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Resilience to shape and weight concerns and disordered eating: the role of self-compassion

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Objective: This research examined applications of self-compassion (SC), an emotionally positive self-attitude in times of hardship, to shape and weight concerns and disordered eating. \textit{Methods:} The Self-Compassion Scale (SCS) assesses Self-Kindness vs. Self-Judgement, Common Humanity vs. Isolation, and Mindfulness vs. Over-Identification. Women from the community (N = 131) completed measures of shape and weight concerns, disordered eating, depression, and global distress. \textit{Results:} After controlling for demographic variables, SCS Self-Kindness, Self-Judgement and Isolation subscales accounted for additional unique variance in shape and weight concern measures, while the SCS Over-Identification subscale accounted for variance in disordered eating. The SCS Mindfulness subscale moderated the relation between distress and disordered eating, such that higher distress was associated with more disordered eating in individuals with low, but not high, Mindfulness. \textit{Discussion:} Whereas a kind non-judgemental self-attitude may be most strongly related to shape and weight esteem, Mindfulness, and lack of Over-Identification may be more central to healthy eating.

\textbf{Keywords:} self-compassion; mindfulness; eating disorders; disordered eating; resilience

Self-compassion (SC) is defined as an emotionally positive self-attitude that involves being ‘open and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding attitude toward one’s inadequacies and failures, and recognizing that one’s experience is part of the common human experience’ (Neff, 2003, p. 224). Neff’s Self-Compassion Scale (SCS) is an empirically validated instrument that operationalises SC as comprised three dimensions; Self-Kindness vs. Self-Judgement, Common Humanity vs. Isolation, and Mindfulness vs. Over-Identification.

SC is strongly linked to psychopathology. In a recent meta-analysis of 20 studies, a large effect size was detected between SC and measures of depression, anxiety, and stress (MacBeth & Gumley, 2012). These effects may be accounted for by findings showing that self-compassionate individuals use healthy coping strategies. For instance, SC is associated with positive cognitive restructuring, such as acceptance and positive reinterpretation, and with fewer avoidance-oriented strategies, such as denial and disengagement, in response to negative feedback (Allen & Leary, 2010). SC is also negatively associated with the tendency...
to focus and ruminate on difficulties in a pessimistic or negative manner (Neff, Kirkpatrick, & Rude, 2007).

In addition to depression and anxiety, SC has been shown to play a beneficial role in women’s relationships with their bodies. Higher SC was associated with decreased social physique anxiety, and with a more intrinsic, as opposed to extrinsic motivation source for exercising (Magnus, Kowalski, & McHugh, 2010). Higher SC has also been shown to be associated with fewer body image concerns after controlling for self-esteem (Wasyliw, MacKinnon, & MacLellan, 2012). With regard to disordered eating, lower SC, and higher fear of SC were associated with more eating disorder pathology in eating disorder patients (Kelly, Carter, Zuroff, & Borairi, 2013). Given the resilience associated with SC in other health domains, it is possible that SC also moderates the relation between distress and disordered eating, such that highly self-compassionate individuals are less prone to disordered eating when they are depressed or anxious. To date, however, this relation has not been tested.

Two studies have shown beneficial effects of inducing a self-compassionate mind-set on eating behaviour and on shape and weight concerns. In one, restrictive eaters who received a short SC intervention were less distressed and less prone to binge eating immediately following the induction than were those who did not receive the induction (Adams & Leary, 2007). In another, women who listened to SC meditation podcasts over three weeks showed improvements in shape and weight concerns relative to a control condition (Albertson, 2012). Thus, there is growing evidence that in addition to being associated with general adaptive coping and increased resilience to stress, SC is also associated with a positive relationship with one’s body and with healthy eating.

To date, research has primarily used global measures of SC in exploring its health benefits. However, a recent analysis of the structure of the SCS suggested that SC may not be best understood as a single factor (Williams, Dalgleish, Karl, & Kuyken, 2014). Possibly, different components of SC exert different influences on health behaviour. For instance, a recent study by Neff concluded that whereas global SCS was a stronger predictor of depression, mindfulness was a stronger predictor of anxiety (Neff & Dahm, in press). Research also suggests that constructs such as SC and mindfulness do not appear to be unitary, but rather have clearly interpretable components (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Williams et al., 2014).

This study seeks to build upon our current understanding of the role SC plays in women’s relationships with their bodies by examining the relation between SCS subscales (Self-Kindness vs. Self-Judgement, Common Humanity vs. Isolation, and Mindfulness vs. Over-Identification) and measures of shape and weight concerns and disordered eating. Two questions will be examined: first, which SCS subscales account for variance in shape and weight concerns and disordered eating after controlling for demographic variables and, second, given the hypothesised moderating influence of SC on the relation between distress and disordered eating, which component of SC is responsible for this effect?

Method

Participants
One hundred and thirty-one women living in a large Canadian city provided consent and responded to an online survey. The survey was advertised on a popular social networking site as well as a classified advertisements website under the community volunteer section. Mean age of participants was 28.76 years (SD = 8.45), 72% of participants were Caucasian, and mean Body Mass Index (BMI) was 24.04 (SD = 4.74). The majority of participants had
a university undergraduate or graduate degree (41% and 13%, respectively), with the remainder reporting their highest education as college diploma (19%), some college or trade school (18%), high school diploma (8%), or some high school (1%). The total sample Brief Symptom Inventory (BSI)-Global Severity Index (GSI) score was 1.85 (SD = .61), which corresponds to the 71st percentile relative to female non-patient norms. The Eating Attitudes Test (EAT) total mean score was 11.05 (SD = 10.81), with 17% of the sample scoring above the risk cut-off score of 20.

**Measures**

*Self-Compassion Scale (SCS; Neff, 2003):* This 26-item measure includes a 5-item Self-Kindness subscale (e.g. ‘I try to be understanding and patient toward aspects of my personality I don’t like’), a 5-item Self-Judgement subscale (e.g. ‘I’m disapproving and judgmental about my own flaws and inadequacies’), a 4-item Common Humanity subscale (e.g. ‘I try to see my failings as part of the human condition’), a 4-item Isolation subscale (e.g. ‘When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world’), a 4-item Mindfulness subscale (e.g. ‘When something painful happens I try to take a balanced view of the situation’), and a 4-item Over-Identification subscale (e.g. ‘When I’m feeling down I tend to obsess and fixate on everything that’s wrong.’). Responses are given on 5-point scales ranging from 1 (almost never) to 5 (almost always). The SCS has demonstrated good internal consistency reliability (.92), as well as good test–retest reliability (r = .93) over a three-week interval. The internal consistency of the SCS in the current sample was .94.

*Center for Epidemiology Studies Depression Scale (CES-D: Bourna, Ranchor, Sanderman, & van Sonderen, 1995):* The CES-D is a widely used 20-item scale that measures current level of depressive symptomatology, with emphasis on depressed mood. Participants use a 4-point scale anchored at 0 (rarely) and 3 (almost always) to indicate how often they experience each of the indicated symptoms. It has high internal consistency and excellent convergent and discriminate validity. The CES-D has been used as a screening tool to identify risk of depression in community samples (Bourna et al., 1995).

*Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982):* The BSI is a well-established inventory of psychiatric symptoms, yielding nine symptom scores and three global indices of distress. In this study, the GSI, the average distress experienced across all nine symptom dimensions, was used. The BSI provides distress scores relative to female adult non-patient norms.

*Weight Bias Internalisation Scale (WBIS; Durso & Latner, 2008):* This 11-item measure assesses the degree to which respondents believe that negative stereotypes and self-statements about weight apply to themselves. Items address acceptance or rejection of weight status, desire for change, the effect of perceived weight status on mood, perceived personal value, ease of life, public appearance and social interaction, and recognition of the existence and unfairness of weight stigma. Participants respond on 7-point scales ranging from 1 (strongly disagree) to 7 (strongly agree). This measure has demonstrated excellent psychometric properties (Durso & Latner, 2008).

*Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987):* The BSQ is a 34-item self-report instrument developed to measure concern about body image in the development, maintenance, and treatment of anorexia nervosa and bulimia nervosa. Respondents are asked to rate the frequency in which they experience various body shape preoccupations over the previous four weeks. Response categories range from 1 (never) to 6 (always), with higher scores indicating a higher frequency of body shape concerns.

*Body Esteem Scale (BES; Franzoi & Shields, 1984):* The BES is a 35-item self-report instrument measuring esteem in relation to body parts. Participants are instructed to rate the degree to
which they feel towards a variety of body parts and functions using a 5-point Likert scale, ranging from 1 (‘I have strong negative feelings’) to 5 (‘I have strong positive feelings’). Higher scores are indicative of greater body esteem. The BES yields a total score, as well as scores for three subdomains: weight concern, sexual attractiveness, and physical condition. The weight concern subscale contains items that can be altered by exercise (e.g. thighs, buttocks, and weight) and has reliably discriminated between non-anorexic women and women diagnosed with anorexia nervosa. The sexual attractiveness subscale comprises items associated with physical attractiveness that cannot be altered by exercise (e.g. face, breasts, or sex organs). The physical condition subscale refers to items relating to physical qualities that are typically not under public scrutiny for women (e.g. stamina, strength, and agility). The BES has demonstrated internal consistency (Cronbach’s alpha > 0.78) and test–retest reliability over a three-month period ($r > 0.75$).

_Eating Attitudes Test (EAT; Garner, Olmsted, Bohr, & Garfinkel, 1982):_ The 26-item EAT measures cognitions, emotions, and behaviours associated with anorexia and bulimia. Research has found this scale to differentiate individuals with bulimia and anorexia nervosa from control individuals (Garner et al., 1982). A score of 20 or more is considered the cut-off for risk of disordered eating.

_Eating Disorders Examination Questionnaire (EDE-Q: Fairburn & Beglin, 1994):_ The 41-item EDE-Q assesses eating disorder behaviours and concerns over the past 28 days. The psychometric properties of the EDE-Q are well established.

**Demographic information.** Participants provided their age, height, weight, highest education level, and ethnicity.

## Results

**Planned statistical analysis**

To determine whether SC was related to shape and weight concerns and disordered eating, bivariate correlations were conducted between SCS global and subscales scores and each of the shape and weight and disordered eating variables. In order to correct for Type I error, alpha was set at .01 in interpreting statistical significance.

To examine whether the SCS global score contributed additional unique variance to shape and weight concerns and disordered eating after controlling for demographic variables, step-wise multiple regressions were conducted. In each regression, BMI and age were entered in the first step and the SCS global score was entered in the second step. Wherever SCS global scores contributed additional unique variance, a second regression was conducted in which the six SCS subscale scores were entered in the second step instead of the SCS global score.

To determine whether SCS global scores moderated relations between distress and eating disorder symptoms, a second set of step-wise multiple regressions were conducted. Wherever the SCS global score was a significant moderator, a second series of regressions were conducted using the six SCS subscale scores instead of the global SCS score. In these analyses, distress was assessed using BSI-GSI and CES-D scores, and disordered eating was assessed using EDE-Q and EAT total scores. For all moderator analyses, variables were standardised in order to minimise inter-correlations among the independent variables. Two hierarchical regressions were conducted examining the possible moderating influence of SCS global scores on the relation between CES-D and EDE-Q scores and on the relation between BSI-GSI and EDE-Q scores. Two hierarchical regressions were also conducted examining the possible moderating influence of SCS global scores on the relation between CES-D and EAT scores and on the relation between BSI-GSI and EAT scores. Scatterplots were produced to illustrate significant moderator findings.
Correlations between SC and body concern measures and disordered eating

Table 1 describes correlations among SCS subscale and global scores and the five measures of shape and weight concerns (WBIS, BSQ, BES-SA, BES-PC, and BES-WC) and two measures of disordered eating (EDE-Q and EAT). As shown in the table, nearly all SCS scores were significantly correlated with measures of shape and weight concern and disordered eating.

SC as predictor of body concern measures after controlling for BMI and age

Regressions were conducted in which SCS global scores were used to predict the five body concern scores after controlling for BMI and age. Five regressions were conducted, and in all cases, SCS global scores accounted for additional unique variance in body concern scores; 15% (Weight Bias), 8% (BSQ), 16% (BES-SA), 14% (BES-PC), and 13% (BES-WC). Table 2 describes results from follow-up step-wise regressions in which SCS subscale scores were entered in the second step after controlling for BMI and age in the first step. As shown in the table, Self-Kindness, Isolation, and Self-Judgement accounted for the additional explained variance in body concern scores.

SC as predictor of disordered eating after controlling for BMI and age

Similarly, two regressions were conducted in which SCS global scores were used to predict the measures of disordered eating after controlling for BMI and age. Global SCS scores accounted for 8% and 7% additional unique variance in EAT and EDE-Q scores, respectively. Table 3 describes results from follow-up step-wise regressions in which SCS subscale scores were entered after controlling for BMI and age. As shown in the table, Over-Identification accounted for the additional explained variance in disordered eating scores.

Global distress and disordered eating as a function of SC

Hierarchical regressions were conducted to determine whether SCS global scores moderate the relation between distress (as measured by the BSI-GSI, and CES-D scores), and two measures of disordered eating (EDE-Q and EAT scores). After controlling for BSI-GSI and SCS global scores in the first step, the interaction between SCS global and BSI-GSI scores was shown to

Table 1. Correlations between SC and measures of body concerns and disordered eating.

<table>
<thead>
<tr>
<th>SC scales</th>
<th>WBIS</th>
<th>BSQ</th>
<th>BES sexual attractiveness</th>
<th>BES weight concern</th>
<th>BES physical concern</th>
<th>EDE-Q total</th>
<th>EAT total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Kindness</td>
<td>-.37***</td>
<td>-.30***</td>
<td>.37***</td>
<td>.34***</td>
<td>.36***</td>
<td>-.22**</td>
<td>-.23**</td>
</tr>
<tr>
<td>Common Humanity</td>
<td>-.33***</td>
<td>-.09</td>
<td>.33***</td>
<td>.28***</td>
<td>.35***</td>
<td>-.11</td>
<td>-.10</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>-.40***</td>
<td>-.25***</td>
<td>.34***</td>
<td>.31***</td>
<td>.36***</td>
<td>-.23**</td>
<td>-.21*</td>
</tr>
<tr>
<td>Self-Judgement</td>
<td>-.47***</td>
<td>-.47***</td>
<td>.32***</td>
<td>.37***</td>
<td>.32***</td>
<td>-.34***</td>
<td>-.31***</td>
</tr>
<tr>
<td>Isolation</td>
<td>-.45***</td>
<td>-.39***</td>
<td>.38***</td>
<td>.34***</td>
<td>.32***</td>
<td>-.31***</td>
<td>-.25**</td>
</tr>
<tr>
<td>Over-Identification</td>
<td>-.41***</td>
<td>-.37***</td>
<td>.25**</td>
<td>.26**</td>
<td>.28***</td>
<td>-.37***</td>
<td>-.33***</td>
</tr>
<tr>
<td>SC total</td>
<td>-.50***</td>
<td>-.39***</td>
<td>.41***</td>
<td>.40***</td>
<td>.42***</td>
<td>-.33***</td>
<td>-.30***</td>
</tr>
</tbody>
</table>

Note: WBIS, Weight Bias Internalisation Scale; BSQ, Body Shape Questionnaire; BES, Body Esteem Scale; EDE-Q, Eating Disorders Examination Questionnaire; EAT, Eating Attitudes Test.

***p < .001.

**p < .01.
explain a significant increase in variance in EDE-Q scores in the second step, $\Delta R^2 = .04$, $\Delta F (1, 101) = 5.55$, $p < .05$. Thus, SC was a significant moderator of the relation between BSI-GSI scores, and EDE-Q disordered eating. SC was also a significant moderator of the relation between CES-D and EDE-Q scores. The interaction term between the SCS global score and CES-D explained a significant increase in variance in EDE-Q scores after controlling for SCS global and CES-D scores, $\Delta R^2 = .04$, $\Delta F (1, 126) = 5.86$, $p < .05$. In order to determine which component of SC was responsible for the moderator effect in predicting EDE-Q scores, the analysis was conducted with each SCS subscale for both BSI-GSI and CES-D. In both cases, the regressions using the Mindfulness subscale were significant $\Delta R^2 = .03$, $\Delta F (1, 104) = 4.87$, $p < .05$ and $\Delta R^2 = .03$, $\Delta F (1, 134) = 5.72$, $p < .05$ for BSI-GSI and CES-D, respectively.

Regressions examining whether SCS global scores moderate the relation between CES-D and BSI-GSI and EAT scores were not significant. However, given that the Mindfulness subscale was

Table 2. SC subscale scores as predictors of shape and weight concerns after controlling for BMI and age.

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$F$ Change</th>
<th>$B$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weight Bias Internalisation Scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>.28</td>
<td>51.02****</td>
<td>.56</td>
</tr>
<tr>
<td>Age</td>
<td>.32</td>
<td>8.29*</td>
<td>−.15</td>
</tr>
<tr>
<td>Isolation</td>
<td>.43</td>
<td>26.75***</td>
<td>−.25</td>
</tr>
<tr>
<td>Self-Kindness</td>
<td>.45</td>
<td>6.72**</td>
<td>−.20</td>
</tr>
<tr>
<td><strong>BSQ</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>.42</td>
<td>27.68***</td>
<td>.46</td>
</tr>
<tr>
<td>Age</td>
<td>.49</td>
<td>10.71*</td>
<td>−.20</td>
</tr>
<tr>
<td>Self-Judgement</td>
<td>.58</td>
<td>17.97***</td>
<td>−.32</td>
</tr>
<tr>
<td><strong>BES Sexual Attractiveness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Kindness</td>
<td>.15</td>
<td>23.70**</td>
<td>.28</td>
</tr>
<tr>
<td>Isolation</td>
<td>.18</td>
<td>6.75**</td>
<td>.23</td>
</tr>
<tr>
<td><strong>BES Weight Concern</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>.19</td>
<td>30.70***</td>
<td>−.44</td>
</tr>
<tr>
<td>Self-Kindness</td>
<td>.31</td>
<td>25.14***</td>
<td>.36</td>
</tr>
<tr>
<td><strong>BES Physical Concern</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>.04</td>
<td>6.91***</td>
<td>−.27</td>
</tr>
<tr>
<td>Age</td>
<td>.08</td>
<td>5.84***</td>
<td>.14</td>
</tr>
<tr>
<td>Self-Kindness</td>
<td>.19</td>
<td>18.52***</td>
<td>.35</td>
</tr>
</tbody>
</table>

***$p < .001$.  
**$p < .01$.  
* $p < .05$.  

Table 3. SC subscale scores as predictors of disordered eating after controlling for BMI.

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$F$ Change</th>
<th>$B$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EAT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>.06</td>
<td>7.73**</td>
<td>.25</td>
</tr>
<tr>
<td>Over-Identification</td>
<td>.18</td>
<td>17.99***</td>
<td>−.34</td>
</tr>
<tr>
<td><strong>Eating Disorders Questionnaire</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>.18</td>
<td>28.48***</td>
<td>.44</td>
</tr>
<tr>
<td>Over-Identification</td>
<td>.30</td>
<td>20.84***</td>
<td>−.34</td>
</tr>
</tbody>
</table>

***$p < .001$.  
**$p < .01$.  
* $p < .05$.  

****p < .001.  
**$p < .01$.  
* $p < .05$.  

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a moderator of the relation between distress and EDE-Q, follow-up analyses were conducted using the Mindfulness subscale in these regressions. The regression testing the moderator effect of Mindfulness on the relation between CES-D and EAT scores was significant $\Delta R^2 = .03$, $\Delta F (1, 135) = 4.97$, $p < .05$. Figure 1 depicts the relation between BSI-GSI and EDE-Q.

**Discussion**

This study examined applications of SC to shape and weight concerns and disordered eating for women in the community. Consistent with previous research demonstrating a link between SC and healthy coping strategies, SC contributed unique variance to all five shapes and weight concern variables and with disordered eating. In addition, SCS Self-Kindness, Self-Judgement and Isolation subscales accounted for additional unique variance in shape and weight concern measures, while the SCS Over-Identification subscale accounted for variance in disordered eating. Finally, the SCS Mindfulness subscale moderated the relation between distress and disordered eating, such that higher distress was associated with more disordered eating in individuals with low, but not high, mindfulness. These findings corroborate previous research showing that SC plays an important role in women’s experience of their bodies. They also suggest that different components of SC may contribute to shape and weight concerns and disordered eating, respectively, offering possible mechanisms by which SC may exert its influence.

The finding that global SCS contributed additional unique variance beyond that accounted for by BMI and age to both shape and weight concerns and disordered eating suggests that promoting SC may be a useful alternative to weight loss as a means to improving well-being and overall health. The subscales accounting for unique variance in the shape and weight concern regressions were Self-Judgement, Self-Kindness, and Isolation. The relation between Self-Kindness and Self-Judgement subscales and shape and weight concerns suggests that a harsh or critical attitude towards oneself in times of hardship is associated with being judgemental of one’s body. Cultivating Self-Kindness may help buffer against societal pressures to attain an unrealistic beauty ideal. The finding that feelings of isolation are also associated with weight bias and low self-appraisal of sexual attractiveness suggests that these appraisals may lead some women to feel
alone in their suffering. Thus, cultivating a perspective that increases awareness of the universality of body concerns may help reduce isolation.

With regard to disordered eating, the SCS subscale that accounted for additional variance after controlling for BMI and age was Over-Identification, suggesting that the tendency to ruminate about negative thoughts or emotions is associated with eating disorder behaviours. This result is also consistent with previous research showing that SC exerts a beneficial effect on binge eating through its association with emotional tolerance (Webb & Forman, 2012). This result is also consistent with previous work on functional avoidance in eating disorders showing that eating disorder symptoms serve a number of valued functions, such as the avoidance of unpleasant emotions (Cockell, Geller, & Linden, 2002; Meyer et al., 2005). For instance, individuals with anorexia nervosa report focusing excess attention on controlling and altering their body, an available and controllable target, in an effort to avoid or displace negative emotions and reduce feelings of distress (Cockell et al., 2002). Findings from the current research suggest that women in the community who experience disordered eating may utilise a similar form of coping. Taken together, these results imply that the capacity to be mindful about and tolerate difficult emotions is associated with lower levels of disordered eating.

Finally, SC moderated the relation between distress and disordered eating as assessed by the EDE-Q and follow-up regressions indicated that the Mindfulness subscale was responsible for this moderating role. That is, individuals with low mindfulness were more prone to disordered eating when distressed, but this was not the case for individuals with high mindfulness. Thus, highly mindful individuals appeared able to experience negative affective states without engaging in disordered eating. The moderating effect of Mindfulness on disordered eating was only partially found using the EAT. The difference in results may be due to the more comprehensive nature and higher specificity of the EDE-Q, which assesses the full range and frequency of cognitive and behavioural symptoms of an eating disorder.

The present study has a few limitations that future research might address. First, it is not known whether relations among SC, shape and weight concerns, and disordered eating generalise to men, or to clinical samples. Second, despite the use of two measures of disordered eating and two measures of distress lending increased support to moderator analyses, the correlational design precludes causality inferences.

Together, findings corroborate the link between SC and resilience to shape and weight concerns and disordered eating. While shape and weight concerns were most strongly linked to Self-Judgement, lack of Self-Kindness and isolation, disordered eating was more strongly linked to low mindfulness and Over-Identification. These findings suggest that helping individuals practice loving kindness, being non-judgemental and increasing social connection may be more helpful in reducing shape and weight concerns while teaching mindfulness may be most helpful in enhancing healthy eating habits. Future research might examine whether the efficacy or potency of interventions aimed at improving body image vs. eating could be increased by targeting different components of SC (e.g. Self-Kindness vs. Mindfulness).

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