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Shame as a Mediator Between Body Dissatisfaction and Disordered Eating Attitudes

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A B S T R A C T

Objective: This study aimed to investigate the mediating role of shame in the relationship between body dissatisfaction and disordered eating attitudes among Canadian adolescents and young adults.

Methods and Materials: A descriptive correlational design was employed with a sample of 400 participants aged 16 to 30 years, selected based on the Morgan and Krejcie sample size table. Participants were recruited from across Canada and completed standardized questionnaires, including the Body Shape Questionnaire (BSQ-34), the Experience of Shame Scale (ESS), and the Eating Attitudes Test-26 (EAT-26). Data were analyzed using SPSS-27 for descriptive statistics and Pearson correlation coefficients, and AMOS-21 was used to perform structural equation modeling (SEM) to examine both direct and indirect pathways between the study variables.

Findings: Descriptive statistics showed high mean scores for body dissatisfaction (M = 92.36, SD = 18.47), shame (M = 71.84, SD = 15.22), and disordered eating attitudes (M = 24.57, SD = 9.13). Pearson correlation results indicated significant positive relationships between body dissatisfaction and shame ($r = .58$, $p < .001$), body dissatisfaction and disordered eating attitudes ($r = .63$, $p < .001$), and shame and disordered eating attitudes ($r = .56$, $p < .001$). SEM results revealed a good model fit ($\chi^2/df = 2.11$, CFI = 0.97, RMSEA = 0.052). Shame significantly mediated the relationship between body dissatisfaction and disordered eating attitudes (indirect effect: $b = 0.13$, $\beta = 0.24$, $p < .001$), while the direct path remained significant ($b = 0.38$, $\beta = 0.46$, $p < .001$), indicating partial mediation.

Conclusion: The findings highlight shame as a significant emotional mechanism that partially explains the relationship between body dissatisfaction and disordered eating attitudes. Addressing shame in prevention and intervention efforts may be crucial in reducing disordered eating among adolescents and young adults experiencing body image concerns.

Keywords: *Body dissatisfaction, Shame, Disordered eating attitudes.*

1. Introduction

Body dissatisfaction, typically defined as a negative subjective evaluation of one's body or body parts, is a well-documented risk factor for disordered eating attitudes. Research across various populations has consistently demonstrated this association, suggesting that individuals who are dissatisfied with their bodies are more likely to engage in harmful eating behaviors, such as extreme dieting, binge eating, or purging. For instance, a study among female undergraduates in Nigeria revealed a significant correlation between body image dissatisfaction and disordered eating attitudes, indicating that these constructs are interlinked in non-Western contexts as well (Olatona et al., 2024). Similarly, research in Kuwait among male college students found that higher levels of body dissatisfaction were predictive of elevated disordered eating attitudes (Ebrahim et al., 2019). The pervasiveness of body image concerns is also evident in athletic contexts, where performance pressures and aesthetic ideals converge. Among female athletes in aesthetic sports, body image concerns were associated with greater eating pathology, underscoring the role of sport-specific body ideals in shaping disordered eating behaviors (Aleksić-Veljković et al., 2020).

Sociocultural influences, such as media exposure and peer comparison, exacerbate body dissatisfaction. In a study of Philippine adolescents, greater affinity for social media was linked to more negative body evaluations and disordered eating behaviors (Shannen et al., 2020). These findings align with the sociocultural theory of body image, which posits that cultural ideals and societal expectations significantly influence how individuals perceive and manage their bodies. In a Malaysian sample, body dissatisfaction was found to be a strong predictor of eating disorder symptoms among university students, reinforcing the universality of this relationship across cultural contexts (Tuan Nor Atiqah Syafiqah Tuan Abd & Shukri, 2019). Moreover, in India, young dancers involved in traditional performance arts reported high levels of disordered eating attitudes due to pressures related to maintaining a particular body shape, emphasizing the need for culturally sensitive research (Kulshreshtha et al., 2020).

While body dissatisfaction is a well-established antecedent of disordered eating attitudes, psychological variables such as shame may function as mechanisms through which body dissatisfaction exerts its influence. Shame, particularly body-related shame, is a painful affective state characterized by feelings of worthlessness and defectiveness, often in response to perceived failures to meet societal body standards. Panero and colleagues (2022) reported that individuals with anorexia nervosa exhibited high levels of shame and self-consciousness, which contributed to the persistence of maladaptive eating behaviors (Panero et al., 2022). Shame may also mediate the link between sociocultural pressures and disordered eating by internalizing external standards and converting them into self-directed criticism and emotional distress. This process is particularly evident among university students, as shown in a study involving Hungarian and Norwegian samples, where body-related shame was more strongly associated with maladaptive eating behaviors than guilt (Vizin et al., 2022).

In adolescent populations, shame appears to develop early and may be shaped by both family dynamics and peer interactions. For example, dyadic predictors such as parental modeling and emotional expression were found to influence child body shame in both Polish and Italian samples, suggesting that shame is deeply embedded in familial and cultural systems (Czepczor-Bernat et al., 2022). Furthermore, studies show that shame can be intensified in individuals who are frequently subjected to body shaming or experience stigmatization based on physical appearance. Victims of body shaming often internalize societal devaluation, leading to more intense body image disturbances and disordered eating attitudes, as evidenced by findings from Indonesia and other Southeast Asian regions (Lestari et al., 2023; Zulkifli et al., 2023).

The link between shame and disordered eating is also supported by theoretical frameworks such as emotion regulation and self-objectification theories. Mendes et al. (2016) argued that experiential avoidance and a tendency to overidentify with distressing emotions, such as shame, were central to the development of eating pathology (Mendes et al., 2016). Similarly, studies have indicated that objectification of the body—viewing the body from an outsider's perspective—can increase vulnerability to shame and, consequently, to eating disorders (David, 2024). These mechanisms are reinforced by empirical data, such as findings from Spain showing that adolescents with low self-worth and high shame were more likely to adopt disordered eating attitudes (Pamies-Aubalat et al., 2022).

Recent research has also begun to examine the specific pathways through which shame mediates the relationship between body dissatisfaction and eating behaviors. In Pakistani adolescents, negative affect—including shame—was found to be a significant mediator between body

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dissatisfaction and disordered eating attitudes (Zainab et al., 2023). This mediating role has been supported across diverse demographic groups. In a sample of gender-diverse adults in China, internalized weight bias, a form of body-related shame, uniquely predicted eating and body image disturbances beyond the influence of BMI or gender identity (Barnhart et al., 2024). In a similar vein, research involving Afro-Caribbean male students in England highlighted that cultural and racial stigmas around body image intensified feelings of shame and impacted mental health and eating behaviors (Mbabazi et al., 2023).

Moreover, shame has been shown to moderate the effect of body dissatisfaction depending on the individual's level of self-compassion or emotional resilience. For instance, Türk et al. (2021) demonstrated that higher self-compassion attenuated the effect of body image concerns on eating pathology, indicating that shame may be particularly detrimental in individuals with poor emotional coping skills (Türk et al., 2021). Relatedly, the internalization of sociocultural ideals, such as feminine or masculine norms, can shape how individuals experience and respond to shame. Uluyol (2022) found that femininity-masculinity perceptions mediated the relationship between body image and eating attitudes, further pointing to the layered and dynamic nature of shame in this context (Uluyol, 2022).

The role of shame as a mediator is not only theoretically compelling but also practically significant. Understanding this mediational pathway can inform intervention efforts aimed at disrupting the link between body dissatisfaction and disordered eating. For example, psychological interventions that target shame, such as compassion-focused therapy, may help individuals reframe negative self-perceptions and reduce maladaptive eating behaviors. MacDonald (2021) proposed that shifting cognitive patterns through mindfulness and emotional awareness could weaken the grip of shame on eating behaviors in restrained eaters (MacDonald, 2021). Likewise, body displacement theory suggests that disordered eating may function as a coping mechanism to distract from underlying emotional pain, particularly shame.

Given these converging lines of evidence, the current study aims to examine the mediating role of shame in the relationship between body dissatisfaction and disordered eating attitudes among Canadian adolescents and young adults.

2. Methods and Materials

2.1. Study Design and Participants

This study employed a descriptive correlational design to investigate the mediating role of shame in the relationship between body dissatisfaction and disordered eating attitudes. The statistical population consisted of adolescents and young adults residing in Canada. Based on the sample size determination table by Morgan and Krejcie, a sample of 400 participants was selected using convenience sampling to ensure adequate statistical power for both correlational and structural analyses. Participants voluntarily completed standardized questionnaires assessing body dissatisfaction, shame, and disordered eating attitudes. Inclusion criteria involved being within the age range of 16 to 30 years, having Canadian residency, and providing informed consent for participation.

2.2. Measures

2.2.1. Eating Attitudes

The Eating Attitudes Test-26 (EAT-26), developed by Garner, Olmsted, Bohr, and Garfinkel in 1982, is one of the most widely used standardized instruments for assessing disordered eating attitudes and behaviors. The questionnaire consists of 26 items divided into three subscales: Dieting, Bulimia and Food Preoccupation, and Oral Control. Respondents rate each item on a six-point Likert scale, ranging from "Always" to "Never," with higher total scores indicating more problematic eating attitudes. A total score of 20 or above typically suggests a risk for disordered eating and the need for further clinical evaluation. The EAT-26 has been validated across diverse populations and has demonstrated high internal consistency and test-retest reliability in numerous studies, confirming its psychometric robustness (Köse & Tayfur, 2021; Scoffier-Mériaux & Paquet, 2022).

2.2.2. Body Dissatisfaction

The Body Shape Questionnaire (BSQ-34), originally developed by Cooper, Taylor, Cooper, and Fairburn in 1987, is a standardized self-report measure used to assess body dissatisfaction, specifically concerns related to body shape and fear of gaining weight. This instrument contains 34 items rated on a six-point Likert scale, ranging from "Never" to "Always," with higher scores reflecting greater levels of dissatisfaction with body shape. The BSQ focuses on

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negative thoughts and feelings about one's body over the past four weeks. Various shorter versions have been created, but the original BSQ-34 remains widely used in research. The tool has shown high internal consistency and construct validity and has been employed extensively in both clinical and non-clinical populations with confirmed reliability (Navadiya et al., 2024; Olatona et al., 2024).

2.2.3. Shame

The Experience of Shame Scale (ESS), developed by Andrews, Qian, and Valentine in 2002, is a standardized instrument designed to assess an individual's propensity to experience shame across multiple domains. The scale consists of 25 items and includes three subscales: Characterological Shame, Behavioral Shame, and Bodily Shame. Participants rate the frequency of their shame experiences on a four-point Likert scale from "Not at all" to "Very much." Higher scores indicate a higher tendency to experience shame. The ESS has been shown to have strong psychometric properties, including high internal consistency and construct validity, and has been validated across different cultural and clinical contexts, making it suitable for research on emotional and psychological processes such as those involved in disordered eating (Linde et al., 2023; Riebel et al., 2024).

2.3. Data Analysis

Data analysis was conducted using SPSS version 27 and AMOS version 21. Initially, Pearson correlation coefficients were calculated to examine the bivariate relationships between disordered eating attitudes (dependent variable) and each independent variable (body dissatisfaction and shame). Following this, a structural equation modeling (SEM) approach was applied to test the proposed mediational model, assessing both direct and indirect pathways between variables. Model fit indices such as the Chi-square statistic, Comparative Fit Index (CFI), Root Mean Square Error of Approximation (RMSEA), and Standardized Root Mean Square Residual (SRMR) were used to evaluate the adequacy of the model.

3. Findings and Results

The final sample consisted of 400 participants residing in Canada, with a majority identifying as female (n = 261, 65.25%) and the remainder identifying as male (n = 139, 34.75%). Participants ranged in age from 16 to 30 years, with a mean age of 21.84 years (SD = 3.91). Regarding educational status, 112 participants (28.00%) were high school students, 193 (48.25%) were undergraduate students, and 95 (23.75%) were graduate students. In terms of ethnic background, 227 participants (56.75%) identified as White, 68 (17.00%) as South Asian, 45 (11.25%) as East Asian, 26 (6.50%) as Black, and 34 (8.50%) as other or mixed ethnicity.

Table 1

Descriptive Statistics for Study Variables (N = 400)

Variable	Mean (M)	Standard Deviation (SD)
Body Dissatisfaction	92.36	18.47
Shame	71.84	15.22
Disordered Eating Attitudes	24.57	9.13

Participants reported a relatively high mean level of body dissatisfaction (M = 92.36, SD = 18.47), based on the BSQ-34. The mean score on the Experience of Shame Scale (ESS) was 71.84 (SD = 15.22), indicating moderate to high experiences of shame across the sample. The average score on the Eating Attitudes Test (EAT-26) was 24.57 (SD = 9.13), which is above the clinical cut-off point, suggesting that a considerable proportion of participants exhibited disordered eating attitudes (Table 1).

Prior to conducting the main analyses, assumptions for Pearson correlation and structural equation modeling were examined and confirmed. Normality was assessed using skewness and kurtosis values, which for all variables ranged between -1.31 and 1.24, indicating acceptable normal distribution. Linearity was evaluated through scatterplots, which demonstrated a linear relationship between body dissatisfaction, shame, and disordered eating attitudes. Homoscedasticity was confirmed using residual plots, showing no pattern in the distribution of residuals. Multicollinearity was ruled out as variance inflation factor (VIF) values for all predictors ranged from 1.06 to 1.31, well below the critical threshold of 10. Additionally, the Kaiser-

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Meyer-Olkin (KMO) measure was 0.84 and Bartlett's Test of Sphericity was significant (χ^2 = 1987.41, p < .001), supporting the factorability of the correlation matrix for SEM analysis.

Table 2

Pearson Correlation Coefficients Between Study Variables (N = 400)

Variables	1	2	3
1. Body Dissatisfaction	—		
2. Shame	.58** (p < .001)	—	
3. Disordered Eating Attitudes	.63** (p < .001)	.56** (p < .001)	—

Correlation results in Table 2 revealed significant positive relationships between all study variables. Body dissatisfaction was positively correlated with shame (r = .58, p < .001) and disordered eating attitudes (r = .63, p < .001). Similarly, shame showed a significant positive correlation with disordered eating attitudes (r = .56, p < .001). These results support the assumptions of the mediation model, indicating meaningful interrelations among the constructs.

Table 3

Fit Indices for the Structural Equation Model

Fit Index	Value	Acceptable Threshold
Chi-Square (χ^2)	124.35	—
Degrees of Freedom (df)	59	—
χ^2/df	2.11	< 3
GFI	0.95	≥ 0.90
AGFI	0.91	≥ 0.90
CFI	0.97	≥ 0.95
TLI	0.95	≥ 0.95
RMSEA	0.052	≤ 0.06

The model demonstrated an excellent fit to the data. The Chi-square to degrees of freedom ratio (χ^2/df = 2.11) was below the recommended threshold of 3. Goodness-of-fit indices were all above or equal to the accepted standards (GFI = 0.95, AGFI = 0.91, CFI = 0.97, TLI = 0.95), and the RMSEA value of 0.052 indicated a good approximation to model fit. These indices confirm that the proposed structural model was appropriate for the data (Table 3).

Table 4

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

Path	b	S.E	Beta	p
Body Dissatisfaction → Shame	0.42	0.05	0.58	< .001
Shame → Disordered Eating Attitudes	0.31	0.04	0.41	< .001
Body Dissatisfaction → Disordered Eating Attitudes (direct)	0.38	0.06	0.46	< .001
Body Dissatisfaction → Disordered Eating Attitudes (indirect via Shame)	0.13	0.03	0.24	< .001
Body Dissatisfaction → Disordered Eating Attitudes (total)	0.51	0.05	0.70	< .001

The structural model revealed that body dissatisfaction significantly predicted shame (b = 0.42, β = 0.58, p < .001), and shame significantly predicted disordered eating attitudes (b = 0.31, β = 0.41, p < .001). The direct path from body dissatisfaction to disordered eating attitudes was also significant (b = 0.38, β = 0.46, p < .001). The indirect effect of body dissatisfaction on disordered eating attitudes through shame was significant (b = 0.13, β = 0.24, p < .001), indicating partial mediation. The total effect (b = 0.51, β = 0.70, p < .001) underscores the strong predictive power of body dissatisfaction on disordered eating when both direct and mediated pathways are considered (Table 4).

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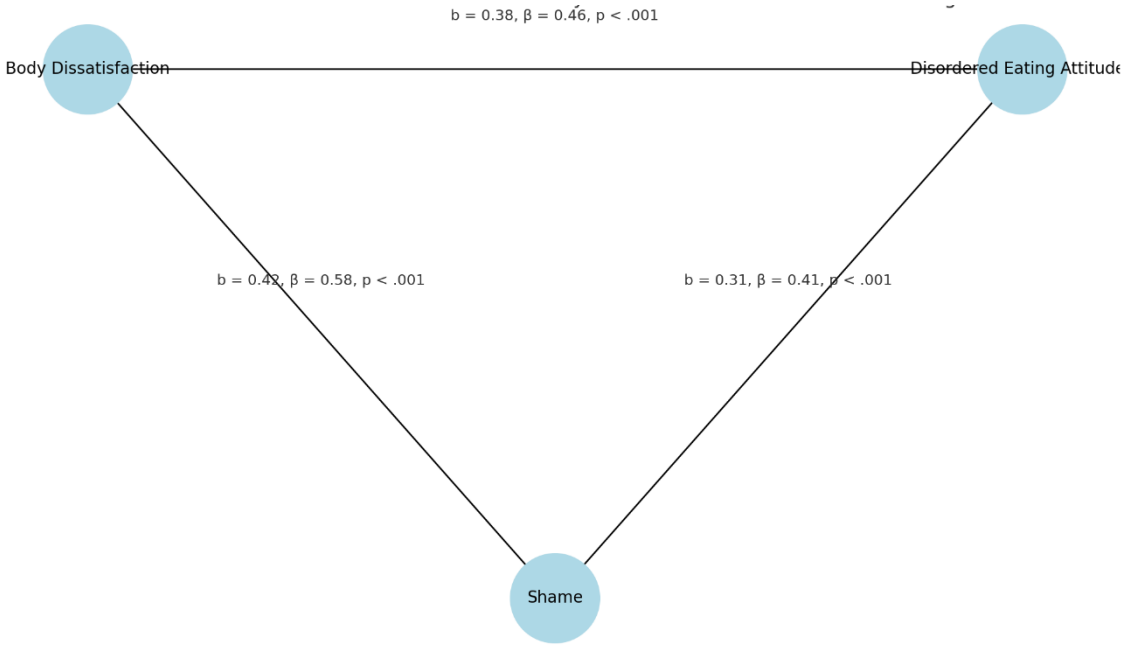
Figure 1

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



4. Discussion and Conclusion

The primary objective of this study was to examine the mediating role of shame in the relationship between body dissatisfaction and disordered eating attitudes among adolescents and young adults in Canada. Results from the Pearson correlation analyses demonstrated significant positive associations between body dissatisfaction and disordered eating attitudes, as well as between shame and disordered eating attitudes. Furthermore, structural equation modeling confirmed that shame significantly mediated the relationship between body dissatisfaction and disordered eating attitudes, indicating that individuals who experience dissatisfaction with their bodies are more likely to develop disordered eating attitudes, partly due to increased experiences of shame.

These findings align with existing literature that consistently highlights body dissatisfaction as a potent predictor of disordered eating attitudes. Numerous studies have demonstrated that individuals who harbor negative evaluations of their bodies are at an elevated risk for maladaptive eating behaviors, including restrictive dieting, binge eating, and purging. For instance, in the context of Indian classical dance, where bodily aesthetics are emphasized, body dissatisfaction was significantly associated with heightened disordered eating attitudes among Kathak dancers (Kulshreshtha et al., 2020). Similarly, among Kuwaiti male college students, body dissatisfaction emerged as a strong correlate of disordered eating, demonstrating that this relationship is robust across genders and cultural contexts (Ebrahim et al., 2019). These parallels support the current study's findings and suggest that cultural expectations and internalized body ideals remain influential in shaping eating-related psychopathology.

The mediating role of shame found in this study offers an important psychological insight into how body dissatisfaction translates into disordered eating attitudes. Shame, as an intensely self-conscious and negative emotion, may compel individuals to attempt to "correct" or hide perceived bodily flaws through maladaptive eating patterns. This interpretation is supported by previous research showing that shame is not merely a consequence but also a driving force of disordered eating behaviors. Panero et al. (2022) reported that individuals with anorexia nervosa exhibit high levels of shame and self-consciousness, reinforcing the notion that shame functions as a central mechanism in eating disorders (Panero et al., 2022). In another study, shame was found to be a more dominant predictor of maladaptive eating behaviors than guilt among university students in Hungary and Norway, emphasizing its

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powerful emotional influence on food-related behaviors (Vizin et al., 2022).

The role of shame as a mediator is further supported by studies exploring the developmental and interpersonal roots of body-related shame. Czepczor-Bernat et al. (2022) demonstrated that parental attitudes and emotional climates significantly contribute to body shame in children, which can persist into adolescence and adulthood, influencing later disordered eating patterns (Czepczor-Bernat et al., 2022). Additionally, cultural practices such as body shaming exacerbate feelings of shame and contribute to distorted body image and eating pathology. Research among Indonesian adolescents confirmed that experiences of body shaming were linked to increased body dissatisfaction, which in turn predicted disordered eating behaviors (Lestari et al., 2023). A similar trend was observed among university students in Malaysia, where body shaming was shown to negatively affect students' body image, reinforcing the psychological pathways observed in the present study (Zulkifli et al., 2023).

The sociocultural environment also plays a crucial role in amplifying body dissatisfaction and shame. Shannen et al. (2020) found that adolescents in the Philippines with high affinity for social media exhibited elevated levels of body dissatisfaction and disordered eating attitudes due to constant exposure to idealized body images (Shannen et al., 2020). This phenomenon is consistent with findings from rural Nicaraguan women, where sociocultural factors such as media influence and peer pressure significantly shaped body image concerns and eating behaviors (Thornborrow et al., 2022). These studies demonstrate how shame can be socially constructed and culturally reinforced, further validating its mediating role in the relationship between body dissatisfaction and disordered eating, as observed in the current research.

Importantly, the present study's findings are consistent with prior work examining the shame-eating disorder link across various demographics. In a study of Pakistani adolescents, Zainab et al. (2023) identified shame and other negative affects as significant mediators between body dissatisfaction and disordered eating, reinforcing the universality of this mechanism (Zainab et al., 2023). Additionally, in a diverse Chinese sample, internalized weight bias—closely linked with shame—was uniquely associated with disordered eating and poor mental health, even after controlling for body mass index and gender identity (Barnhart et al., 2024). These findings underscore the pervasiveness of shame in diverse cultural and gender groups and support its central role in disordered eating pathology.

Further supporting the psychological dynamics at play, David (2024) emphasized how objectification of the body, particularly among adolescent girls, increases vulnerability to shame and negative self-perception, which can lead to disordered eating behaviors (David, 2024). A similar concept was explored by Mendes et al. (2016), who argued that individuals who avoid distressing emotional experiences, such as shame, are more likely to resort to disordered eating as a coping mechanism (Mendes et al., 2016). These perspectives reinforce the current study's model by illustrating the affective and cognitive pathways through which body dissatisfaction manifests into disordered eating via shame.

In addition to emotional and cognitive frameworks, gender and identity variables further contextualize the findings. Uluyol (2022) found that femininity and masculinity perceptions mediated the relationship between body image and eating attitudes, suggesting that internalized gender norms influence the experience of shame and its impact on eating behavior (Uluyol, 2022). Likewise, the intersection of racial identity and body image was highlighted by Mbabazi et al. (2023), who reported that British-born Afro-Caribbean male students experienced shame and mental distress related to body image ideals imposed by dominant Western norms (Mbabazi et al., 2023). These insights highlight how cultural and gender-based expectations may shape both body dissatisfaction and the shame that fuels disordered eating.

Interestingly, research also suggests that emotional resilience and self-regulatory capacities can buffer the harmful effects of shame. Türk et al. (2021) showed that self-compassion served as a protective factor, weakening the relationship between shame and disordered eating pathology (Türk et al., 2021). This points to the importance of emotional regulation strategies in mitigating shame's impact. Similarly, MacDonald (2021) found that individuals who adopted mindfulness-based strategies, such as body mapping and self-reflection, demonstrated improved emotional regulation and reduced vulnerability to disordered eating behaviors (MacDonald, 2021). These studies offer practical implications for therapeutic interventions that may target shame directly to alleviate disordered eating risk.

The findings of this study are also consistent with earlier research that emphasized the psychosocial profiles of individuals vulnerable to eating disorders. Pamies-Aubalat et al. (2022) observed that adolescents with low self-worth

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and high emotional sensitivity—traits often associated with shame—were more likely to develop disordered eating behaviors in response to body dissatisfaction (Pamies-Aubalat et al., 2022). Ryan et al. (2021) also highlighted how emotional responses to bodily changes and premenstrual cravings led women to engage in food-related behaviors that reflected deeper psychological processes, such as shame or loss of control (Ryan et al., 2021). These insights support the emotional complexity observed in the present study and further validate the role of shame as a significant mediator.

In sum, the current study adds to the growing literature by providing empirical evidence that shame is a critical psychological mechanism in the pathway from body dissatisfaction to disordered eating attitudes. This mediational relationship appears to be consistent across diverse cultures, genders, and age groups, highlighting the universal nature of body image challenges and their emotional sequelae. Understanding this mechanism is crucial for designing targeted interventions that address the underlying emotional distress—specifically shame—that often fuels maladaptive eating behaviors.

5. Limitations & Suggestions

Despite the study's strengths, several limitations must be acknowledged. First, the study relied solely on self-report measures, which are susceptible to social desirability bias and may not capture the full complexity of internal emotional states such as shame. Second, the cross-sectional design limits causal inference, making it impossible to determine the temporal order of body dissatisfaction, shame, and disordered eating attitudes. Third, while the sample was sufficiently large and based on established sample size tables, it was drawn through convenience sampling and may not fully represent the broader Canadian population. Fourth, the study focused exclusively on Canadian adolescents and young adults, and results may not generalize to older age groups or to populations in other cultural settings. Finally, although structural equation modeling provided a robust analytic framework, other mediators or moderators—such as self-esteem, peer influence, or media exposure—were not included in the model and could offer additional explanatory value.

Future studies should consider employing longitudinal designs to assess how the relationship between body dissatisfaction, shame, and disordered eating attitudes unfolds over time. Experimental or intervention-based research could help establish causal relationships and evaluate the effectiveness of strategies aimed at reducing shame. Additionally, future research should explore the role of potential moderators, such as self-compassion, cultural identity, or gender norms, in influencing this mediational pathway. Qualitative studies could also provide deeper insights into the lived experiences of shame and body dissatisfaction, enriching the quantitative findings. Expanding the sample to include diverse cultural, age, and gender groups would further enhance the generalizability of results. Finally, integrating physiological or behavioral data—such as eating logs or hormonal markers—could improve the precision and reliability of future research in this area.

Practitioners working with adolescents and young adults experiencing body dissatisfaction and disordered eating should incorporate interventions that specifically target shame. Therapy models such as Compassion-Focused Therapy (CFT) or Acceptance and Commitment Therapy (ACT) may be particularly effective in helping clients develop healthier self-concepts and emotional regulation strategies. Educators and school counselors should be trained to recognize early signs of body-related shame and promote body positivity through school-based programs. Public health initiatives should aim to reduce stigmatizing messages around body image and weight in media and community discourse. Lastly, culturally sensitive approaches that acknowledge the influence of gender, ethnicity, and social norms are essential for creating inclusive and effective prevention and treatment strategies.

Authors' Contributions

Authors contributed equally to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

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

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