toward difficult goals and personal development.

2.3.2 The Potential Role of Self-Compassion

A large, ever-growing body of literature accentuates protective factors that may contribute toward the cultivation and protection of positive body image in the midst of sociocultural threats that men and women so frequently experience (Maher et al., 2021; Tylka & Piran, 2019). Self-compassion has been consistently recognised in the literature as a psychological trait that can be adopted and strengthened over time to help people to respect and appreciate their bodies even amid the most difficult of times (Kelly et al., 2019; Maher et al., 2021; Vimalakanthan et al., 2018). Self-compassion involves expressing compassion and empathy toward oneself during difficult times or instances of suffering (Neff, 2011). Self-compassion extends to all instances of suffering, even those that are caused by perceived personal inadequacies, failures, flaws and life events that are emotionally distressing (Neff, 2011).

Self-compassion is comprised of three essential components and their opposing subcomponents (Neff, 2011). The first component, self-kindness (vs self-judgement), entails cultivating a disposition to be kind, caring and understanding to oneself, instead of being overly judgemental and critical. Self-kindness involves the ability to turn inwards and comfort oneself during difficult times instead of enduring and bearing the tough time (Neff, 2011). The second component, common humanity (vs isolation), encompasses recognising that one's experiences of difficult times, mistakes and failures are a shared human experience, rather than isolating oneself when difficult times occur. The final component, mindfulness (vs overidentification), involves having an awareness of the present moment experience that is non-judgemental, balanced and clear as opposed to ruminating and ignoring things that one does not like about life or themselves (Neff, 2011). Being mindful allows people to take more of an objective perspective of their experience and helps prevent one from over-identifying with their shortcomings. Self-compassion is disparate conceptually from self-esteem; As self-esteem can sometimes hinder people from confronting their

flaws which can forestall their experience of distress and can elicit self-enhancing deceptions (Neff, 2009; Neff & Vonk, 2009).

An extensive and expanding body of literature provides evidence supporting self-compassion as an advantageous characteristic (Leary et al., 2007; Neff et al., 2005). Self-compassion has consistently demonstrated links with positive mental health (Bluth & Neff, 2018). People who are self-compassionate report lower rates of common psychopathologies (MacBeth & Gumley, 2012) such as anxiety (Ferreira et al., 2013), depression (Ferreira et al., 2013; Javidi et al., 2021), post-traumatic stress (Javidi et al., 2021) and greater positive wellbeing (Bluth & Blanton, 2015; Zessin et al., 2015).

Self-compassion has been indicated to be positively associated with life satisfaction (Bag et al., 2022; Barnard & Curry, 2011), emotional intelligence (Barnard & Curry, 2011; Heffernan et al., 2010), optimism (Bag et al., 2022; Barnard & Curry, 2011), positive affect (Bag et al., 2022; Barnard & Curry, 2011), wisdom (Barnard & Curry, 2011), mastery of goals (Babenko & Oswald, 2019), personal initiative (Barnard & Curry, 2011; Sharma & Davidson, 2015), curiosity (Sharma & Davidson, 2015), happiness (Barnard & Curry, 2011; Hollis-Walker & Colosimo, 2011), eudaimonic well-being (Ferguson et al., 2015) and resilience (Bag et al., 2022) and negatively associated with negative affect (Bag et al., 2022; Barnard & Curry, 2011; Neff et al., 2007), self-criticism (Leary et al., 2007; Neff et al., 2007), perfectionism (Adams et al., 2023), neuroticism (Muris et al., 2019), rumination (Neff et al., 2007) and stress (Bag et al., 2022).

Additionally, self-compassion has been connected to healthier body image, including higher body appreciation (Homan & Tylka, 2015), body image flexibility (Kelly et al., 2014), and body satisfaction (Pullmer et al., 2019) and lower disordered eating (Breines et al., 2014), body shame (Breines et al., 2014), body surveillance (Daye et al., 2014), social physique anxiety (Magnus et al., 2010; Mosewich et al., 2011), psychological distress (Pullmer et al., 2019), and eating pathology (Pullmer et al., 2019). These findings have also been replicated in experimental research. For

example, one study found that a community group of women allocated to a 3-week online self-compassion meditation training regime reported greater body appreciation and less body dissatisfaction and body shame relative to the waitlist control group (Albertson et al., 2015).

There is some corroboration that self-compassion may be a moderator[4] or buffer of the relationship between upsetting events and negative feelings toward the self (Leary et al., 2007). Indeed, women with lower levels of self-compassion compared to women with higher levels of self-compassion have been found to report a significantly stronger relationship between body-related shame and depressive symptoms whereas this relationship was not found in women with higher levels of self-compassion (Sick et al., 2020). Self-compassionate people, by definition, can respond in instances that challenge their personal adequacy in a kind and non-judgemental way, which can allow them to regulate and process negative emotions that may arise effectively (Leary et al., 2007; Neff, 2003). Experimental studies manipulating self-compassion have found that when contrasted with a control group not receiving a self-compassion intervention, self-compassion increases positive affect and decreases negative self-feelings (Leary et al., 2007). For example, a community and university sample of women were asked to reflect on a self-conscious moment that happened that day that was related to their body, eating or exercise habits (Barbeau et al., 2022). Those induced to write self-compassionately after thinking about this event post-treatment had decreased bulimic symptoms relative to the body-focused self-esteem group and control group (Barbeau et al., 2022).

Self-compassion has been frequently shown to regulate negative emotions (Callow et al., 2021; Miyagawa et al., 2018), which consequently means that it may be able to buffer individuals' from factors that elicit feelings of inadequacy and shame toward their bodies (Sick et al., 2020). For example, given that society frequently defines *attractiveness* as being muscular for men and thin for

[4] Moderators alter the direction or strength of the association between two variables, posing the question of "when or for whom" a specific relationship exists (Karazsia et al., 2013).

women (Grogan, 2022), the self-perception of being "overweight" is often associated with internalised weight stigma, shame, guilt and self-conscious emotions for women (Lucibello et al., 2021). For men, often the perceived failure to meet the muscular ideal can contribute toward a negative self-image, low self-esteem, low body satisfaction (Barlett et al., 2008), engagement in risky behaviours such as taking muscle-enhancing pills, steroids, excessive exercise or cosmetic surgery (Cafri et al., 2005), and muscle dysmorphia (Leone et al., 2005). Kelly et al. (2014) conducted research which indicated that among women, self-compassion weakened the positive relationship between eating pathology and BMI and the negative relationship between BMI and body image flexibility. The authors proposed that self-compassion served as a protective factor for women, as treating oneself with kindness and understanding helped to counteract the stigma and shame related to a higher BMI in a culture that idolises being thin. Another study found that self-compassion weakened the relationship between body fat dissatisfaction and men's internalisation of lean appearance ideals (Maher et al., 2021). These authors concluded that self-compassion could protect men from adverse body image outcomes and the sociocultural processes that contribute toward these outcomes.

This notion of self-compassion as a protective factor has also been supported substantially by a meta-analysis of 28 studies exploring the associations between self-compassion, disordered eating and body image (Braun et al., 2016). The authors found significant evidence for the protective role of self-compassion against negative body image and disordered eating outcomes. One cross-sectional, correlational study included in the meta-analysis found among a women sample that having a self-compassionate self-perspective may safeguard women's body appreciation even amid body-related threats that women are so frequently confronted with (Homan & Tylka, 2015). Additionally, Homan and Tylka (2015) found appearance contingent self-worth and body comparison to be negatively linked to body appreciation; however, this relationship was moderated by self-compassion. Since the publication of the meta-analysis, additional work by Schmidt et al.

(2019) found self-compassion to account for 39% of the variance in college women's overall body appreciation. A survey of 93 college-aged women found that higher levels of daily self-compassion positively predicted daily body appreciation (Kelly & Stephen, 2016).

Despite growing evidence for the protective role of self-compassion in the development of positive body image, there are some inconsistent findings in the literature depending on the instruments used to measure these constructs (Muris, 2016; Muris et al., 2016). For example, in adolescent girls, Rodgers et al. (2017) used the 3 SCS subscale measures self-kindness, common humanity and mindfulness as opposed to the full 26 item SCS (Neff, 2003) and found a relationship between perceived body size and appearance esteem (conceptually similar to body appreciation; Avalos et al., 2005; Mendelson et al., 2001), but this effect was not moderated by the components of self-compassion (self-kindness, common humanity and mindfulness). Similarly, although it should be interpreted with caution due to lack of power, Modica (2019) found in a sample of 232 adult women aged 20-72 years of age, that self-compassion did not moderate the relationship between social media appearance comparisons and appearance esteem. Given these inconsistent findings, it is imperative to determine when and for whom self-compassion serves as a protective factor for positive body image.

2.4 Importance of Replication Studies and the Present Study Hypotheses

Direct replication of the initial findings where the hypothesis was first proposed is one way to explain links between variables more clearly (Nosek & Errington, 2020). Replication studies are essential to the comprehension and credibility of psychological findings in general and are considered critical to the advancement of research (Zwaan et al., 2018; Martin & Clarke, 2017). Although replication is starting to spread throughout psychology as a whole, body image research needs to catch up (Makel et al., 2012; Zwaan et al., 2018). Replication research does not have a one-size-fits-all method, although specific guidelines have been established (Nosek & Errington, 2017; LeBel et al., 2019). In general, direct replications should replicate the original study’s

procedures and methodologies as precisely as feasible, and any methodological changes from the original protocol should be recorded and justified. Furthermore, replication studies are more credible and reputable when the original authors are not part of the research team (LeBel et al., 2019).

Homan and Tylka (2015) study utilised a cross-sectional, correlational design to examine the protective role of self-compassion on body appreciation amid two potential challenges to body appreciation that being body comparison and appearance contingent self-worth among 263 U.S women. The authors found that self-compassion moderated the negative relationships between body appreciation and appearance contingent self-worth and body comparison (Homan & Tylka, 2015).

Homan and Tylka's (2015) article has been cited widely in the body image literature, with 202 citations at the time of writing. It has been replicated in a larger and more diverse U.S sample of 363 women by Siegel et al. (2020), who found similar findings to the original article. However, to date, no one has examined these research questions in a non-North American context. This is important because A/NZ is a much smaller country than the U.S and A/NZ's history, traditions, culture and norms differ from the U.S. Consequently, in the current study, the researcher carried out a direct replication of Homan and Tylka's (2015) study with a more diverse sample in an A/NZ population to retest their original hypotheses. Based on Homan and Tylka's (2015) findings and the Siegel et al. (2020) replication, the following hypotheses are proposed:

Hypothesis 1 (H1). Body comparison and appearance contingent self-worth will be inversely related to body appreciation.

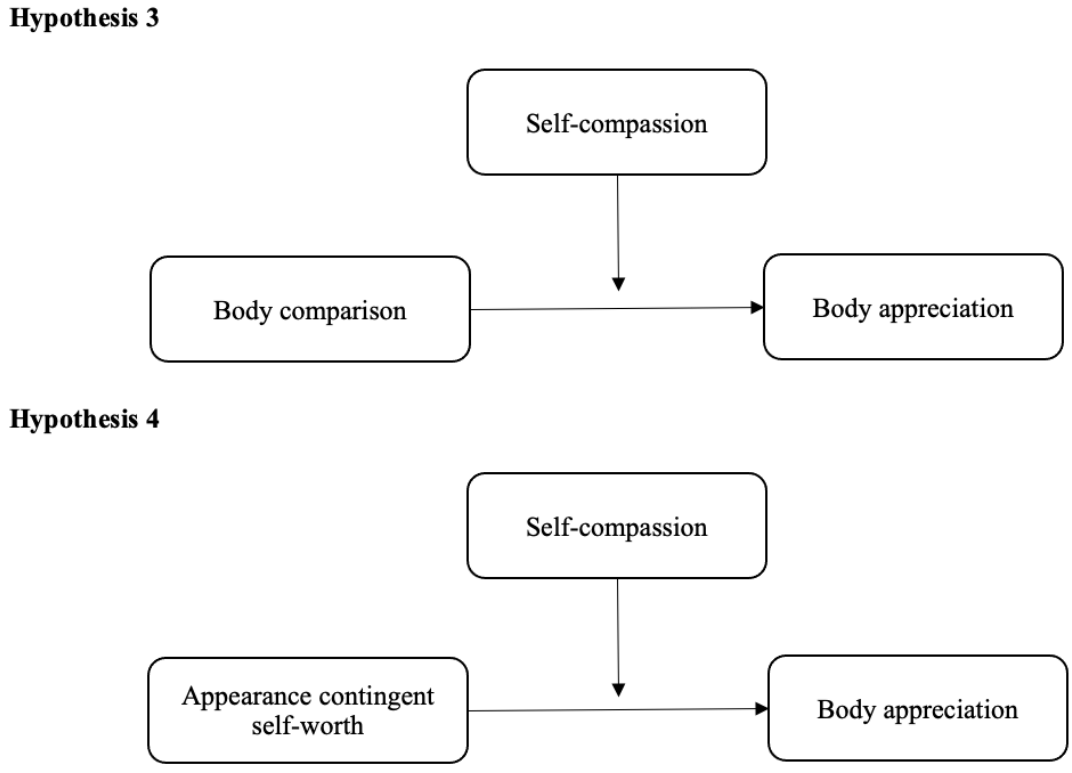
Hypothesis 2 (H2). Self-compassion will be positively associated with body appreciation.

Hypothesis 3 (H3) and 4 (H4). Self-compassion will moderate these relations by weakening the inverse associations between body comparison and body appreciation (H3), and appearance contingent self-worth and body appreciation (H4).

Additionally, given the aforementioned increased risk of body image disturbance amongst gender diverse people, the present study sought to oversample gender diverse participants in order to examine H1-4 in this population. In order to achieve this, we aimed to recruit equal numbers of cisgender and gender diverse participants and conduct separate analyses on these two groups.

Figure 1

Theoretical Display of Body Comparison and Appearance Contingent Self-Worth Predicting Body Appreciation and Self-Compassion as a Moderator and Age as a Covariate



Chapter Three: Methodology

3.1 Research Design

A quantitative cross-sectional survey design was employed in this study. Data was collected via an anonymous online Qualtrics survey from October 31st to December 1st, 2022 (a total of 32 days). The target sample was A/NZ adults aged 18 years and over. Inclusion criteria of the study was that participants must be over the age of 18 years old, living in A/NZ and fluent in English. Participants were excluded from the study if they did not meet the inclusion criteria. The survey included demographic questions as well as self-report measures of self-compassion, body appreciation, body comparison and appearance contingent self-worth.

The study used non-probability sampling. An *a priori* power analysis was conducted using G*Power software (version 3.1.9.7; Faul et al., 2009) to estimate the required sample size for a medium effect size (f2 = .15; Cohen, 1992) in a regression model with five predictors (allowing for the inclusion of covariates). Assuming an α of .05 and a target power of .95, we aimed to recruit a minimum of 138 participants. Additionally, given our exploratory hypothesis concerning gender diversity, we doubled this number, so we aimed to recruit 138 cisgender and 138 gender diverse participants.

3.2 Ethics

The ethical issues of the study were considered over numerous months. Foremost, before ethical approval was granted for the study, several peer review discussions and analyses of potential ethical issues were undertaken. The researcher discussed ethical issues they had identified with Dr. Ilana Seager van Dyk (supervisor of the study and an expert in rainbow research), Dr. Tatiana Tairi (research consultant for the study and an expert in self-compassion research), and Dr. Pita King (cultural consultant for the study and a Kaupapa Māori Lecturer). Several additional ethical issues were proposed by all individuals involved, and a thorough discussion of each issue established how they would be addressed in the study.

To guide in the researchers consideration of ethical concerns the researcher looked at the Massey University Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants.

Depriving potential participants the opportunity to make their own decision as to whether or not they want to participate and whether they want to answer particular survey questions was the first risk identified. Therefore, participant autonomy was addressed by allowing participants to freely decide whether they would like to participate as well as allowing them to choose not to respond to questions they did not want to and allowing them at any time to withdraw from the study. Another risk identified by the researcher was the potential harm that could occur from some of the survey questions as they could be personally meaningful to those participants whom may have experienced body-related challenges. Therefore, non-maleficence was managed by allowing participants to stop the survey at any time and providing all participants with a list of several free support options and their relevant contact details in the information sheet (see Appendix A) and at the end of the survey. It was also identified that there would be an ethical risk if the present study did not provide its information and findings to benefit those involved and future research. Therefore, beneficence was attended to by granting participants with the opportunity to be provided with a summary of the research findings at the end of the study and planning to publish the study in a publicly accessible, peer-reviewed journal in order to help inform future research and interventions. Additionally, organisations approached for participant recruitment were offered the opportunity for a webinar on the findings of the study so that communities with whom the study engaged could benefit from the findings. It was also determined that a potential ethical risk could be discrimination of particular groups. Therefore, justice was addressed by having no restrictions on participants' ethnicity or gender. Consent was managed by informing participants in the information sheet that completion of the survey implied consent. The first item of the survey asked participants to consent to the collection of their responses to the survey (see Appendix B).

One of the biggest potential risks for participants completing this survey is a breach of confidentiality especially for gender diverse participants as it may not be safe for them to be known as gender diverse so it was significantly important to ensure that those participants were safeguarded. This risk was addressed by protecting participants' identity through the utilisation of an anonymous survey. To maintain participants' confidentiality once the data was collected, data collection and storage were managed by securely collecting data in Qualtrics and storing data in password-protected files.

Given that this study was conducted in Aotearoa New Zealand, it was vital that the study design, implementation, and analytic plan met our obligations to Māori under Te Tiriti o Waitangi. Principles concerning the study were discussed and addressed during cultural consultation with Dr. Pita King, in which changes that needed to be made for the study to be more inviting to and inclusive of potential Māori participants were discussed. The researcher, accordingly, made adaptations to the study participant survey, information sheet and flyers. Adaptations included seeking advice from several Māori friends who helped the researcher adapt the study information sheet, survey and flyers by including te reo Māori and incorporating Māori symbols to increase the acceptability of the survey for Māori and to meet Te Tiriti o Waitangi obligations.

The study was approved by the Massey University Human Ethics Committee (Human Ethics Southern B Committee – SOB 22/47) on the 31st of October 2022 (see Appendix C).

3.3 Participants

Of the 258 participants who consented to undertake the survey, listwise deletions of 51 people were made because they had more than 95% missing data, and one participant was excluded due to not meeting inclusion criteria for age. In total, 206 A/NZ adults were included in the data analyses. Demographic characteristics are presented in Table 1. Participants were, on average, 34.8 years old (*SD* = 12.43), ranging from 18 to 75 years. In order to allow participants the opportunity to report how they would like to be described in the study, participants described their gender and

sexual orientation using open-response boxes in combination with questions asking participants to indicate whether they identify as cis- vs transgender, binary vs. nonbinary gender, and rainbow vs. heterosexual sexual orientation. Most participants in the current sample identified as cisgender (*n* = 183; 88.8%), binary (*n* = 178; 86.4%), and heterosexual/straight (*n* = 150; 72.8%). The majority of participants identified as female (*n* = 162; 78.6%). Over 80% of the current sample listed their ethnicity as New Zealand European (*n* = 170; 82.5%); however, several participants identified with more than one ethnicity (*n* = 30; 14.6%). Over 14% of participants indicated their ethnicity as Māori, just under 3% of participants labelled their ethnicity as Chinese, and roughly 9% of participants self-described their ethnicity due to their ethnicity not being listed, yielding representation from eighteen different ethnicities from the ethnicities listed.

Table 1.
Demographic Characteristics of the Sample

Variable	*n*	%
Gender Category^		
Cisgender	183	88.8
Trans/Transgender	15	7.3
Neither Cisgender nor Transgender	6	2.9
Unsure	1	0.5
Gender Binary Category^		
Binary	178	86.4
Nonbinary	19	9.2
Neither Binary nor Nonbinary	7	3.4
Unsure	1	0.5
Self-Described Gender#		
Agender/Transgender	1	0.5
Cisgender Female	5	2.5
Cisgender Male	1	0.5
Female	162	78.6
Female/Questioning Nonbinary	1	0.5
Gender	1	0.5
Male	21	10.2
Nonbinary	8	3.9
Nonbinary/Transgender Masculine/Takatāpui	1	0.5
Nonbinary Female	1	0.5
Nonbinary Transgender Woman	1	0.5
Queer/Nonbinary	1	0.5
Transgender Man	1	0.5
Did Not Indicate	1	0.5
Sexual Orientation Category		
Rainbow	49	23.8
Heterosexual/Straight	150	72.8
Neither	6	2.9
Unsure	1	0.5
Sexual Orientation#		
Asexual	3	1.5
Bisexual	15	7.3
Gay	5	2.4
Heterosexual	137	66.6
Lesbian	7	3.4
Pansexual	6	2.9
Queer	5	2.4
Takatāpui	2	1
Other	22	10.9
Did Not Indicate	4	1.9
Ethnicity*		
Māori	30	14.6
New Zealand European	170	82.5
Pākehā	2	1
Samoan	3	1.5
Chinese	6	2.9
Indian	5	2.4
South African	2	1
Other	18	9

Note. N = 206. Mean age = 34.8 years (SD = 12.4). ^Participants selected one of four options. #Participants answered this question in an open-response box. *Participants could select as many options as applied.

3.4 Data Collection Procedure

The researcher primarily used social media platforms (Instagram, Facebook and LinkedIn) to advertise the study. Several posts and stories, which included the study flyer and the study URL, invited participants to engage in the research (see Appendix D and E). The advertising study flyer included a link to the information sheet and survey. The information sheet indicated the study objectives, what was needed of each participant, support resources and the eligibility requirements (see Appendix A). To be eligible to participate in the study, participants needed to be: 18 years or over, living in Aotearoa New Zealand, and fluent in English. On the information sheet at the bottom, participants were presented with the option to proceed with the survey.

Given the study's aim to examine self-compassion and body-related attitudes in gender diverse A/NZ adults, the researcher contacted several gender-diversity related organisations/groups (e.g., Rainbow organisations/groups that focus on the well-being of community members) and invited them to take part in the research (see Appendix E and F). Of the 40 organisations/groups contacted, 13 organisations/groups responded, and 12 agreed to support recruitment by resharing the study flyer and URL: Te Ngākau Kahukura, Alphabet Book Club, UniQ Massey Wellington, Holding Your Own Hoo, Rainbow Networking Group – Auckland, Massey University Psychology Students, Massey Psychology Students Research Support, Te Anau Community Page, Birkenhead/Hillcrest/Northcote Community, Massey@Distance, Coaches in Sync, and Auckland Massey Distance Students.[5] Each of the organisations/groups that agreed to help with recruitment

[5] Te Ngākau Kahukura is an organisation that makes communities, environments and systems safer and more inclusive for rainbow people across Aotearoa NZ. Alphabet Book Club is an online bookstore in Aotearoa NZ, that sells books and products with positive LGBTQIA+ representation. UniQ Massey Wellington is Massey University Wellington's rainbow/queer group on Instagram. Holding Your Own Hoo, Rainbow Networking Group – Auckland, Massey University Psychology Students, Massey Psychology Students Research Support, Te Anau Community Page, Birkenhead/Hillcrest/Northcote Community, Massey@Distance, Coaches in Sync, and Auckland Massey Distance Students are all Facebook community groups.

allowed the researcher to post the study flyer on their respective pages or posted the study flyers with a short description themselves.

The survey was designed by the researcher (more information is included in the measures section) and was reviewed by Dr. Tatiana Tairi (an expert in self-compassion research) and Dr. Ilana Seager van Dyk (a senior lecturer in clinical psychology at Massey University and expert in rainbow research) who both recommended some changes. Firstly, they advised that the researcher shorten the survey length as much as possible, to reduce the burden on participants. Secondly, they suggested altering some of the language used to make it more appropriate for all genders. Finally, they encouraged the researcher to include open response boxes in some demographic questions to allow participants to describe themselves however they would like (rather than presenting forced-choice options). These recommendations were incorporated into the final version of the survey, which was later built using Qualtrics software. It was determined from the pre-tests that the average time needed to complete the questionnaire was approximately 20 minutes.

3.5 Measures

The survey questionnaire (see Appendix B) consisted of 43 items in total. The first section of the survey included 10 questions on demographic characteristics (including age, ethnicity, weight, height, gender, sexual orientation), which were partially informed by the questions used in Homan and Tylka's (2015) research. Six demographic items related to sexual orientation and gender identity, including questions regarding how the participants would like their sexual orientation and gender to be described in the study. In addition to the demographic questions, four psychological scales were included to measure self-compassion, body appreciation, body comparison and appearance contingent self-worth. These measures are described in the following paragraphs:

The corresponding scales measured these constructs: Self-Compassion Scale-Short Form (Raes et al., 2011), Body Appreciation Scale-2 (Tylka & Wood-Barcalow, 2015b), Body

Comparison Orientation subscale from the Body, Eating, and Exercise Comparison Orientation Measure (BEECOM; Fitzsimmons-Craft et al., 2012), and Appearance subscale from the Contingencies of Self-Worth Scale (CSW; Crocker et al., 2003).

The Body Appreciation Scale-2 and the Body Comparison Orientation subscale from the Body, Eating, and Exercise Comparison Orientation Measure had some items that were reworded to be more inclusive/accountable to all genders (e.g., beautiful was reworded to attractive and muscular was added beside thin).

Self-Compassion Scale – Short Form

The Self-Compassion Scale-Short Form (SCS-SF), a condensed, 12-item version of the original 26-item Self-Compassion Scale (SCS, Neff, 2003), measures an individual's propensity for self-compassion based on thoughts and behaviours they have about themselves (Raes et al., 2011). The self-report SCS-SF scale, like the original SCS, measures three bipolar components of self-compassion across six, two-item subscales using positively and negatively framed items: self-kindness (e.g., "When I'm going through a very hard time, I give myself the caring and tenderness I need") vs. self-judgment (e.g., "I'm intolerant and impatient towards those aspects of my personality I don't like," common humanity (e.g., "I try to see my failings as part of the human condition") vs. isolation (e.g., "When I fail at something that's important to me, I tend to feel alone in my failure,") and mindfulness (e.g., "When something painful happens I try to take a balanced view of the situation") vs. over-identification (e.g., "When I fail at something important to me I become consumed by feelings of inadequacy") (Neff, 2003; Raes et al., 2011). Participants are asked to rate each item on a five-point Likert scale from 1 (almost never) to 5 (almost always), depending on how frequently they behave in the manner described. The mean of the subscale item responses is used to calculate subscale scores (Raes et al., 2011). To calculate a total score for self-compassion, the negative subscale items (self-judgment, isolation, and over-identification) are

reverse-scored, and the overall mean is computed (Raes et al., 2011). The range of mean scores is from 1 to 5, with higher scores suggesting greater self-compassion.

Two Dutch samples and an English sample were used by Raes et al. (2011) to construct the SCS-SF and cross-validate its factorial structure. The SCS-SF showed adequate internal consistency (Cronbach's alpha 0.86 in all samples; Raes et al., 2011), and exhibited a nearly perfect correlation with the original SCS (r = 0.97 in all samples). The six-factor structure discovered in the original SCS and one higher-order factor of self-compassion were supported by confirmatory factor analysis on the SCS-SF (Raes et al., 2011). As the internal consistencies of the subscales were somewhat low, Raes et al. (2011) recommends using the full SCS instead of the SCS-SF for investigations of subtypes of self-compassion. As we were not interested in the subtypes of self-compassion for this study, we used the total score of the SCS-SF.

The SCS-SF has been used in a large variety of populations, including medical students (Babenko & Guo, 2019), nurses (Lluch-Sanz et al., 2022), pregnant women (Kaya & Akdoğan, 2022), caregivers of children with Autism Spectrum Disorder (ASD) (Chan et al., 2020), young adults (Wang et al., 2022), people living in chronic pain (Davey et al., 2020), law enforcement officers (Kaplan et al., 2020), psychology, counselling and psychotherapy practitioners (Keyes et al., 2022), to name a few. In the present study, Cronbach's alpha coefficient of internal consistency for the SCS-SF total score was 0.87.

Body Appreciation Scale-2

The Body Appreciation Scale-2 (BAS-2; Tylka & Wood-Barcalow, 2015b), an improved, 10-item version of the original 13-item Body Appreciation Scale (BAS, Avalos et al., 2005), measures individuals' acceptance of, favourable opinions toward, and respect for their bodies. Participants rate each item on a five-point Likert scale from 1 (never) to 5 (always), depending on how frequently they behave in the manner described. Example items include "I feel good about my body", "I appreciate the different and unique characteristics of my body", and "I feel like I am

beautiful even if I am different from media images of attractive people" (Tylka & Wood-Barcalow, 2015b). Scores for the 10 items are averaged, and a higher score indicates higher levels of body appreciation.

Tylka and Wood-Barcalow (2015b) used U.S. college and online community populations of 820 women and 767 men (Amazon Mechanical Turk) in three studies to examine the reworded, newly developed, and retained items' psychometric properties and construct the final BAS-2. The BAS-2's unidimensionality and invariance across sex and sample type were confirmed by confirmatory factor analysis (Tylka and Wood-Barcalow, 2015b), and the BAS-2's unidimensional factor structure has also been indicated among several cultural groups including samples of Chinese (Swami et al., 2016), Spanish (Swami et al., 2017a), Canadian (Dignard & Jarry, 2019), Danish (Lemoine et al., 2018), Romanian (Swami et al., 2017b), Portuguese (Lemoine et al., 2018), French (Kertechian & Swami, 2017), Polish (Razmus & Razmus, 2017), Swedish (Gattario & Frisén, 2019; Lemoine et al., 2018), Iranian (Atari, 2016), Malay (Swami et al., 2019), and the United States (Swami et al., 2017c). The BAS-2 has been used in a variety of populations, including sexual minority adults (Soulliard & Vander Wal, 2019), adolescents (Jankauskiene & Baceviciene, 2022), university students (Ng & Lin, 2020; Sundgot-Borgen et al., 2021), older adults (Meneses et al., 2019) and postoperative breast cancer patients (Umemura et al., 2020), to name a few. The BAS-2 demonstrated good internal consistency (Cronbach's alpha 0.94 and 0.93 for men and women, respectively), according to Tylka and Wood-Barcalow (2015b). For construct validity among men and women, the BAS-2 showed a substantial positive correlation with appearance evaluation and a strong negative correlation with body dissatisfaction (Tylka & Wood-Barcalow, 2015b). Additionally, the internalisation of media appearance ideals and body surveillance for both men and women were strongly and negatively correlated with the BAS-2 (Tylka & Wood-Barcalow, 2015b). For criterion-related validity for both men and women, the BAS-2 was positively related to intuitive eating and inversely related to eating disorder symptomology (Tylka & Wood-Barcalow, 2015b). It

was determined that incremental validity was supported as it is distinct from low levels of body dissatisfaction and high levels of appearance evaluation (Tylka & Wood-Barcalow, 2015b).

In the present study, Cronbach's alpha coefficient of internal consistency for the BAS-2 total score was 0.94, suggesting strong internal reliability.

Body Comparison Orientation subscale from the Body, Eating, and Exercise Comparison Orientation Measure

The Body Comparison Orientation (BCO) subscale from the Body, Eating, and Exercise Comparison Orientation Measure (BEECOM, Fitzsimmons-Craft et al., 2012), is a six-item self-report measure of a person's propensity to make body-related social comparisons (Fitzsimmons-Craft et al., 2012). Participants rate each item on a seven-point Likert scale ranging from 1 (never) to 7 (always), depending on how frequently they engage in the described behaviour. Example items include "In social situations, I think about how my figure "matches up" to the figures of those around me", "I notice how I compare with my peers in terms of specific parts of the body (e.g., stomach, hips, breasts, shoulders, etc.)" and "When I see a peer who is wearing revealing clothing, I have thoughts of how my own body compares." (Fitzsimmons-Craft et al., 2012). Scores for the six items are averaged, and higher scores reflect higher levels of body-related comparisons.

Fitzsimmons-Craft et al. (2012) generated the BEECOM items through an extensive review of the relevant literature, including a review of other measures of social comparison and descriptions of how social comparison is associated with disordered eating and body dissatisfaction. Exploratory factor analysis was used to generate and refine items which yielded three factors. Confirmatory factor analysis was then used to confirm this three-factor structure (Fitzsimmons-Craft et al., 2012). Additionally, the BEECOM scores provided evidence of high internal consistency for the full scale (Cronbach's alpha = 0.96) and the subscales (Body Comparison Orientation: Cronbach's alpha = 0.94). Additionally, the subscales are highly correlated (Body & Eating: r = .70; Body & Exercise: r = .68; Eating & Exercise: r = .76; all ps < .001) (Fitzsimmons-

Craft et al., 2012). Fitzsimmons-Craft et al. (2012) provided evidence for the concurrent, discriminant and convergent validity of the BEECOM total and subscale scores. High test-retest reliability was found for the BEECOM total scale (r = .90) and for the subscales (Body Comparison Orientation: r = .85), which was determined by means of calculating correlation coefficients between scores at the first and second administrations (Fitzsimmons-Craft et al., 2012).

The BCO has been used among different populations, including university students (Homan & Tylka, 2015), high school students (Maheux et al., 2021), and postpartum women (Thompson & Bardone-Cone, 2022), to name a few. In the present study, Cronbach's alpha coefficient of internal consistency for the BCO total score was 0.95.

Appearance subscale from the Contingencies of Self-Worth Scale

The Contingencies of Self-Worth Scale (CSWS; Crocker et al., 2003) is a well-received personality self-report measure designed to gauge the areas in which one's self-esteem is upheld by accomplishments and successes as well as jeopardised by challenges and failures. The CSWS includes seven subscales, only one of which was used in this study. The five-item Appearance Contingent Self-Worth subscale (ACSW) measures the degree to which an individual believes their self-worth depends on their appearance (Crocker et al., 2003). The ACSW contains positively and negatively framed items that describe individuals' thoughts and behaviours regarding how their self-esteem/self-worth is impacted by their physical appearance (Crocker et al., 2003). Participants are asked to rate each item on a seven-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree), depending on how frequently they engage in the manner described. Example items include "My self-esteem does not depend on whether or not I feel attractive," "My self-esteem is influenced by how attractive I think my face or facial features are," and "My self-esteem is unrelated to how I feel about the way my body looks" (Crocker et al., 2003). To calculate a total score for appearance contingent self-worth, the negative subscale items ("My self-esteem does not depend on whether or not I feel attractive" and "My self-esteem is unrelated to how I feel about the

way my body looks.") must first be reversed scored. The scores for the five items are then averaged, such that a higher score indicates higher levels of appearance contingent self-worth (Crocker et al., 2003).

The CSWS appearance subscale score demonstrated good internal consistency (Cronbach's alpha 0.83). Crocker et al. (2003) indicated reasonably high test-retest reliability for the appearance subscale with test-retest reliabilities at different time points ranging from 0.66 to 0.75. According to Crocker et al. (2003), the data supported the construct, convergent and discriminant validity of the CSWS. The CSWS correlations with other personality characteristics never surpassed 0.30, demonstrating that they measure empirically distinct constructs. Additionally, the pattern of considerable correlations broadly supported the construct validity of the CSWS subscales (Crocker et al., 2003).

The CSWS and the ACSW have been used among different populations, including university students (Briganti et al., 2019), patients seeking cosmetic surgery in Iran (Valikhani & Goodarzi, 2017), adolescents (Ching & Wu, 2022), men with a gay sexual orientation (Ching et al., 2021), and undergraduate female students (Schleien & Bardone-Cone, 2016), to name a few. In the present study, Cronbach's alpha coefficient of internal consistency for the total ACSW score was 0.77.

3.6 Data Analysis Procedure

All statistical analyses were conducted using IBM SPSS Statistics (Version 28) computer software. Additionally, the PROCESS macro for SPSS by Hayes (2022) was used for moderation analyses. Before conducting any analyses, listwise deletion of 51 cases was performed due to incomplete data (see 3.3 participants section).[6] The final sample size of cisgender participants (N = 183) was larger than the target sample size identified by the *a priori* power analysis (N = 138), so

[6] The incomplete data sets found in the 51 cases seemed to be a consequence of participants accessing the survey on Qualtrics but discontinuing the study when the survey commenced. That is, no demographic questions (the first questions in the survey) or measures were completed by these participants.

there was still adequate power to detect meaningful effects. Additionally, descriptive statistics (including means, standard deviations and minimum and maximum scores for demographic information and the four key measures) were calculated.. The distribution of the study's main variables was also examined for normality violations. Skew and kurtosis for the four main variables in the study indicated normal distribution and were within proposed limits for regression analyses (which is less than 3.00 for skew and less than 10.00 for kurtosis; Kline, 2010). Cronbach's alpha was calculated to examine the internal reliability of the four key measures used in the study. This measure indicates how closely the items in each scale measure the target construct (Pallant, 2011). The reliability of a scale evaluates the degree to which variation in measurement is caused by real individual variations or measurement error (Kline, 1992). Nunnally (1978) indicates that a Cronbach's alpha value of 0.70 or above is acceptable. All four key measures in the study achieved Cronbach's alphas above 0.70.

For hypotheses 1 and 2, Pearson's product-moment correlations were calculated, and for hypotheses 3 and 4, two regression-based moderation analyses were conducted to determine what relationships were present in the sample. Pearson's product-moment correlation coefficient was conducted using SPSS software and was calculated for the relationships between the total scores of each of the four main study variables and age. Two regression-based moderation analyses were performed using Process macro for SPSS (Hayes, 2022) to test self-compassion as a moderator. In model one, body appreciation was entered as the outcome; body comparison, self-compassion, and their interaction (i.e., body comparison x self-compassion) were entered as predictors, and age was entered as a covariate. In model two, body appreciation was entered as the outcome; appearance contingent self-worth, self-compassion, and their interaction (i.e., appearance contingent self-worth x self-compassion) were entered as predictors, and age was entered as a covariate.

Chapter Four: Results

4.1 Data Cleaning

Data were screened and cleaned before any analyses were conducted (Pallant, 2011). The data were screened to ensure that the researcher was only analysing complete sets of survey data as opposed to incomplete surveys consisting of missing sections or half-completed surveys. From the 258 surveys gathered, 206 were fully completed, meaning the participant had completed all sections. Additionally, one participant was excluded due to not meeting the inclusion criteria for age. The incomplete surveys were not used in any data analyses performed. Due to not meeting the sample size goal for gender diverse participants, our exploratory analyses looking specifically at this population were not run as any results would have been underpowered and unrepresentative of gender diverse people.

4.2 Internal Consistency

The Body Appreciation Scale-2 (BAS-2) and the Body Comparison Orientation Subscale (BCO), two of the four key measures, achieved excellent internal consistency with Cronbach's α of more than 0.90, indicating excellent reliability (Nunnally, 1978). The Appearance Contingent Self-Worth subscale (ACSW) demonstrated acceptable internal consistency (α = 0.77). The Self-Compassion Scale Short-Form (SCS-SF) reported a Cronbach's alpha of 0.87 overall, indicating good internal consistency, while the internal consistency of the six subscales varied. Although the internal consistency of the self-judgement subscale (α = 0.77) and the over-identification subscale (α = 0.70) was acceptable, the internal consistency of the self-kindness subscale (α = 0.66), common humanity subscale (α = 0.65), isolation subscale (α = 0.65) and the mindfulness subscale (α = 0.56) were questionable and poor. Although the alphas were lower, suggesting lower internal consistency, they were consistent with past studies using these scales (Bratt & Fagerström, 2020; Raes et al., 2011). These low scores likely result from the subscales containing only two items or a lack of construct unidimensionality.

4.3 Descriptive Statistics

Means, standard deviations and minimum and maximum scores for the SCS-SF, the BAS-2, the BCO, and the ACSW measures total scores and age are presented in Table 2.

Table 2

Means, Standard Deviations, Minimum and Maximum Scores of Variables of Interest

Variables	Mean	SD	Min Score	Max Score
Self-compassion	2.91	0.66	1	5
Body appreciation	3.12	0.81	1	5
Body comparison	4.67	1.35	1	7
Appearance contingent self-worth	4.94	1.03	2	7

Note. $N = 206$.

The skewness of the participants' SCS-SF total scores was found to be .41, indicating that the distribution was slightly right-skewed (i.e., indicating that scores were towards more self-compassion). The kurtosis of SCS-SF total scores was found to be .16, indicating that the distribution is platykurtic and more heavy-tailed than the normal distribution (i.e., indicating that there were fewer and less extreme outliers than the normal distribution). The skewness of the participants' BAS-2 total scores was found to be .20, indicating that the distribution was moderately right-skewed (i.e., indicating that the scores were towards more body appreciation). The kurtosis of BAS-2 total scores was found to be -.55, indicating that the distribution is platykurtic and was more light-tailed compared to the normal distribution. The skewness of participants' BCO total scores was found to be -.04, indicating that the distribution was somewhat left-skewed (i.e., indicating that the scores were towards less body comparison). The kurtosis of BCO total scores was found to be -.30, indicating that the distribution is platykurtic and more heavy-tailed than the normal distribution. Lastly, the skewness of participants' ACSW total scores was found to be -.55, indicating that the distribution was marginally left-skewed (i.e., indicating that scores were towards less appearance contingent self-worth). The kurtosis of ACSW total scores was found to be .30,

indicating that the distribution is platykurtic and was more heavy-tailed compared to the normal distribution. Additionally, all four key measures; SCS-SF, BAS-2, BCO and ACSW participants' total scores indicated normal distribution and skew and kurtosis values were within the proposed limits for moderation analyses (that is, less than 3.00 for skew and less than 10.00 for kurtosis; Kline, 2010).

4.4 Associations Between Body Comparison, Appearance Contingent Self-Worth, and Body Appreciation (H1)

The intercorrelations between all four key measures and age are displayed in Table 3. All Pearson moment correlations (apart from age and body appreciation) were statistically significant in the anticipated directions, with *r*s ranging from -.19 to .64.

Concerning hypothesis 1, a moderate negative association was found for body comparison and body appreciation, $r = -.42$, $p < .001$, such that those participants with higher levels of body appreciation tended to have lower body comparison. Similarly, the same association was found for appearance contingent self-worth and body appreciation, $r = -.37$, $p < .001$, such that those participants with higher levels of body appreciation tended to have lower appearance contingent self-worth. These results indicated support for hypothesis one. Additionally, a large positive association was found for appearance contingent self-worth and body comparison, $r = .58$, $p < .001$, such that those participants with higher appearance contingent self-worth tended to have higher body comparison.

4.5 Association Between Self-Compassion and Body Appreciation (H2)

Concerning hypothesis 2, a large positive association was found between self-compassion and body appreciation, $r = .64$, $p < .001$, such that those participants higher in self-compassion tended to have higher body appreciation. These results indicated support for hypothesis two. This finding is consistent with previous work that higher levels of self-compassion are associated with higher levels of body appreciation. A moderate negative association was found for body

comparison and self-compassion, $r = -.44$, $p < .001$, such that those participants higher in self-compassion tended to have lower body comparison. Indeed, this effect was also found for appearance contingent self-worth and self-compassion, $r = -.42$, $p < .001$, such that those participants higher in self-compassion tended to have lower appearance contingent self-worth. These findings are consistent with previous work that higher levels of self-compassion are associated with lower levels of body comparison and appearance contingent self-worth.

Table 3

Inter-Correlations of Variables of Interest

Variables	1	2	3	4	5
1. Self-compassion	-				
2. Body appreciation	.64**	-			
3. Body comparison	-.44**	-.42**	-		
4. Appearance contingent self-worth	-.42**	-.37**	.58**	-	
5. Age	.19*	-.08	-.19*	-.26**	-

Note. *$p < .05$. **$p < .001$. $N = 206$.

4.6 Moderation Analyses

The moderation analyses predicting body appreciation with self-compassion as a moderator are displayed in Table 4. It was hypothesized that self-compassion would moderate by weakening the negative association between (H3) body comparison and body appreciation and (H4) appearance contingent self-worth and body appreciation, as seen in Figure 1. In order to test self-compassion as a moderator, two regression-based moderation analyses were performed using Hayes' PROCESS macro to test H3 and H4 (Hayes, 2022).

4.7 Moderation Analyses of Self-Compassion on the Relationship Between Body Comparison and Body Appreciation (H3)

To test H3, a moderation regression-based analyses on Hayes' PROCESS macro (Hayes, 2022) was undertaken to determine whether self-compassion moderated the relationship between body comparison and body appreciation (see Model 1 in Table 4). Body appreciation was entered as

the outcome; body comparison, self-compassion, and their interaction (i.e., body comparison x self-compassion) were entered as predictors, and age was entered as a covariate. Overall, the model was significant, R^2 = .49, F(4, 200) = 47.67, p <.001. The effect of age on body appreciation was negative and significant, B = −.02, 95% CI [−.02, −.01], t = −4.53, p < .001, such that younger participants tended to have higher body appreciation. The effect of self-compassion on body appreciation was positive and significant, B = .83, 95% CI [0.41, 1.24], t = 3.92, p < .001, such that those participants higher in self-compassion tended to have higher body appreciation. Body comparison did not predict body appreciation, B = −.06, 95% CI [−.32, .20], t = −0.47, p = .640. There was no significant interaction between body comparison and self-compassion, and therefore there was no moderating effect of self-compassion on the relationship between body comparison and body appreciation, B = −.02, 95% CI [−.11, .06], t = −0.47, p = .640, contrary to our H3 prediction that self-compassion moderates the relationship between body comparison and body appreciation, therefore refuting hypothesis 3.

Table 4

Regression Analyses Predicting Body Appreciation from Body Comparison and Appearance Contingent Self-Worth with Self-Compassion as the Moderator

Step	R^2	*B*	*SE*	95% CI	*t*	*p*
Model 1						
Body Comparison		-0.06	0.13	-0.32, 0.20	-0.47	.640
Self-Compassion		0.83	0.21	0.41, 1.24	3.92	<.001
Body Comparison x Self-Compassion	0.49	-0.02	0.04	-0.11, 0.06	-0.47	.640
Age		-0.02	0.00	-0.02, -0.01	-4.53	<.001
Model 2						
Appearance Self-Worth		-0.18	0.15	-0.48, 0.12	-1.17	.245
Self-Compassion		0.68	0.24	0.21, 1.15	2.84	.005
Appearance Self-Worth x Self-Compassion	0.48	0.02	0.05	-0.08, 0.11	0.33	.740
Age		-0.02	0.00	-0.02, -0.01	-4.50	<.001

Note. N = 206. BA = Body Appreciation, measured by Body Appreciation Scale-2 (Tylka & Wood-Barcalow, 2015b). Body Comparison, measured by Body, Eating, and Exercise Comparison Orientation Measure (Fitzsimmons-Craft et al., 2012). Self-Compassion, measured by Self-Compassion Scale-Short Form (Raes et al. 2011). Appearance Contingent Self-Worth, measured by Contingencies of Self-Worth Scale (Crocker et al., 2003). Age was added as a covariate to both models given its association with Body Comparison and Appearance Contingent Self-Worth.

4.8 Moderation Analyses of Self-Compassion on the Relationship Between Appearance Contingent Self-Worth and Body Appreciation (H4)

To test hypothesis 4, a moderation regression-based analyses on Hayes' PROCESS macro (Hayes, 2022) was undertaken to determine whether self-compassion moderated the relationship between appearance contingent self-worth and body appreciation (see Model 2 in Table 4). Body appreciation was entered as the outcome; appearance contingent self-worth, self-compassion, and their interaction (i.e., appearance contingent self-worth x self-compassion) were entered as predictors, and age was entered as a covariate. Overall, the moderation model was significant, $R2 = .48$, $F(4, 200) = 45.50$, $p < .001$. The effect of age on body appreciation was negative and significant, $B = -.02$, 95% CI [−.02, −.0], $t = -4.50$, $p < .001$, such that younger participants tended to have higher body appreciation. Self-compassion positively and significantly predicted body appreciation, $B = .68$, 95% CI [.21, 1.1], $t = 2.83$, $p < .050$, such that those participants higher in

self-compassion tended to have higher body appreciation. Similar to model 1, there was no significant interaction between appearance contingent self-worth and self-compassion, and therefore was no moderating effect of self-compassion on the relationship between appearance contingent self-worth and body appreciation, $B = .02$, 95% CI [−.08, .11], $t = 0.33$, $p = .740$, contrary to the hypothesis that self-compassion moderates the relationship between appearance contingent self-worth and body appreciation, therefore refuting hypothesis 4.[7]

[7] As a post hoc analysis, we tested whether the results changed at all if we only looked at female participants; given the original study on which this study is replicated only included cisgender women (Homan & Tylka, 2015), we wanted to test this possibility. The results stayed the same in terms of significance and direction.

Chapter Five: Discussion

In A/NZ, there are concerning rates of EDs and normativity of body discontent (Tantleff-Dunn et al., 2011; Wells et al., 2006). Increasing positive body image has been proposed as a mechanism for reducing symptoms of EDs and body discontent (Piran & Tylka, 2019). However, no research has been conducted that examines positive body image and threats to positive body image among New Zealanders. Furthermore, a gap in the literature exists on factors associated with cultivating and protecting New Zealanders positive body image. For that reason, this project aimed to replicate the findings of Homan and Tylka (2015), such that it was hypothesised that (a) body comparison and appearance contingent self-worth would be inversely related to body appreciation, (b) self-compassion would be positively associated with body appreciation, and (c) self-compassion would moderate the negative relationship between body appreciation and (i) body comparison and (ii) appearance contingent self-worth.

Findings supported the study's hypotheses one and two, as body comparison and appearance contingent self-worth were inversely related to body appreciation; that is, participants who compared their body to others more and/or based their self-worth on their appearance, tended to appreciate their body less. In line with the original study upon which this is based (Homan & Tylka, 2015) and other literature (Siegel et al., 2020), self-compassion was found to be positively related to body appreciation, such that those who had higher levels of self-compassion tended to appreciate their bodies more. However, contrary to our predictions (H3 & H4) and the existing literature (Homan & Tylka, 2015; Siegel et al., 2020), self-compassion did not moderate the relations between body comparison and body appreciation, nor the relationship between appearance contingent self-worth and body appreciation. Additionally, the present study found that age showed a significant negative relationship with body appreciation, such that younger participants tended to appreciate their bodies more, which was not found in the original study by Homan and Tylka (2015) nor Siegel et al. (2020) replication. In the following paragraphs, I will discuss possible explanations

for these differing results, as well as strengths and limitations of the current research, and future directions.

5.1 Levels of Self-Compassion, Body Appreciation, Body Comparison and Appearance Contingent Self-Worth

The present study found different levels of the main study variables (i.e., self-compassion, body appreciation, body comparison and appearance contingent self-worth) compared to Homan and Tylka (2015) in which this study is based.

Participants in the current study reported lower self-compassion (M = 2.91 for the current study vs. M = 3.12 for the original study), lower body appreciation (M = 3.12 for the current study vs. M = 3.46 for the original study), higher body comparison (M = 4.67 for the current study vs. M = 3.79 for the original study), and higher appearance contingent self-worth (M = 4.94 for the current study vs. M = 4.51 for the original study) compared to the original study in which this was based (Homan & Tylka, 2015). Such that, the present study sample, comparative to Homan and Tylka (2015), had lower levels of self-compassion and body appreciation and higher levels of body comparison and appearance contingent self-worth, as measured by the SCS-SF, BAS-2, BEECOM and CSWS.

The lower incidence of self-compassion and body appreciation and higher incidence of body comparison and appearance contingent self-worth could be due to several factors. Firstly, the current study included people of all genders (not just those who identify as women, as in Homan & Tylka (2015), so the difference could be related to having a more diverse sample with the inclusion of those who identified as male and gender diverse. Those who identify as male are found in the literature to report greater levels of self-compassion and body appreciation compared to females (Paquette et al., 2022a; Yarnell et al., 2015; 2019). Additionally, one study has found heterosexual, cisgender adolescent males to report the highest levels of body appreciation, followed by gender and sexually diverse adolescent boys and heterosexual, cisgender girls; of note, gender and sexually

diverse adolescent girls and sexually diverse non-binary adolescents had significantly lower body appreciation than heterosexual, cisgender boys and gender and sexually diverse boys (Paquette et al., 2022b). Despite the inclusion of those who identify as male in the present study hypothetically increasing the average levels of self-compassion and body appreciation, based on levels reported in the literature (Paquette et al., 2022a; Yarnell et al., 2015; 2019), the inclusion of those who identify as female (78.6%) and gender diverse (7.3%) may exhibit lower levels of self-compassion and body appreciation and therefore may bring the average levels of self-compassion and body appreciation down comparative to Homan and Tylka's (2015) original study and Siegel et al. (2020) replication whose samples only included women.

Since there is limited research on the differences in levels of body comparison between males and females (van den Berg et al., 2007), the gender composition of this sample may not be the best explanation for why the present study exhibited much higher levels of body comparison and appearance contingent self-worth than Homan and Tylka's (2015) original study and Siegel et al. (2020) replication. Instead, the recruitment method may have influenced this finding. The researcher used their social media platforms, which primarily has a following of individuals involved in high-performance sports, sports at the community/recreational level, going to the gym and lifting weights or doing cardio etc.. As a result, it is possible that the higher levels of body comparison and appearance contingent self-worth exhibited in the present study were a result of the sample being more invested in gym culture, and other activities that involve a lot of body comparison and appearance being the central feature of self-worth such as body building. However, the present study did not collect information about participants' gym and sporting involvement that would help support this hypothesis.

Perhaps the overarching factor as to why the levels of main study variables were different from the original study and replica is a product of culture. Homan and Tylka's (2015) and Siegel et al.'s (2020) study samples were primarily White Americans, and the present study's sample is

comprised of New Zealanders. Aotearoa New Zealand is one of the most ethnically diverse countries in the world, having over 200 different ethnicities within our communities (Ministry of Ethnic Communities, 2016). Indeed, the present study's participants reported approximately 25 different ethnicities, including Māori (endorsed by 14.6% of participants), the indigenous peoples' of A/NZ. Culture is likely important, as one study investigated the relationship between BMI, self-esteem and self-reported confidence and capability in expressing oneself culturally as Māori (cultural efficacy) and found that higher cultural efficacy protected Māori from developing lowered self-esteem, which is typically linked with higher BMI in the Western population (Houkamau et al., 2021). In other words, the study found that cultural efficacy predicted body satisfaction for Māori. Therefore, it is possible that high cultural efficacy among Māori protected them from the sociocultural negative body image messages communicated in the Western population. However, other studies have suggested that Māori may find themselves being subject to Western appearance ideals which impacts their body image, a finding that is not shocking given A/NZ comprises 70.2% of Europeans, making it incredibly hard not to at some point be exposed and subject to Western worldviews/ideologies and feeling compelled to conform (Fear et al., 1996; Moewaka Barnes & Borell, 2002; Statistics New Zealand, 2020). Regardless, it is possible that differences in the ethnic makeup of this sample led to the observed differences in levels of self-compassion, body appreciation, body comparison and appearance contingent self-worth compared to Homan and Tylka's (2015) study in which this study was based.

5.2 Main Findings Concerning Positive Body Image and Self-Compassion

The present study's findings support hypotheses one and two and the main findings of Homan and Tylka's (2015) original study and Siegel's et al. (2020) replication, such that body comparison and appearance contingent self-worth were negatively related to body appreciation (H1) and self-compassion was positively related to body appreciation (H2). Consistent with the original study, increased frequency of body comparisons and making one's self-worth dependent on

appearance was associated with decreased body appreciation. However, contrary to the original study by Homan and Tylka (2015) and Siegel et al. (2020) replication, the present study was unable to add support to the moderating role of self-compassion in that self-compassion did not moderate the negative relations between body-related threats (body comparison and appearance contingent self-worth) and body appreciation. In other words, self-compassion in the present study did not appear to help protect A/NZ adults' body appreciation in the face of two factors found to be associated with negative feelings about the body.

This finding was explored further in the present study to decipher what differences existed between the original study by Homan and Tylka (2015) and the present study. One of the most significant differences was the study's sample; therefore, the present study conducted a post hoc analysis to test whether the results changed at all if we only looked at female participants, given that the original study on which this study is replicated had only a strictly female sample; however, the results stayed the same in terms of significance and direction (i.e., the results still did not replicate the earlier studies). In addition, perhaps the sample of the present study, no matter their level of self-compassion, were still significantly susceptible to body-related threats that impacted their ability to appreciate their bodies. This finding is intriguing in that self-compassion significantly predicted body appreciation, meaning that those who were more self-compassionate tended to appreciate and respect their bodies more than those who were not. However, even though self-compassionate people were able to appreciate and respect their bodies, they were unable to maintain appreciating and respecting their bodies when confronted by body-related threats. Being self-compassionate did not protect them from comparing their bodies to others and/or staking their self-worth on their appearance, even though previous research has found self-compassion to protect people from these body-related threats (Homan & Tylka, 2015; Siegel et al., 2020). One explanation for these differing results could be a consequence of the present study not controlling for BMI, a factor in which Homan and Tylka (2015) controlled for in their original study. The

present study chose not to include a measure of BMI because BMI measures have significant limitations (e.g., only include measures of height and weight), are susceptible to incorrect interpretation (e.g., can describe someone as obese when they are not), and do not account for essential biomarkers and confounding dynamics (Dalili et al., 2020). However, it is unlikely that not controlling for BMI specifically was the reasoning behind the differing results, as Siegel's et al. (2020) replication study found the same main effects as the Homan & Tylka (2015) study without controlling for BMI.

Other studies investigating the moderating role of self-compassion have found inconsistent findings. One study explored the moderating role of self-compassion on the positive relationship between BMI and ED pathology and the negative relationship between BMI and body image flexibility (Kelly et al., 2014). Findings indicated support for the protective role of self-compassion among undergraduate women from the consequences associated with a higher BMI such as ED pathology (Kelly et al., 2014).

Similarly, Rodgers et al. (2017) examined whether self-compassion would buffer the mediated relationship between perceived overweight status and decreased appearance esteem via appearance comparison among emerging adults and found among girls in their sample, self-compassion to be directly protective against appearance concerns and among boys in their sample, to buffer against the effects of particular risk factors. Both studies, alongside Homan and Tylka (2015) and Siegel et al. (2020), provide evidence for the protective role of self-compassion and its importance for positive body image, a finding inconsistent to the present study that did not find self-compassion to protect participants body appreciation from the threats of body comparison and appearance contingent self-worth.

Similar to the present study concerning not finding evidence for the protective role of self-compassion. Modica (2019) conducted a study to determine whether self-compassion protected body esteem from the threats of Facebook appearance comparison and body surveillance; however,

the researchers did not find evidence of moderation. In other words, self-compassion had no impact on the strength of the relationship between Facebook appearance comparison and body esteem, as well as Facebook appearance comparison and body surveillance, even when controlling for age and BMI. However, these findings should be interpreted cautiously since the study lacked sufficient power, an issue in which the present study did not have, having reached over the required sample size. Similarly, Cusack et al. (2022) longitudinally investigated self-compassion, body satisfaction and disordered eating symptoms in male collegiate athletes. They found self-compassion did not moderate the relationship between body satisfaction and disordered eating symptoms. Despite males reporting higher levels of self-compassion, it is intriguing that self-compassion is found to protect women from disordered eating and body image issues but not men (Cusack et al., 2022). Perhaps a plausible explanation for this finding and the present study's findings is that there may be other psychological variables through which self-compassion may promote more and be protective of positive body image (Cusack et al., 2022). Therefore, it appears imperative as a consequence of the varied research on the protective role of self-compassion to decipher under what conditions and for whom this phenomenon is true.

Although Homan and Tylka (2015) found evidence for the moderating effect of self-compassion, their effect sizes were small, similar to other research investigating the moderating effect of self-compassion (Daye et al., 2014; Kelly et al., 2014). Perhaps the present study found different results because self-compassion language may not be a salient feature of A/NZ everyday dialogue. Self-compassion stems from Buddhist philosophy, and research has revealed that it varies between cultures (Neff, 2003a). For example, people in Thailand (a nation where 95% of the population identifies as Buddhist) demonstrated higher levels of self-compassion than people in the US, possibly because the Buddhist worldview places emphasis on compassion for oneself and others and accepts failures and imperfections as a normal part of life (Neff et al., 2008). Although A/NZ includes collectivistic cultures such as 16.5% Māori, 70.2% of New Zealanders identify as

European; thus, some aspects of self-compassion, such as common humanity, may be a less salient part of many New Zealanders daily lives. Thus, it is possible that the present study did not find a moderating role of self-compassion due to cultural differences in the experience of self-compassion. Additionally, anti-Asian xenophobia is widely prevalent in A/NZ (New Zealand Human Rights Commission, 2021) so perhaps this could explain the rejection of Eastern ideas related to self-compassion.

Nevertheless, the present study found evidence to suggest that self-compassion may be a mechanism involved in enhancing positive body image. Given this finding, it may be advantageous for researchers and clinicians developing interventions to reduce disordered eating and increase positive body image to consider the inclusion of activities that cultivate self-compassion.

Individuals may benefit substantially from positive body image and self-compassion exercises to help enhance their positive relationship with their body and related behaviours and attitudes. Indeed, a recent study conducted a RCT to test the efficacy of a self-guided mental health app called “Intellect,” which aims to improve body image and self-compassion (Ong & Sündermann, 2022). The study found that participants in the intervention group reported a significant reduction in body dissatisfaction and improvements in body appreciation and self-compassion compared to the active waitlist control group (Ong & Sündermann, 2022). In general, interventions focussed on fostering positive body image may be enhanced by incorporating self-compassion components; this way, people will be able to increase their use of self-compassion, which can both enhance their appreciation of their bodies, as well as improve their self-esteem and wellbeing in other domains (Ong & Sündermann, 2022).

5.3 Study Limitations and Directions for Future Research

Although this project had many strengths (including its ethnically diverse sample, inclusion of men and gender diverse people, replication of a prior study in a New Zealand sample, strengths-based approach, positive focus), it also had several limitations that future research should consider.

Firstly, the present study did not reach the required gender diverse sample size of 138 participants. Therefore, the exploratory hypotheses were not explored among this sample as we would not have had enough power to detect medium effects. Although we reached out to numerous gender diverse organisations and groups during the recruitment phase, future studies should engage in whanaungatanga (relationship-building) with gender diverse collaborators and community partners early in the research process to build trust and increase engagement in the study from this community. Social media platforms were valuable during the recruitment phase; however, future studies should consider having a longer recruitment period in order to allow busy community organisations to respond. Given the high rates of EDs among trans and gender diverse individuals, with estimates ranging from 2% to 18% (Coelho et al., 2019), it is vital that future research appropriately engage with this community in order to conduct projects that can ameliorate ED symptoms in this vulnerable group.

Relatedly, despite the present study including male-identified and gender-diverse people (rather than only women as previous studies have done), these participants only represented 17.5% of the total sample, and thus were underrepresented. Due to small sample sizes within these groups, between-group (e.g., cis-men vs. cis-women) comparisons and conclusions could not be made.

Next, though the study sample closely reflected the common features of the A/NZ population, other characteristics may have been underrepresented or absent due to the sampling/recruitment methods employed. The study primarily used the researchers' social media to recruit participants, which meant that some populations within NZ may not have been reached, such as those that do not have access to the internet or social media, those who live rurally, and those within different age brackets etc. This meant that the sample did not precisely represent all of the diversity within NZ, though it did somewhat represent the NZ population. The sample was found to consist of 14.6% Māori, 82.5% New Zealand European, 2.9% Chinese, 2.4% Indian, 1.5% Samoan and 9% other (participants were able to select more than one ethnicity), which very roughly reflects

the same ethnicity percentages reported in the New Zealand 2018 census (e.g., 70.2% European, 16.5% Māori, 15.1% Asian peoples; Statistics New Zealand, 2020). Future research should employ a variety of recruitment methods to capture a more representative sample of A/NZ.

Next, the present study did not ask questions concerning participants' clinical diagnoses of eating and body image disorders, nor did it specifically target this population. Therefore, researchers may want to test the present study's findings in clinical samples because it is unknown whether these effects would be applicable to people who have clinical levels of body disturbance, such as those with EDs or body dysmorphic disorder.

In addition, the present study utilised social media as the primary source of data collection, which meant that some groups within NZ were unable to participate, such as those that do not have social media or access to the internet. However, in A/NZ, for both men and women across all ages, social media usage in the form of Facebook has been associated with poorer body satisfaction and what is of concern is that the adverse effects of social media are not going away anytime soon; in fact, social media is expanding, with more platforms becoming available such as Instagram, TikTok and Twitter, to name a few (Stronge et al., 2015). Given that social media users often do not have much control over what they are exposed to, users may find themselves inadvertently comparing their body-related attitudes and behaviours to social media accounts, projecting unrealistic and unobtainable standards. Future research should employ a variety of data collection methods, such as physical posters and meetings with organisations, towns, and community groups alongside social media; this way, a better representation of the population will be achieved.

The present study also chose to directly replicate Homan & Tylka's (2015) original study, so the SCS-SF (Raes et al., 2011), BEECOM (Fitzsimmons-Craft et al., 2012) and CSWS were administered (Crocker et al., 2003). However, the present study employed the updated version of the BAS (Tylka & Wood-Barcalow, 2015b), which Homan & Tylka (2015) did not employ (Tylka & Wood-Barcalow, 2015b). Perhaps this could explain the contrasting findings between the present

study (e.g., not finding self-compassion to protect participants body appreciation) and the original study (Homan & Tylka, 2015). The present study did not use the revised and updated version of the BEECOM as the revised version is an abbreviated version of the original BEECOM that specifically targets those who are recovering from an ED and therefore was not applicable to the present study's sample (Saunders et al., 2019). Future research may employ different psychometric measures that capture the construct being measured more precisely. Furthermore, future researchers should consider adapting the SCS-SF items to capture more precisely appearance-related self-compassion as opposed to global self-compassion (e.g., I have been understanding of the aspects of my body that I don't like), as this would be more reflective and distinctive of how self-compassionate people are with regard to their bodies as opposed to just generally (as seen in Thøgersen et al., 2017).

Importantly, even though it is conceivable that self-compassion appears to help protect body appreciation even in the midst of two challenges to it (body comparison and appearance contingent self-worth), the cross-sectional, non-experimental design of the present study prevents any causal inferences from being made (Homan & Tylka, 2015; Siegel et al., 2020). Future research should consider employing experimental and longitudinal designs to obtain more clarity on the causal directions between these variables and solidify whether self-compassion is in fact a protective factor for body appreciation.

Given that the current cultural landscape (especially concerning an influx of social media usage) frequently exposes people to threats to their positive body image, future research should aim to focus on developing prevention and intervention efforts that protect people from psychological distress related to their body image. Future research might also examine the role self-compassion has on varying threats to body image, such as experiences of personal safety anxiety (Calogero et al., 2019), social physique anxiety (Thøgersen et al., 2017), sexual objectification (Kozee et al., 2007), interactions with body-focused others (Kelly et al., 2016), sex as power attitudes (Erchull &

Liss, 2013) and beauty as currency beliefs (Calogero et al., 2017). In general, research should focus on interventions and variables that may help to protect people from the pernicious downstream consequences of these and other body-related threats until risks to people's positive body image are no longer a prevalent element of life for people.

The findings of this study demonstrate that self-compassion may be a promising mechanism associated with New Zealanders' body appreciation and positive body image. Therefore, the next step for future research would be to pilot a self-compassion intervention for the NZ population, especially among those groups that may be more vulnerable or susceptible to experiences eliciting significant body dissatisfaction. Indeed, research has found that brief meditation and more structured training programmes can help people develop a kinder self-perspective, according to several mindfulness interventions (Boellinghaus et al., 2013; Neff & Germer, 2013)

Until positive body image is normative among New Zealanders and threats to positive body image are no longer a central component of daily life for people, research should focus on interventions that help to safeguard positive body image from these body-related threats**,** and in so doing, improve the wellbeing of diverse New Zealanders.

Chapter Six: Conclusion

By conducting a study that aimed to directly replicate Homan and Tylka's (2015) well-known study, we are hopeful that additional researchers on body image will be compelled to conduct research in this area. Body image issues affect individuals of different ages, genders, sizes, and ethnicities (Grabe & Hyde, 2006; Runfola et al., 2013). For this reason, it is crucial that research on the subject, especially that which accentuates potential interventions or protective mindsets, is transparent, reproducible, and successful across time and groups. The present study found contradicting findings and effects compared to previous research investigating the same phenomenon, accentuating the lack of consistency in body image research across populations. Suppose the ultimate goal is to create a world in which body appreciation or positive body image is normative instead of body dissatisfaction. In that case, transparency in body image research needs to be strengthened, and consequently, more confidence may be gained in the veracity of findings (Zwaan et al., 2018).

Despite such, this study does add to the increasing evidence that self-compassion is advantageous for body appreciation and, consequently, positive body image. Although the study did not find self-compassion to protect body appreciation from body comparison and appearance contingent self-worth, it found that even when other variables were accounted for, self-compassion still significantly and positively predicted body appreciation, such that those with higher levels of self-compassion appreciated their bodies more than those with lower levels of self-compassion. The relationships between self-compassion, body comparison, appearance contingent self-worth and body appreciation are under-researched in A/NZ; thus, the present study has been able to add to the limited understanding of these unique relationships. In this way, these findings have provided a more thorough understanding of these relations within an A/NZ population as well as with a sample that is more diverse than the original study by Homan and Tylka (2015) and Siegel's et al. (2020) replication, whose samples were comprised entirely of women.

Additionally, the present study indicated the importance of self-compassion for New Zealanders' body image and thus has contributed initial evidence for the inclusion of self-compassion in prevention and intervention efforts with this population. Although further research (including experimental and longitudinal studies) is needed, the findings of this study suggest that self-compassion interventions/training programs could yield significant benefits for the A/NZ population especially in relation to appreciating their bodies. Although, because the findings of the present study did not find evidence that self-compassion protected participants body appreciation from body comparison and appearance contingent self-worth it is equally important for prevention and intervention programs to address those factors as well.

The implications of these results should be considered. Given the increased prevalence of EDs and body discontent in NZ and the lack of positive body image and self-compassion prevention interventions, conducting more research in this area and implementing appropriate interventions will be critical. Since the COVID-19 pandemic, NZ has seen a significant increase in demand for clinical services for EDs (Hansen et al., 2021; Leask, 2021; Marsh, 2021; Strongman, 2021; Wilkinson, 2020). With COVID-19 still looming and social media usage increasing (which causes isolation and exposure to unrealistic appearance ideals; Hwang et al., 2020; Jung et al., 2022), the importance of providing preventative strength-based interventions to vulnerable populations or even the whole population at large cannot be understated. By increasing research attention and public health funding for ED prevention, we may be able to prevent the deleterious effects of EDs on those who develop them.

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Appendices

Appendix A: Information Sheet

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

The relationship between self-compassion, body comparison, appearance contingent self-worth and body appreciation among New Zealand adults.

INFORMATION SHEET

Kia ora, my name is Aleisha Braven. I am a post-graduate student, conducting this study as part of a Masters of Health Science in Psychology at Massey University. My research is supervised by Dr Ilana Seager van Dyk, Senior Lecturer in the School of Psychology.

I am inviting you, as an Aotearoa New Zealand adult, to participate in my study, which explores the relationships between self-compassion and important psychological variables related to body-related attitudes and behaviours (i.e. body comparison, appearance contingent self-worth and body appreciation) among New Zealand cisgender and gender diverse adults. The value of understanding and endorsing positive body image has been recognised by researchers within the last decade. Body appreciation, one of the most comprehensively studied aspects of positive body image, is defined as encompassing positive/good opinions toward the body irrespective of its appearance, and accepting the body along with its imperfections and discrepancies from societal appearance standards. However, more research is needed on the causes and correlates of body appreciation. It is imperative to consider what factors contribute toward and sustain body appreciation, as it has significant links to well-being. Your contribution to this study will improve our understanding of the role self-compassion has on body appreciation amid two potential challenges to it: body comparison and appearance contingent self-worth.

You are eligible to participate in this study if you are:

- Over 18 years old;
- Living in New Zealand; and
- Fluent in English.

You will be asked to fill out an anonymous survey, administered online that will take approximately 20 minutes. The survey will include a few demographic questions along with questions that will measure self-compassion, body appreciation, appearance contingent self-worth, and body comparison. In each section of the survey, you will be provided with detailed instructions on how to answer the questions. All questions will be close-ended, where you will be required to select the answer that describes you best. There are no right or wrong answers to any of the questions. Although I do not expect any significant distress to be caused to you by your participation, some questions may be triggering. However, if any parts of the survey do cause you distress, you are encouraged to contact any of the support services provided at the end of this document.

The data collected will be used for research purposes and will be securely stored for five years, after which it will be destroyed. Once the survey is completed you will be given the opportunity to enter a prize draw to win one of ten $40 vouchers and indicate if you would like to receive a summary of the research findings. If you wish to enter the draw and/or receive a summary of the research findings, anonymity will be maintained by using a separate

survey to collect your contact details. There is no link between the two data sets other than time and date.

Your participation in the study is completely voluntary. All of your responses to the questionnaires will be anonymous. If you decide to participate, you have the right to:

- withdraw from the study without having to provide a reason any time before you submit your responses;
- decline to answer any particular question;
- be given access to a summary of the study findings when it is concluded.

Completion and return of the questionnaire implies consent.

Should you have any questions about the research please do not hesitate to contact us:

Researcher: Aleisha Braven, Masters Student, Massey University.
Email: aleishabraven@hotmail.com
Supervisor: Dr Ilana Seager van Dyk, Senior Lecturer, School of Psychology, College of Humanities & Social Sciences, Massey University.
Email: I.SeagervanDyk@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 22/47. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43347, email humanethicsnorth@massey.ac.nz.

Support Resources

A full list of mental health crisis teams is available here:
https://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services/crisis-assessment-teams

Lifeline
0800 543 354 (0800 LIFELINE)
or free text 4357 (HELP) 24/7

1737 Need to Talk?
Free call or text 1737 for support from a trained counsellor

Depression Helpline
0800 111 757 or text 4202

OUTline
0800 688 5463 (0800 OUTLINE)

Rainbow Youth
https://ry.org.nz/get-support

Anxiety Helpline
0800 269 4389 (0800 Anxiety)

Healthline
0800 611 166

Centre for Psychology
Level 3
North Shore Library Building (off Kell Drive)
229 Dairy Flat Highway
Albany Village, Auckland
Tel: (09) 213 6095

Massey Health and Counselling Centre
(For Massey Students and Staff Only)
09 213 6700
Studenthealth@massey.ac.nz
https://www.massey.ac.nz/massey/student-life/services-and-resources/health-

Fax: (09) 414 7328
Email: Centreforpsychology@massey.ac.nz

counselling-
services/counselling/counselling_home.cfm

Appendix B: Survey/Questionnaire

CONSENT

Thank you for participating in this questionnaire. Your participation implies consent. You have the right to decline to answer any particular question.

I have read and understood the information sheet for this study and consent to collection of my responses.
(Please click on the 'Yes' choice if you wish to proceed)

○ Yes

○ No

Section 1: Demographic Information

1. What is your current age?
   a) [open-response box]

2. What is your sexual orientation?
   a) [open response box]

3. What is your gender?
   a) a) [open response box]

4. Are you intersex/do you have a variation of sex characteristics?
   a) Yes, I am intersex/have a variation of sex characteristics
   b) No, I am not intersex/have a variation of sex characteristics
   c) I don't understand the question

5. When we describe who participated in our study, which of these *sexual orientation-related* categories would you like us to include you in?
   a) A Rainbow category (usually refers to people who identify as lesbian, gay, bisexual, pansexual, takatapui, or some other non-heterosexual sexual orientation)
   b) A heterosexual/straight category (usually refers to people who are attracted exclusively to others of a different gender)
   c) Neither cisgender nor transgender describe me because: _____
   d) Unsure because: _____

6. When we describe who participated in our study, which of these *gender-related* categories would you like us to include you in?
   a) A trans/transgender category (usually refers to people who were given a gender and/or sex label at birth that does not accurately represent them)
   b) A cisgender category (usually refers to people who are the same gender and/or sex they were assigned at birth)
   c) Neither cisgender nor transgender describe me because: _____
   d) Unsure because: _____

7. And which of these other *gender-related* categories would you like us to include you in?
   a) Binary (someone who identifies as completely a man/male or woman/female)
   b) Nonbinary (someone who has an identity other than completely woman/female or man/male)
   c) Neither binary nor nonbinary describe me because: _____
   d) Unsure because: _____

8. Which ethic group(s) do you identify with?
   - New Zealand European
   - Māori
   - Samoan
   - Cook Islands Māori
   - Tongan
   - Niuean
   - Chinese
   - Indian
   - Other (*Please specify)*

9. Height (in meters)
   a) [open-response box]

10. Weight (in kgs)
    a) [open-response box]

Section 2: Survey

Part 1 - SCS: HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. Indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

1. When I fail at something important to me I become consumed by feelings of inadequacy.
2. I try to be understanding and patient towards those aspects of my personality I don't like.
3. When something painful happens I try to take a balanced view of the situation.
4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

5. I try to see my failings as part of the human condition.
6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
7. When something upsets me I try to keep my emotions in balance.
8. When I fail at something that's important to me, I tend to feel alone in my failure
9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm disapproving and judgmental about my own flaws and inadequacies.
12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Part 2 - BAS-2: HOW I TYPICALLY APPRECIATE MY BODY

Please indicate whether the question is true about you never, seldom, sometimes, often, or always.

Never				Always
1	2	3	4	5

1. I respect my body.
2. I feel good about my body.
3. I feel that my body has at least some good qualities.
4. I take a positive attitude towards my body.
5. I am attentive to my body's needs.
6. I feel love for my body.
7. I appreciate the different and unique characteristics of my body.
8. My behaviour reveals my positive attitude toward my body; for example, I hold my head high and smile.
9. I am comfortable in my body.
10. I feel like I am attractive even if I am different from media images of attractive people (e.g., models, actresses/actors).

Part 3 - BEECOM: HOW OFTEN DO YOU TYPICALLY COMPARE YOUR APPEARANCE TO OTHERS

Please rate each of the following items regarding how often you compare yourself to your **peers** in terms of appearance. Remember, there are no right or wrong answers, so please be as honest as possible.

Never						Always
1	2	3	4	5	6	7

1. I pay attention to whether or not I am as thin/muscular, than my peers.
2. In social situations, I think about how my figure "matches up" to the figures of those around me.
3. I notice how I compare with my peers in terms of specific parts of the body (e.g., stomach, hips, breasts, shoulders, etc.).
4. I compare my body shape to that of my peers.
5. When I see a peer who is wearing revealing clothing, I have thoughts of how my own body compares.
6. I pay attention to whether or not I am as toned as my peers.

Part 4 - CSW: HOW MUCH DOES YOUR SELF-WORTH DEPEND ON YOUR APPEARANCE

Please read each statement carefully before answering. Indicate how often you behave in the stated manner, using the following scale:

Strongly disagree						Strongly agree
1	2	3	4	5	6	7

1. My self-esteem does not depend on whether or not I feel attractive.
2. My self-esteem is influenced by how attractive I think my face or facial features are.
3. My sense of self-worth suffers whenever I think I don't look good.
4. My self-esteem is unrelated to how I feel about the way my body looks.
5. When I think I look attractive, I feel good about myself.

Thank you for your responses.

SUPPORT

Support lines
If any parts of the survey have caused you distress, you are encouraged to contact the following free support lines:

General mental health support:

- Text 1737 or call 0800 1737 1737 anytime
- Youthline: www.youthline.co.nz (Free phone 0800 376 633) or visit your local centre for youth
- Lifeline: 0800 54 33 54 or text 4357
- OUTline: call 0800 688 5463 between 6pm and 9pm for LGBTIQ+ people

Prize Draw and Results Summary:
Clicking the Submit button below will submit your responses then transfer you to a separate survey to collect contact details if you wish to participate in a prize draw to win one of ten gift vouchers or request a summary of research findings.

Appendix C: Approval of Ethics

Link to the application

HoU Review Group:

ReviewerGroup:
Dr Ilana Seager van Dyk

Researcher: Aleisha Braven
Project Title: The role of self-compassion on body appreciation, body comparison and appearance contingent self-worth among Aotearoa New Zealand adults.

Dear Aleisha,

Thank you for the above application that was considered by the Massey University Human Ethics Human Ethics Southern B Committee at their meeting held on 31/10/2022.

On behalf of the Committee I am pleased to advise you that ethical approval has been granted for your research.

Approval is valid for three years. If this project has not been completed within three years from the date of this letter, an amendment to extend the approval must be requested by contacting the Research Ethics Office at humanethics@massey.ac.nz.

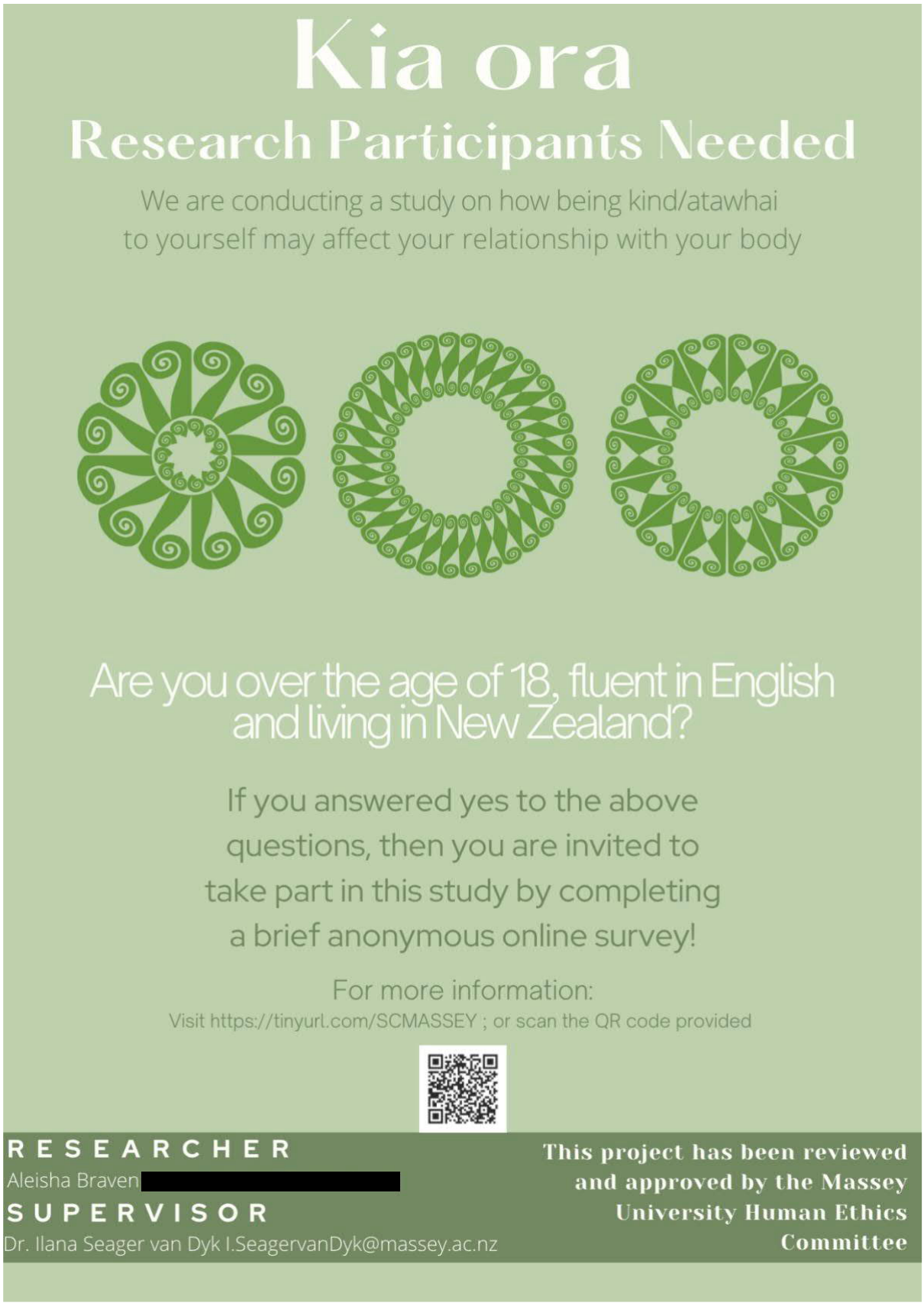
If the nature, content, location, procedures or personnel of your approved application change, please contact the Research Ethics Office at humanethics@massey.ac.nz to request an amendment form.

If you wish to print an official copy of this letter:

1. Please login to the RIMS system (https://rme.massey.ac.nz).
2. In the Ethics menu, select Ethics Applications.
3. Using the Advanced option, select Ethics Applications (Area), Application ID (Search On), enter the ethics notification number in the Value area and select Find on the toolbar.
4. With the application the Results Tab, tick the empty box on the far left of the application and select Reports from the toolbar.
5. Select the "Human Ethics - Low Risk Notification Letter" link, this will open the report viewer.
6. Select the application code from the Report Parameters dropdown and submit. You can then select an export option from the top toolbar (Print, Save).

Yours sincerely
Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and
Director (Research Ethics)

Appendix D: General Flyer



Appendix E: Gender-Diverse Flyer

Appendix F: Letter to Organisation

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

The relationship between self-compassion and body comparison, appearance contingent self-worth and body appreciation among New Zealand adults.

ORGANISATION LETTER

Kia ora [INSERT ORGANISATION NAME],

My name is Aleisha Braven. I am undertaking my Master's thesis at Massey University under the supervision of Dr. Ilana Seager van Dyk, who is a mental health researcher and clinical psychologist with a particular focus on Rainbow communities. I have a Bachelor of Health Science with a major in psychology from Auckland University of Technology (2020) and subsequently, I completed a Post Graduate Diploma in Health Science with a major in psychology. I currently work as a telephone counsellor and mental health support worker for Lifeline and Emerge Aotearoa as well as volunteer for Anxiety New Zealand. My position within those organisations has allowed me to gain a strong real-life understanding of mental health and wellbeing and a passion for helping people with their mental health. I have a significant interest in eating disorders, disordered eating, body image, and body-related attitudes and behaviours which have been the driving force behind my chosen Master's thesis topic.

For my master's, I aim to explore the relationship between self-compassion and body appreciation, body comparison and appearance contingent self-worth. Research suggests that body image is an important aspect of several individuals' self-concept. Individuals of all genders and ages can be dissatisfied with their bodies and body discontent is so prevalent that it has come to be normative. For example, we know that body dissatisfaction is quite common among gender diverse individuals who experience body-related dysphoria.

For many people, their appearance has come to be a central and vital component of their overall sense of self-worth. Research suggests that people who evaluate their self-worth based on their appearance can experience significant negative consequences on their body image, and self-esteem and even potentially develop a mental disorder. Several men and women also compare their personal appearance to images they see of people in the media as well as people in their everyday lives. This form of social comparison is a vital component in the development and maintenance of eating disturbance and body dissatisfaction.

There is a large, ever-growing body of literature that accentuates protective factors that may contribute toward the cultivation and protection of positive body image amid the sociocultural threats that men and women so frequently experience. Self-compassion which involves expressing compassion and empathy toward oneself during difficult times or instances of suffering has been consistently recognised as a psychological trait that can be adopted and strengthened over time to help people to respect and appreciate their bodies.

Understanding the relationship between self-compassion and body appreciation, body comparison and appearance contingent self-worth is imperative as it has practical implications for cultivating positive body image among men and women.

In order to conduct this research, I need your help. I am seeking Aotearoa New Zealand adults to complete a questionnaire for the purpose of this research. I am interested in advertising my study in your organisation by putting my study flyer up to gain participants for this research. Would you please be able to advise if you approve of me advertising my study in your organisation? I have attached a copy of the study flyer for you to look at.

I appreciate your time, and would be happy to provide a research summary or webinar of my findings once the project is complete if that would be of interest to your organisation. Please do not hesitate to contact me if you have any questions.

Ngā mihi,

Aleisha Braven

Email: [redacted]
Ph. [redacted]