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Modeling Emotional Eating through Self-Compassion, Body Dissatisfaction, Emotion Regulation, and Psychological Distress

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A B S T R A C T

Objective: This study aimed to model emotional eating through self-compassion, body dissatisfaction, emotion regulation difficulties, and psychological distress among Canadian adults.

Methods and Materials: This cross-sectional correlational study was conducted on 742 adults residing in Canada. Participants were recruited through online advertisements, university mailing lists, community organizations, and social media platforms. Data were collected using the Emotional Eating Scale, Self-Compassion Scale, Body Shape Questionnaire-34, Difficulties in Emotion Regulation Scale, and Depression Anxiety Stress Scales-21. After screening the data for missing values, normality, outliers, and multicollinearity, descriptive statistics, reliability analysis, Pearson correlations, confirmatory factor analysis, and structural equation modeling were performed. Model fit was evaluated using χ^2/df, CFI, TLI, IFI, GFI, AGFI, RMSEA, and SRMR. Indirect effects were examined through bias-corrected bootstrapping with 5,000 resamples.

Findings: The measurement model demonstrated excellent fit to the data, $\chi^2(392) = 823.47$, $\chi^2/df = 2.10$, CFI = .965, TLI = .961, IFI = .965, GFI = .929, AGFI = .914, RMSEA = .039, and SRMR = .041. In the structural model, self-compassion negatively predicted emotional eating, emotion regulation difficulties, and psychological distress. Body dissatisfaction positively predicted emotional eating and psychological distress. Emotion regulation difficulties positively predicted both emotional eating and psychological distress, while psychological distress positively predicted emotional eating. Bootstrap analysis confirmed significant indirect effects of self-compassion on emotional eating through emotion regulation difficulties and psychological distress, body dissatisfaction on emotional eating through psychological distress, and emotion regulation difficulties on emotional eating through psychological distress. The model explained 69% of the variance in emotional eating.

Conclusion: The findings indicate that emotional eating is shaped by a network of protective and risk-related psychological factors. Higher self-compassion appears to reduce emotional eating directly and indirectly by lowering emotional dysregulation and psychological distress, whereas body dissatisfaction and emotion regulation difficulties increase emotional eating through distress-related pathways. These results highlight the importance of integrated interventions targeting self-compassion, body image, emotion regulation, and psychological distress.

Keywords: *Emotional eating; Self-compassion; Body dissatisfaction; Emotion regulation; Psychological distress; Structural equation modeling*

1. Introduction

Emotional eating has become an increasingly important construct in contemporary psychological, nutritional, and behavioral health research because it reflects a maladaptive pattern in which food intake is driven less by physiological hunger and more by affective states, emotional tension, distress, or attempts to regulate uncomfortable internal experiences. Rather than representing only a dietary behavior, emotional eating is now widely conceptualized as a psychologically embedded response pattern located at the intersection of affect regulation, body image, self-evaluation, and mental health vulnerability. This conceptual expansion is particularly important because emotional eating may occur across clinical, subclinical, and community populations and may contribute to cycles of guilt, shame, body dissatisfaction, loss of control, weight fluctuation, and disordered eating symptoms. Contemporary reviews of eating disorder symptoms and evidence-based treatment approaches emphasize that maladaptive eating behaviors should be understood through multidimensional frameworks that include emotional, cognitive, interpersonal, and body-related mechanisms rather than through narrow models focused only on food consumption or weight status (Ortiz et al., 2026). Similarly, narrative work on disordered eating in emerging adults highlights that eating-related problems often emerge during developmental periods marked by identity formation, heightened social comparison, increased autonomy, and greater exposure to appearance-based pressures, making psychological mechanisms central to prevention and intervention efforts (El-Jor et al., 2025). In this regard, emotional eating can be viewed as an important behavioral indicator of broader difficulties in emotional coping and self-regulation.

A central psychological process in emotional eating is psychological distress, particularly when symptoms of depression, anxiety, and stress are experienced as persistent, overwhelming, or difficult to tolerate. Individuals who experience elevated distress may use eating as a short-term strategy for emotional relief, distraction, self-soothing, or avoidance, even when this strategy later intensifies guilt, shame, or perceived loss of control. Evidence from women with generalized anxiety disorder has shown that emotional eating is closely related to anxiety-related emotional vulnerability, suggesting that distress-driven eating may function as an affective coping response among individuals who experience chronic worry and heightened emotional arousal (Natasha Kim de Oliveira da et al., 2023). Research on mindful eating and eating disorder risk similarly supports the role of depression and body mass index as mediating mechanisms, indicating that emotional symptoms and weight-related concerns may jointly shape eating-related risk pathways (Aydin & Cetin, 2026). Studies of body image, narcissism, envy, loneliness, depression, and suicidal ideation further suggest that emotional distress may intensify the psychological consequences of negative body-related self-evaluation, particularly when self-compassion is limited or when interpersonal comparison processes are salient (Tran et al., 2026). These findings indicate that emotional eating should not be treated as an isolated behavioral outcome but as part of a broader distress-regulation system.

Body dissatisfaction is another major risk factor in models of emotional eating and disordered eating. It refers to negative evaluation of one's body size, shape, appearance, or weight and often develops in response to sociocultural standards, perceived deviations from idealized norms, weight stigma, social comparison, and internalized criticism. Contemporary systematic and narrative reviews indicate that body image concerns are strongly connected with self-esteem, emotion regulation, and eating disorder symptoms in adults, supporting the idea that body dissatisfaction may serve as both a direct and indirect contributor to maladaptive eating behaviors (Abdoli et al., 2025). Broader reviews of body perception and psychological well-being have also demonstrated that body image satisfaction is shaped by cultural, gendered, and media-related influences, and that negative body perception is associated with poorer mental health outcomes (Merino et al., 2024). The psychological

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significance of body dissatisfaction is further demonstrated in research on bariatric surgery patients, where body dissatisfaction has been linked with suicidal risk and gender-specific vulnerability over time (Goldzweig et al., 2024). These findings suggest that body dissatisfaction is not merely a cosmetic concern; rather, it is a clinically meaningful psychological condition that may increase emotional distress and maladaptive efforts to regulate emotion through eating.

The sociocultural context in which body dissatisfaction develops has been transformed by social media, digital self-presentation, and intensified exposure to idealized body images. Social media environments frequently promote appearance comparison, self-objectification, and internalization of body ideals, while simultaneously exposing individuals to health, fitness, and dietary messages that may be framed as wellness but can intensify body surveillance and dissatisfaction. Research on the healthy eating movement on social media suggests that even ostensibly positive health-related content may have adverse psychological effects when it reinforces rigid ideals, appearance-based comparison, or anxiety about eating practices (Zaharia & Gonța, 2024). Work examining emotional distress and body dissatisfaction has also identified the mediating role of social media and emotional regulation, indicating that digital exposure may intensify negative body evaluation through emotion-related pathways (López-Montón et al., 2024). Studies of young women using multi-method approaches further show that weight bias internalization can become embedded in self-concept and emotional experience, contributing to shame and body-related vulnerability (Friedman, 2023). Similarly, postpartum research demonstrates that social comparison is meaningfully related to body dissatisfaction and disordered eating, suggesting that body-related risk can emerge in distinct life stages and is not restricted to adolescence or early adulthood (Thompson & Bardone-Cone, 2022). These findings underscore the importance of examining body dissatisfaction as a psychological risk factor within contemporary social and digital environments.

Self-compassion has emerged as a potentially protective factor against emotional eating, body dissatisfaction, psychological distress, and eating disorder risk. Self-compassion involves responding to personal suffering, perceived inadequacy, or failure with kindness, mindfulness, and recognition of shared human imperfection rather than with harsh self-criticism, shame, or isolation. This construct is particularly relevant to emotional eating because individuals who lack self-compassion may experience negative emotions as threatening, shameful, or intolerable and may therefore rely on eating as an immediate strategy for emotional relief. Evidence from the United Kingdom during COVID-19 lockdown showed that self-compassion mediated the association between pandemic-related stress and body image disturbance, suggesting that compassionate self-relating can buffer the effects of stress on body-related distress (Swami et al., 2021). Qualitative research has also identified pathways through which self-compassion improves positive body image, including reduced self-criticism, greater body acceptance, and more flexible responses to appearance-related concerns (Raque-Bogdan et al., 2023). Studies integrating sociocultural perspectives further argue that self-compassion may reduce the harmful effects of idealized body norms by weakening shame-based responses and supporting more positive body image processes (Mills et al., 2022). These findings support the theoretical position that self-compassion may reduce emotional eating directly and indirectly by decreasing distress, shame, and body dissatisfaction.

Recent empirical work has extended this protective model across different populations and psychological contexts. In adolescents, self-compassion has been shown to play an important role in the relationship between self-perceived and other-perceived body image, mindfulness, and personality-related vulnerabilities, indicating that compassionate self-awareness may reduce the psychological impact of negative body perception (An et al., 2025). Research among adolescents with physical deformities has similarly highlighted the relevance of self-compassion for body-related psychological adjustment, particularly when individual and contextual variables influence the experience of visible difference (Meiri et al., 2024). Among women with polycystic ovary syndrome, regulatory emotional self-efficacy and self-compassion have been identified as mediating mechanisms linking anxiety, depression, body image distress, and subjective well-being, further demonstrating the relevance of self-compassion in conditions where body image and emotional distress are closely intertwined (Wang et al., 2024). Additional work on adolescents with polycystic ovary syndrome has shown that self-esteem and self-compassion mediate the relationship between body dissatisfaction and depression, suggesting that self-compassion may interrupt the pathway from negative body evaluation to emotional suffering (Huangfu et al., 2024). Together, these findings indicate that self-compassion may be especially important in models that seek

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to explain how body dissatisfaction and distress become translated into maladaptive eating behavior.

Emotion regulation is another core mechanism in emotional eating. Emotion regulation refers to the ability to identify, understand, tolerate, modify, and respond adaptively to emotional states. When individuals experience difficulties in emotion regulation, they may struggle with impulse control, emotional clarity, goal-directed behavior, acceptance of emotions, and access to effective coping strategies. In such circumstances, eating may become a rapid but temporary means of reducing distress, numbing negative affect, or escaping from emotional overload. A pilot study of an online self-compassion program for autistic adults demonstrated that self-compassion can improve emotion regulation and mental health outcomes, supporting the idea that compassionate self-relating may strengthen adaptive emotional functioning (Cai et al., 2024). Longitudinal research has also shown that childhood emotional maltreatment is associated with disordered eating behaviors through repetitive negative thinking and body dissatisfaction, suggesting that emotion-related cognitive processes can link early adverse experiences to later eating pathology (Wu et al., 2025). Research on adverse childhood experiences and eating disorder symptoms among high-risk adolescents further identifies emotion regulation, self-compassion, and body image as important associated mechanisms, emphasizing the interconnected nature of emotional vulnerability and eating-related outcomes (Poon et al., 2025). These findings provide strong justification for including emotion regulation difficulties as a central mediator in models of emotional eating.

The role of self-compassion and emotion regulation is also supported by studies examining specific behavioral and clinical risks. Research on self-weighing and disordered eating among women indicates that psychological resilience and self-compassion may moderate the relationship between weight-monitoring behaviors and eating-related pathology, suggesting that the emotional meaning assigned to body-related behaviors may be as important as the behaviors themselves (Türkcan et al., 2025). Studies on the adverse consequences of social media use similarly indicate that self-compassion may serve as a protective factor by reducing the psychological harm associated with comparison, appearance exposure, and self-critical evaluation (Manjanatha et al., 2025). Research on facial negative physical self and social anxiety among college students also shows that rumination and self-compassion are involved in the relationship between negative physical self-evaluation and social anxiety, demonstrating that self-compassion may influence not only body image but also broader interpersonal and affective outcomes (Yan et al., 2025). In populations exposed to violence, body shaming, and self-harm, qualitative evidence suggests that the body can become a site of psychological conflict, shame, and distress, particularly among adolescents with histories of suicide attempts (Rizk-Hildbrand et al., 2025). These studies suggest that self-compassion, body dissatisfaction, and emotional regulation difficulties are not independent constructs but overlapping psychological processes that may jointly shape emotional eating.

Intervention-oriented research further supports the importance of examining emotional eating through a multidimensional psychological model. Behavioral interventions designed to attenuate driven overeating and weight regain after bariatric surgery emphasize that maladaptive eating is sustained by learned behavioral patterns, emotional triggers, and difficulties maintaining adaptive coping strategies after weight-related treatment (Ames et al., 2022). Mindfulness- and compassion-based clinical trial protocols for post-bariatric surgery patients similarly suggest that eating behavior may improve when interventions target awareness, acceptance, and compassionate self-regulation rather than focusing exclusively on dietary restriction (Porto et al., 2024). Scoping work on compassion-focused therapy in relation to body dissatisfaction, stigma, and eating disorders further indicates that compassion-based approaches may be particularly relevant for individuals whose eating problems are embedded in shame, weight stigma, and negative body evaluation (Dover & Clements, 2025). Research on psychological interventions for dancers' mental health also shows that populations exposed to appearance evaluation and performance pressure may benefit from interventions that address emotional distress, body image, and self-critical standards (Zhang et al., 2025). These intervention perspectives reinforce the need for structural models that clarify how protective factors such as self-compassion and risk factors such as body dissatisfaction, emotion regulation difficulties, and psychological distress contribute to emotional eating.

The COVID-19 pandemic further intensified scholarly attention to emotional eating, body dissatisfaction, and psychological vulnerability because periods of isolation, uncertainty, stress, and disrupted routine increased the salience of both emotional distress and eating-related coping. A review of the pandemic's impact on perceptual

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disturbances and dysfunctional eating attitudes and behaviors showed that distressing social conditions can worsen body-related concerns and maladaptive eating patterns, suggesting that emotional eating should be examined within broader psychosocial contexts (Monthuy-Blanc et al., 2023). The pandemic also amplified digital exposure and social comparison, which may have increased body dissatisfaction and reduced opportunities for adaptive emotional coping. In this context, self-compassion became particularly relevant because it may buffer individuals against shame, perceived failure, and self-criticism during periods of stress and uncertainty. At the same time, psychological distress may intensify emotional eating when individuals lack effective emotion regulation skills or when eating becomes one of the few accessible strategies for immediate emotional relief. Therefore, a model that simultaneously examines self-compassion, body dissatisfaction, emotion regulation difficulties, and psychological distress can provide a more integrated explanation of emotional eating than models that evaluate these variables separately.

Despite substantial progress in the literature, several conceptual and empirical gaps remain. First, many studies have examined body dissatisfaction, self-compassion, distress, or emotion regulation in relation to eating outcomes separately, while fewer have integrated these variables within a single explanatory model. Second, existing studies often focus on clinical eating disorder symptoms, adolescent samples, or specific medical groups, leaving a need for community-based adult models that examine emotional eating as a dimensional behavioral outcome. Third, although self-compassion is increasingly recognized as protective, its direct and indirect associations with emotional eating through emotion regulation and psychological distress require further clarification. Fourth, body dissatisfaction may influence emotional eating both directly and indirectly through distress, yet this pathway needs additional empirical modeling. Finally, the interdependence of emotion regulation difficulties and psychological distress suggests that emotional eating may emerge from a cascade in which negative self-evaluation and poor affect regulation intensify emotional symptoms, which in turn increase eating in response to emotion. Addressing these gaps is important because emotional eating is not only a behavioral issue but also a manifestation of broader psychological distress, body-related self-criticism, and limited emotional coping capacity.

The aim of this study was to model emotional eating through self-compassion, body dissatisfaction, emotion regulation difficulties, and psychological distress among Canadian adults.

2. Methods and Materials

2.1. Study Design and Participants

This study employed a cross-sectional correlational design using structural equation modeling (SEM) to investigate the direct and indirect relationships among self-compassion, body dissatisfaction, emotion regulation, psychological distress, and emotional eating in a Canadian adult population. The study was conducted between January and April 2026 across multiple provinces in Canada, including Ontario, British Columbia, Alberta, and Quebec. A total of 742 adults participated in the study. Participants were recruited through online advertisements, university mailing lists, community organizations, and social media platforms using a voluntary convenience sampling strategy. Eligibility criteria included being at least 18 years of age, residing in Canada, possessing sufficient English language proficiency to complete the questionnaires independently, and providing informed consent prior to participation. Individuals who reported a current diagnosis of severe cognitive impairment or psychotic disorders that could interfere with questionnaire completion were excluded from the study.

2.2. Measures

Emotional eating was assessed using the Emotional Eating Scale (EES) developed by Arnow, Kenardy, and Agras (1995). The instrument is designed to measure the tendency to eat in response to a range of emotional states rather than physiological hunger. The questionnaire consists of 25 items assessing eating behavior in response to emotions such as anxiety, anger, frustration, sadness, and depression. Participants indicate the extent to which each emotion increases their desire to eat using a five-point Likert-type scale ranging from no desire to eat to an overwhelming urge to eat. Higher total scores indicate greater emotional eating tendencies. Numerous international studies have demonstrated excellent internal consistency, test-retest reliability, and construct validity of the Emotional Eating Scale across community and clinical populations, making it one of the most widely used instruments for evaluating emotion-driven eating behaviors.

Self-compassion was measured using the Self-Compassion Scale (SCS) developed by Neff (2003). The full

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version of the instrument contains 26 items measuring six dimensions of self-compassion, including self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. Responses are recorded on a five-point Likert scale ranging from almost never to almost always. Negatively worded items are reverse scored before calculating the total score, with higher scores reflecting greater self-compassion. The Self-Compassion Scale has demonstrated excellent psychometric properties across numerous cultural contexts, including high internal consistency, factorial validity, convergent validity, and temporal stability. Previous research has consistently supported its reliability and validity among adult populations.

Body dissatisfaction was assessed using the Body Shape Questionnaire-34 (BSQ-34) developed by Cooper, Taylor, Cooper, and Fairburn (1987). The questionnaire contains 34 items evaluating concerns related to body shape, weight, body image, and appearance over the previous four weeks. Participants respond using a six-point Likert scale ranging from never to always. Total scores are obtained by summing responses across all items, with higher scores representing greater dissatisfaction with body shape and appearance. The BSQ has consistently demonstrated excellent internal consistency, criterion validity, convergent validity with eating disorder symptoms, and sensitivity in both clinical and non-clinical populations. Previous investigations have confirmed its reliability and validity in diverse adult samples.

Emotion regulation difficulties were measured using the Difficulties in Emotion Regulation Scale (DERS) developed by Gratz and Roemer (2004). The instrument includes 36 items organized into six domains: nonacceptance of emotional responses, difficulties engaging in goal-directed behavior, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity. Participants rate each statement on a five-point Likert scale ranging from almost never to almost always. Higher scores indicate greater difficulties in regulating emotions. The DERS has consistently demonstrated strong internal consistency, excellent construct validity, and satisfactory test-retest reliability across both community and clinical populations. Numerous studies have confirmed its suitability for assessing multidimensional emotion regulation deficits.

Psychological distress was measured using the Depression Anxiety Stress Scales-21 (DASS-21) developed by Lovibond and Lovibond (1995). This self-report instrument contains 21 items equally distributed across three subscales assessing depression, anxiety, and stress. Participants rate the extent to which each statement applied to them during the previous week using a four-point Likert scale ranging from did not apply to me at all to applied to me very much or most of the time. Scores for each subscale are summed and multiplied by two to obtain scores comparable to the original 42-item version. Higher scores indicate greater psychological distress. The DASS-21 has demonstrated excellent reliability, convergent validity, discriminant validity, and factorial validity across numerous international studies and has become one of the most widely used measures of emotional distress in psychological research.

2.3. Data analysis

Data analysis was conducted using IBM SPSS Statistics version 29 for preliminary analyses and IBM SPSS AMOS version 29 for structural equation modeling. Initially, descriptive statistics including means, standard deviations, skewness, and kurtosis were calculated for all study variables. Data were screened for missing values, univariate and multivariate outliers, and adherence to assumptions of normality, linearity, and multicollinearity. Internal consistency reliability of each instrument was evaluated using Cronbach's alpha and composite reliability coefficients. Pearson correlation analyses were performed to examine bivariate associations among the study variables. Confirmatory factor analysis was subsequently conducted to evaluate the measurement model and verify the construct validity of the latent variables before testing the structural model. Structural equation modeling using maximum likelihood estimation was then employed to examine the hypothesized direct and indirect pathways among self-compassion, body dissatisfaction, emotion regulation difficulties, psychological distress, and emotional eating. Model fit was evaluated using multiple goodness-of-fit indices, including the chi-square to degrees of freedom ratio (χ^2/df), Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), Goodness-of-Fit Index (GFI), Adjusted Goodness-of-Fit Index (AGFI), Root Mean Square Error of Approximation (RMSEA), and Standardized Root Mean Square Residual (SRMR). Indirect effects were tested using bias-corrected bootstrap analyses with 5,000 resamples, and statistical significance was determined at a probability level of $p < .05$ throughout all analyses.

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3. Findings and Results

A total of 742 participants completed all study questionnaires and were included in the final analyses. The sample consisted of 429 women (57.8%), 304 men (41.0%), and 9 participants (1.2%) who identified as another gender or preferred not to disclose their gender. Participants ranged in age from 18 to 67 years (M = 34.82, SD = 11.47). Regarding educational attainment, 18.5% had completed high school, 34.8% held a bachelor's degree, 32.6% had completed a master's degree, and 14.1% possessed a doctoral or professional degree. Approximately 61.2% of participants were employed full-time, 14.8% were employed part-time, 15.4% were university students, and 8.6% reported being unemployed or retired. The average body mass index (BMI) was 25.41 kg/m² (SD = 4.69), with values ranging from 17.3 to 42.6 kg/m². Preliminary screening indicated that missing data represented less than 1% of all responses and were handled using expectation-maximization estimation. Examination of skewness and kurtosis statistics suggested acceptable univariate normality for all observed variables. Mahalanobis distance identified seven multivariate outliers; however, their exclusion did not meaningfully alter the results, and therefore all participants were retained in the final analyses to preserve statistical power.

Table 1

Descriptive Statistics, Reliability Coefficients, and Correlations Among the Study Variables

Variable	Mean	SD	Skewness	Kurtosis	Cronbach's α	CR	AVE	1	2	3	4	5
1. Emotional Eating	63.28	18.44	0.38	-0.44	.94	.95	.67	—				
2. Self-Compassion	81.74	16.83	-0.29	-0.36	.93	.94	.65	-.59**	—			
3. Body Dissatisfaction	92.51	26.72	0.41	-0.21	.96	.96	.71	.66**	-.54**	—		
4. Emotion Regulation Difficulties	83.19	20.58	0.46	-0.33	.95	.95	.69	.71**	-.69**	.63**	—	
5. Psychological Distress	31.74	14.29	0.52	-0.28	.94	.95	.68	.68**	-.72**	.59**	.76**	—

Table 1 presents the descriptive statistics, internal consistency coefficients, composite reliability indices, average variance extracted values, and Pearson correlation coefficients for all study variables. Emotional eating demonstrated a moderate average score (M = 63.28, SD = 18.44), while participants reported relatively high variability in body dissatisfaction and emotion regulation difficulties. Internal consistency was excellent for every instrument, with Cronbach's alpha coefficients ranging from .93 to .96, exceeding the recommended threshold of .70. Composite reliability values ranged from .94 to .96, while average variance extracted values exceeded .65 for all latent constructs, indicating satisfactory convergent validity. Examination of the correlation matrix revealed that emotional eating was significantly and positively associated with body dissatisfaction ($r = .66$, $p < .001$), emotion regulation difficulties ($r = .71$, $p < .001$), and psychological distress ($r = .68$, $p < .001$). Conversely, emotional eating demonstrated a strong negative association with self-compassion ($r = –.59$, $p < .001$). Self-compassion also exhibited significant negative relationships with body dissatisfaction, emotion regulation difficulties, and psychological distress, suggesting that individuals with greater self-compassion experienced lower emotional vulnerability across multiple psychological domains. The strongest bivariate association was observed between emotion regulation difficulties and psychological distress ($r = .76$, $p < .001$), supporting the theoretical assumption that ineffective emotional regulation is closely linked with elevated emotional symptoms. Collectively, these findings provide preliminary empirical support for the hypothesized relationships and justify proceeding with structural equation modeling.

Table 2

Model Fit Indices

Fit Index	Recommended Value	Obtained Value
χ^2	—	823.47
df	—	392
χ^2/df	<3.00	2.10
CFI	>.90	.965
TLI	>.90	.961

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IFI	>.90	.965
GFI	>.90	.929
AGFI	>.90	.914
RMSEA	<.08	.039
SRMR	<.08	.041

The adequacy of the measurement model was evaluated through confirmatory factor analysis prior to testing the structural relationships. As shown in Table 2, all goodness-of-fit indices indicated an excellent correspondence between the hypothesized measurement model and the observed data. The chi-square to degrees of freedom ratio was 2.10, remaining well below the recommended threshold of 3.00. Incremental fit indices, including the Comparative Fit Index (.965), Tucker-Lewis Index (.961), and Incremental Fit Index (.965), all exceeded the accepted criterion of .90 and approached the more stringent standard of .95, reflecting outstanding model fit. Similarly, the Goodness-of-Fit Index (.929) and Adjusted Goodness-of-Fit Index (.914) demonstrated satisfactory absolute model fit. Error indices further supported the adequacy of the model, with the Root Mean Square Error of Approximation (.039) and Standardized Root Mean Square Residual (.041) remaining substantially below the recommended cut-off values. Standardized factor loadings for all observed indicators ranged from .71 to .92 and were statistically significant ($p < .001$), confirming that each observed variable adequately represented its corresponding latent construct. These findings collectively demonstrate that the measurement model possessed excellent psychometric quality and provided a sound basis for evaluating the structural relationships among the study variables.

Table 3

Standardized Direct, Indirect, and Total Effects of the Structural Model

Path	β	SE	CR	p
Self-Compassion → Emotional Eating	-.24	.041	-5.87	<.001
Self-Compassion → Emotion Regulation Difficulties	-.57	.036	-15.84	<.001
Self-Compassion → Psychological Distress	-.39	.042	-9.31	<.001
Body Dissatisfaction → Emotional Eating	.31	.043	7.21	<.001
Body Dissatisfaction → Psychological Distress	.27	.039	6.92	<.001
Emotion Regulation Difficulties → Emotional Eating	.33	.046	7.18	<.001
Emotion Regulation Difficulties → Psychological Distress	.45	.037	12.16	<.001
Psychological Distress → Emotional Eating	.26	.041	6.34	<.001

The structural model demonstrated excellent overall fit and supported all hypothesized direct relationships among the latent constructs. As presented in Table 3, self-compassion exerted a statistically significant negative direct effect on emotional eating ($\beta = –.24$, $p < .001$), indicating that individuals reporting greater self-compassion exhibited lower tendencies toward emotionally driven eating behaviors. Self-compassion also showed strong inverse effects on emotion regulation difficulties ($\beta = –.57$, $p < .001$) and psychological distress ($\beta = –.39$, $p < .001$), suggesting that greater self-kindness and emotional acceptance substantially reduced emotional dysregulation and distress. Body dissatisfaction emerged as another significant predictor, exerting positive effects on both psychological distress ($\beta = .27$, $p < .001$) and emotional eating ($\beta = .31$, $p < .001$). Emotion regulation difficulties demonstrated the strongest direct influence on psychological distress ($\beta = .45$, $p < .001$) while simultaneously exerting a substantial positive effect on emotional eating ($\beta = .33$, $p < .001$). Finally, psychological distress significantly predicted emotional eating ($\beta = .26$, $p < .001$), indicating that elevated depressive, anxious, and stress-related symptoms contributed independently to maladaptive eating behaviors. Collectively, these findings suggest that emotional eating develops through multiple interconnected psychological pathways rather than through a single isolated mechanism.

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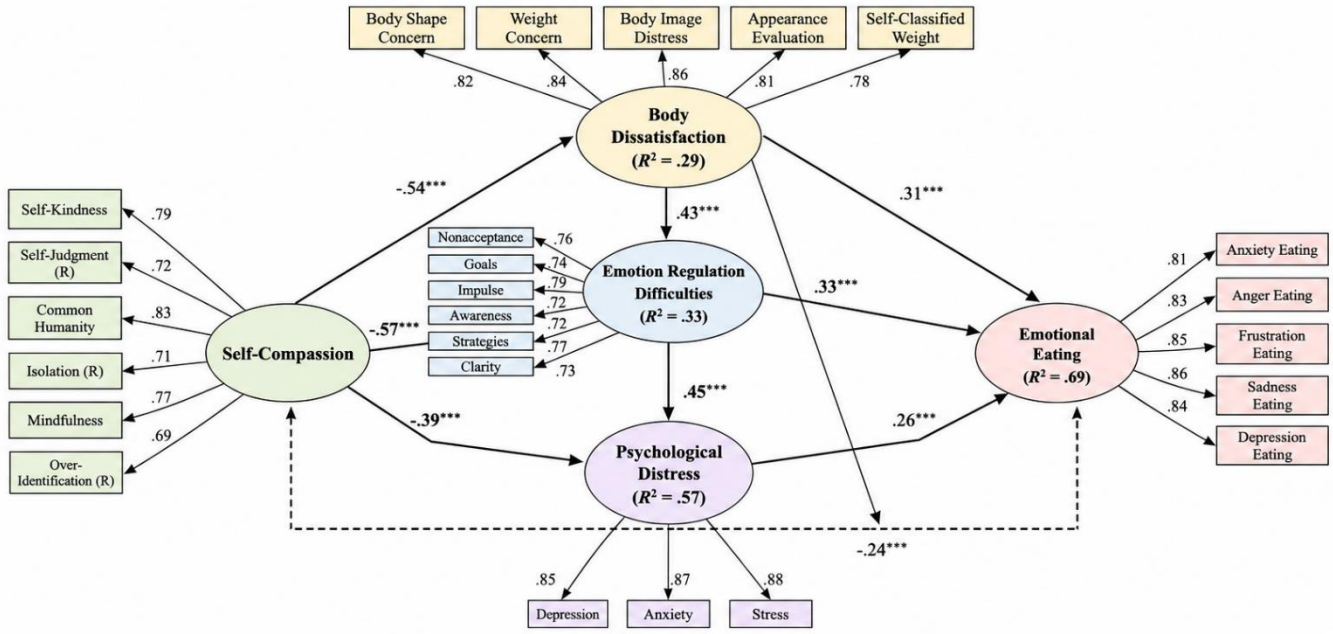
Table 4

Bootstrap Analysis of Indirect Effects and Explained Variance

Indirect Path	Standardized Effect	Boot SE	95% CI	p
Self-Compassion → Emotion Regulation Difficulties → Emotional Eating	-.19	.029	-.247 to -.136	<.001
Self-Compassion → Psychological Distress → Emotional Eating	-.10	.021	-.144 to -.064	<.001
Body Dissatisfaction → Psychological Distress → Emotional Eating	.07	.018	.039 to .109	<.001
Emotion Regulation Difficulties → Psychological Distress → Emotional Eating	.12	.020	.083 to .164	<.001

Figure 1

Final Structural Equation Model



Note. Standardized coefficients are reported. Solid lines indicate hypothesized paths; dashed line indicates a direct path.

All coefficients are significant at ***$p < .001$.

Model fit: $\chi^2(392) = 823.47$, $\chi^2/df = 2.10$, *CFI* = .965, *TLI* = .961, *IFI* = .965, *GFI* = .929, *AGFI* = .914, *RMSEA* = .039, *SRMR* = .041.

Bootstrap analyses using 5,000 resamples confirmed the presence of several statistically significant indirect pathways, indicating that the proposed mediating mechanisms were supported. Self-compassion demonstrated significant indirect negative effects on emotional eating through both emotion regulation difficulties (β = –.19, p < .001) and psychological distress (β = –.10, p < .001). These findings suggest that individuals with higher self-compassion experience fewer emotional regulation deficits and lower psychological distress, which subsequently reduce their likelihood of engaging in emotional eating. Body dissatisfaction also indirectly predicted emotional eating through increased psychological distress (β = .07, p < .001), indicating that negative body image contributes to maladaptive eating partly by increasing emotional suffering. Furthermore, emotion regulation difficulties indirectly influenced emotional eating through psychological distress (β = .12, p < .001), highlighting distress as an important psychological mechanism linking emotional dysregulation with maladaptive eating behavior. The structural model explained 33% of the variance in emotion regulation difficulties, 57% of the variance in psychological distress, and an impressive 69% of the variance in emotional eating. These proportions indicate that the proposed model possesses substantial explanatory power and successfully accounts for the majority of individual differences in emotional eating within this Canadian adult sample. Overall, the results provide strong empirical support for the theoretical model, demonstrating that emotional eating is shaped by a complex network of protective and risk factors

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involving self-compassion, body dissatisfaction, emotion regulation, and psychological distress.

4. Discussion

The present study aimed to model emotional eating through self-compassion, body dissatisfaction, emotion regulation difficulties, and psychological distress among Canadian adults. The findings supported the proposed structural model and demonstrated that emotional eating was significantly associated with a network of protective and risk-related psychological variables. The descriptive and correlational results showed that emotional eating was positively correlated with body dissatisfaction, emotion regulation difficulties, and psychological distress, while it was negatively correlated with self-compassion. These initial associations indicate that individuals who reported stronger tendencies toward emotionally driven eating also tended to experience greater dissatisfaction with their body, more difficulty regulating emotional states, and higher symptoms of depression, anxiety, and stress. In contrast, higher self-compassion was associated with lower emotional eating and lower levels of psychological vulnerability. These findings are consistent with contemporary multidimensional models of eating-related problems, which conceptualize maladaptive eating not merely as a behavioral response to food cues but as an affectively driven pattern embedded in self-evaluation, distress tolerance, emotion regulation, and body-related cognition (El-Jor et al., 2025; Ortiz et al., 2026). The strength of the observed associations also supports the view that emotional eating should be studied as part of a broader psychological system rather than as an isolated dietary or weight-related behavior.

One of the central findings of the study was that self-compassion had a significant negative direct effect on emotional eating. This result suggests that individuals who approach themselves with kindness, mindfulness, and a sense of common humanity are less likely to rely on eating as a strategy for coping with distressing emotions. Self-compassion may reduce emotional eating by weakening self-critical reactions, decreasing shame after perceived dietary failure, and promoting more adaptive acceptance of difficult emotional experiences. This finding aligns with previous research showing that self-compassion may buffer the negative psychological effects of stress on body image disturbance (Swami et al., 2021) and may improve positive body image through reduced self-judgment, greater acceptance, and more flexible self-relating (Raque-Bogdan et al., 2023). It also corresponds with theoretical perspectives suggesting that self-compassion can reduce shame-based responses to idealized body norms and thereby interrupt pathways leading from negative body evaluation to disordered eating attitudes (Mills et al., 2022). The present results further extend this literature by showing that self-compassion is not only relevant to body image or eating disorder symptoms, but also directly predicts emotional eating in an adult community sample.

The model also demonstrated that self-compassion negatively predicted both emotion regulation difficulties and psychological distress. These results suggest that self-compassion may function as a broad emotional resilience factor that reduces vulnerability to dysregulated affect and distress symptoms. Individuals with higher self-compassion may be more capable of recognizing emotional pain without overidentifying with it, responding to personal setbacks without harsh self-criticism, and tolerating negative affect without resorting to impulsive or avoidant coping behaviors. This interpretation is consistent with evidence that self-compassion-based programs can improve emotion regulation and mental health outcomes (Cai et al., 2024). It also aligns with findings among women with polycystic ovary syndrome indicating that self-compassion and regulatory emotional self-efficacy are important mediating mechanisms linking body image distress, anxiety, depression, and subjective well-being (Wang et al., 2024). Similar findings have been reported in adolescents with polycystic ovary syndrome, where self-compassion and self-esteem mediated the relationship between body dissatisfaction and depression (Huangfu et al., 2024). Thus, the present study reinforces the idea that self-compassion may protect against emotional eating partly because it reduces the emotional instability and psychological distress that often precede maladaptive eating episodes.

Body dissatisfaction emerged as another significant predictor in the structural model, showing both a direct positive effect on emotional eating and an indirect effect through psychological distress. This finding indicates that negative evaluation of body shape, appearance, or weight may increase the likelihood of eating in response to emotions, both independently and through its contribution to emotional suffering. Individuals who experience dissatisfaction with their body may be more vulnerable to shame, anxiety, sadness, and self-critical rumination, all of which may increase the probability of using food as a short-term strategy for emotional relief. This pattern is consistent with systematic evidence showing that body image concerns

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are strongly connected with self-esteem, emotion regulation, and eating disorder symptoms in adults (Abdoli et al., 2025). It is also consistent with broader reviews showing that body perceptions are closely linked to psychological well-being and that body image satisfaction is shaped by sociocultural, gendered, and psychological influences (Merino et al., 2024). The indirect pathway from body dissatisfaction to emotional eating through psychological distress further supports studies demonstrating that negative body image may have clinically meaningful emotional consequences, including increased distress and risk-related outcomes in vulnerable populations (Goldzweig et al., 2024; Tran et al., 2026).

The significant effect of body dissatisfaction on psychological distress also supports the view that body image concerns are emotionally consequential rather than superficial or merely aesthetic. Body dissatisfaction may become a persistent source of self-monitoring, comparison, perceived inadequacy, and internalized stigma. In contemporary social environments, this vulnerability may be intensified by digital media, appearance comparison, and health-related content that can promote rigid standards of body control. Previous research has shown that social media and emotion regulation may mediate the relationship between emotional distress and body dissatisfaction (López-Montón et al., 2024), while exposure to healthy eating movements on social media may have psychological effects on body image when wellness content becomes tied to body surveillance or moralized eating standards (Zaharia & Gonța, 2024). Research on weight bias internalization also suggests that body-related stigma can become internalized as self-criticism and emotional vulnerability (Friedman, 2023). Similarly, evidence from postpartum women indicates that social comparison is associated with body dissatisfaction and disordered eating (Thompson & Bardone-Cone, 2022). These findings support the present model by showing that body dissatisfaction may be one of the psychological routes through which appearance-based pressures are translated into emotional distress and maladaptive eating behaviors.

Emotion regulation difficulties had a strong direct effect on emotional eating and also predicted psychological distress. This result suggests that individuals who struggle to understand, accept, and manage emotions are more likely to engage in eating as a response to emotional discomfort. Emotional eating may therefore serve as an avoidant or compensatory regulation strategy when individuals lack adaptive strategies for tolerating distress, inhibiting impulses, or pursuing goal-directed behavior during emotional arousal. This finding is consistent with longitudinal evidence showing that emotional maltreatment may contribute to disordered eating behaviors through repetitive negative thinking and body dissatisfaction, highlighting the relevance of emotion-related cognitive and regulatory mechanisms in eating pathology (Wu et al., 2025). It also aligns with research on adverse childhood experiences and eating disorder symptoms, which identifies emotion regulation, self-compassion, and body image as associated mechanisms among high-risk adolescents (Poon et al., 2025). The present findings extend this literature by demonstrating that emotion regulation difficulties are not only associated with emotional eating but also contribute to psychological distress, which in turn further increases emotional eating risk.

Psychological distress significantly predicted emotional eating and mediated several pathways in the model. This finding indicates that symptoms of depression, anxiety, and stress may represent a proximal emotional condition through which self-compassion, body dissatisfaction, and emotion regulation difficulties influence eating behavior. When distress becomes intense or chronic, eating may be used to temporarily reduce unpleasant affect, distract attention, or create a sense of immediate comfort. However, this relief may be short-lived and followed by guilt, shame, or renewed distress, thereby reinforcing a maladaptive cycle. The association between distress and emotional eating is consistent with evidence from women with generalized anxiety disorder, where emotional eating was closely related to anxiety-related vulnerability (Natasha Kim de Oliveira da et al., 2023). It also aligns with research showing that depression and body mass index may mediate the relationship between mindful eating and eating disorder risk (Aydin & Cetin, 2026). Furthermore, studies on facial negative physical self and social anxiety suggest that self-compassion and rumination are important mechanisms linking physical self-evaluation to emotional distress (Yan et al., 2025). The present findings therefore support the interpretation that emotional eating is partly a distress-regulation behavior and that psychological distress is a key mechanism connecting body image and emotion regulation problems to maladaptive eating.

The bootstrap findings provided additional support for the proposed mediational structure. Self-compassion indirectly reduced emotional eating through both emotion regulation difficulties and psychological distress, suggesting that compassionate self-relating may lower emotional eating by

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improving emotional regulation capacity and reducing distress symptoms. Body dissatisfaction indirectly increased emotional eating through psychological distress, indicating that negative body evaluation contributes to emotional eating partly because it intensifies emotional suffering. Emotion regulation difficulties also indirectly predicted emotional eating through psychological distress, supporting the idea that dysregulation may create distress states that subsequently increase eating in response to emotion. These findings are consistent with intervention-oriented literature emphasizing the importance of mindfulness- and compassion-based approaches for improving eating behavior and emotional functioning, particularly among individuals with weight-related or body-related concerns (Dover & Clements, 2025; Porto et al., 2024). They also align with behavioral intervention perspectives indicating that driven overeating and weight regain are sustained by emotional triggers, learned coping patterns, and difficulties maintaining adaptive self-regulation (Ames et al., 2022). Therefore, the present study suggests that interventions for emotional eating may be most effective when they simultaneously target self-compassion, body dissatisfaction, emotion regulation, and distress.

The model explained 69% of the variance in emotional eating, 57% of the variance in psychological distress, and 33% of the variance in emotion regulation difficulties. These explained variance values indicate that the proposed model has substantial explanatory power, especially for emotional eating. The high explained variance in emotional eating suggests that the included variables capture core psychological processes underlying emotionally driven food intake. This finding is particularly important because emotional eating is often influenced by multiple interacting systems, including self-evaluation, distress, body image, social comparison, emotion regulation, and learned coping responses. The findings are consistent with research on social media, self-compassion, and disordered eating, which suggests that self-compassion may protect individuals from the adverse psychological effects of appearance-based comparison and digital exposure (Manjanatha et al., 2025). They also correspond with studies indicating that self-compassion may moderate the relationship between body-related behaviors, such as self-weighing, and disordered eating among women (Türkcan et al., 2025). Moreover, evidence from adolescent populations exposed to violence, body shaming, and self-harm suggests that the body can become a central site of psychological distress, shame, and maladaptive coping (Rizk-Hildbrand et al., 2025). Taken together, the present findings support the need for integrative models that view emotional eating as a product of self-critical body evaluation, emotional dysregulation, and distress, while also recognizing self-compassion as a protective psychological resource.

5. Conclusion

The present findings also have implications for populations exposed to appearance-based performance demands, developmental pressures, or stressful social conditions. For example, research on dancers' mental health highlights the relevance of psychological interventions in groups exposed to high body scrutiny, performance expectations, and appearance-related evaluation (Zhang et al., 2025). Research on perceptual disturbances and dysfunctional eating attitudes during the COVID-19 pandemic further suggests that social stress, isolation, and uncertainty can intensify body image problems and maladaptive eating behaviors (Monthuy-Blanc et al., 2023). The present study contributes to this literature by showing that emotional eating is best understood through an integrated pathway in which lower self-compassion, greater body dissatisfaction, emotion regulation difficulties, and psychological distress operate together. This model is clinically meaningful because it suggests that emotional eating interventions should move beyond dietary control and address the psychological conditions that make emotional eating more likely. In particular, strengthening self-compassion, reducing body-related shame, improving emotion regulation skills, and treating distress symptoms may help disrupt the cycle through which negative affect becomes translated into eating behavior.

6. Limitations & Suggestions

The present study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design limits causal interpretation, and although the structural model was theoretically grounded, the direction of effects cannot be definitively established. Second, all variables were assessed using self-report instruments, which may introduce response bias, social desirability effects, and shared method variance. Third, although the sample was drawn from Canadian adults and included a relatively large number of participants, the use of online convenience sampling may limit generalizability to clinical populations, rural communities, individuals with limited digital access, or culturally specific groups. Fourth,

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the study did not include objective behavioral eating measures, ecological momentary assessment, or clinical interviews, which could have provided more detailed information about real-time emotional eating episodes and eating disorder symptoms. Fifth, the model did not examine potentially important moderators such as gender, age, body mass index category, ethnicity, socioeconomic status, trauma history, social media use, or prior treatment history. Finally, although the model explained a substantial proportion of variance in emotional eating, other relevant variables such as impulsivity, sleep quality, food insecurity, interpersonal stress, weight stigma, and dietary restraint were not included.

Future research should use longitudinal and experimental designs to clarify the temporal and causal relationships among self-compassion, body dissatisfaction, emotion regulation, psychological distress, and emotional eating. Prospective studies would be especially useful for determining whether low self-compassion predicts later emotional eating through increases in emotional dysregulation and distress, or whether repeated emotional eating episodes gradually worsen self-criticism and body dissatisfaction. Future studies should also examine whether the model operates similarly across gender groups, age groups, body mass index categories, and diverse cultural communities. Clinical samples, including individuals with binge-eating disorder, obesity, anxiety disorders, depressive disorders, and eating disorder histories, should be studied to determine whether the same pathways remain stable under higher levels of symptom severity. The use of ecological momentary assessment, daily diary methods, wearable devices, and behavioral eating tasks could provide more precise evidence regarding real-time emotional triggers and eating responses. Finally, future research should test intervention models that directly modify self-compassion, body dissatisfaction, emotion regulation skills, and psychological distress to determine whether changes in these mechanisms lead to measurable reductions in emotional eating.

The findings suggest several practical implications for clinicians, counselors, dietitians, and health professionals working with individuals who experience emotional eating. Interventions should avoid focusing exclusively on weight control, dietary restriction, or food monitoring, because such approaches may overlook the emotional and self-evaluative mechanisms that maintain emotional eating. Instead, treatment plans should include strategies that strengthen self-compassion, reduce shame and self-criticism, improve body acceptance, and teach adaptive emotion regulation skills. Clinicians may benefit from assessing emotional eating alongside depression, anxiety, stress, body dissatisfaction, and difficulties in emotional awareness or impulse control. Psychoeducation can help clients understand emotional eating as a coping response rather than as a personal failure, which may reduce shame and increase treatment engagement. Practical interventions may include compassion-focused exercises, mindfulness-based eating awareness, cognitive restructuring of body-related beliefs, distress tolerance training, and emotion regulation skills practice. In community and preventive settings, programs that promote body respect, media literacy, flexible eating attitudes, and compassionate self-care may help reduce emotional eating risk before more severe disordered eating patterns develop.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed in this article.

Declaration

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