“DO I LOOK OKAY?”: UNPACKING THE RELATIONS BETWEEN BODY IMAGE, SEXUAL ORIENTATION, GENDER IDENTITY, AND MENTAL HEALTH

by

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A DISSERTATION

Presented to the Faculty of

The Graduate College at the University of Nebraska

In Partial Fulfillment of Requirements

For the Degree of Doctor of Philosophy

Major: Psychological Studies in Education

(School Psychology)

Under the Supervision of Professor Susan M. Swearer

Lincoln, Nebraska

May, 2018

“DO I LOOK OKAY?”: UNPACKING THE RELATIONS BETWEEN BODY IMAGE, SEXUAL ORIENTATION, GENDER IDENTITY, AND MENTAL HEALTH

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University of Nebraska, 2018

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Body image dissatisfaction leads to an array of social and mental health adverse effects among youth and young adults. The purpose of this dissertation study is to assess the relations between self-reported body image satisfaction and bullying victimization, depression, and anxiety among youth and young adults across self-identified sexual orientation and gender identity subgroups. Individuals who self-identify as belonging to sexual and/or gender minority groups are at higher risk for experiencing higher levels of body image dissatisfaction and, in turn, psycho-social consequences. Data were collected from youth (ages 13-18) and young adults (ages 19-25) who participated in a larger, international research study. The current study found that individuals who identified as questioning their sexual orientation, those who identified as transgender, and participants’ aged 13-19 reported lower body image satisfaction. Additionally, lower body image satisfaction was associated with elevated depressive and anxious symptomatology. Interaction effects between body image dissatisfaction and sexual identity on mental health symptomatology were found for depressive symptomatology and for anxious symptomatology solely in young adults. This research advances empirical literature by being one of the first to examine psychosocial outcomes of body image differences across multiple self-identified sexual orientation and gender identity subgroups. Implications for research and clinical practice as well as study limitations are discussed.

ACKNOWLEDGEMENTS

The path towards this dissertation has been arduous, yet so fulfilling. Its completion is in large part due to so many individuals who challenged, supported, and inspired me along the way. I am tremendously fortunate for my advisor, Dr. Susan Swearer, whose leadership and passion has had great influence on my personal and professional growth. Thank you, Sue, for your guidance, encouragement, depth of knowledge, and constructive suggestions not only for this project, but also throughout graduate school.

My sincerest gratitude is also extended to my extraordinary committee members for their time and expertise in support of this project. I would like to thank Dr. Eric Buhs for his mentorship and influence on my career path very early on as well as for providing me with thoughtful suggestions to improve my work. I also want to thank Dr. Kurt Geisinger for his meticulous feedback and insight for methodological improvements. A big thank you also goes to Dr. Scott Napolitano for his unwavering support and mentorship. Finally, I am grateful to Dr. Reece Peterson for his enthusiastic encouragement and thoughtful feedback in support of my work. In addition to my committee members, Michael Zweifel, friend and colleague, has done work that was pivotal for this project – thank you! I am grateful to have had the opportunity to learn from each of you.

I would also like to thank Cynthia Germanotta, President of Born This Way Foundation; Maya Enista Smith, Executive Director, Born This Way Foundation; and Lady Gaga, Co-Founder of Born This Way Foundation for your support of academic research examining the correlates, mediators, and moderators that youth and young

people need in order to create a kinder and braver world. This dissertation study could not have been conducted without your commitment to understanding social relationships through empirical research.

Finally, I wish to thank my family. ¡Gracias por su apoyo incondicional! No creo haber podido llegar aquí sin ustedes. Gracias por celebrar cada paso hacia esta meta con tanto entusiasmo; por recordarme una y otra vez que lo lograría, especialmente cuando dudaba de mi misma; y, últimamente, por inculcar en mi los valores que me hacen amar tanto esta profesión. Infinitas gracias. Lastly, I am indebted to my partner, Nick Asay, for his unending support throughout this process. Your confidence in me was a steadfast reminder to stay positive and work harder toward my goal. I am forever grateful.

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Chapter One: Introduction

Body image is not limited to aesthetic features of the individual, but is a reflection of societal pressures, social values, and body-related experiences (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). As a construct, body image takes into consideration the individual's health, abilities (i.e., functions of perceptions, sensations, and mobility), and sexual development (Luskin & McCann, 2011). Hence, body image can be studied by examining the individual's appearance-related beliefs in association with mental health outcomes as a function of individual characteristics (e.g., gender, sexual orientation, age). Furthermore, evidence supports that a negative cycle exists in which body image dissatisfaction places youth at risk for being victimized that, in turn, increases body dissatisfaction (Wang, Iannotti, & Luk, 2010; Fox & Farrow, 2009).

Body image dissatisfaction leads to a variety of detrimental effects among youth and young adults. Differing from body image appearance standards imposed by society, peers, family, or the community one identifies with may increase youths' and young adults' risk of psychological maladjustment (Lanza, Echols, & Graham, 2013), such as eating disorders, low self-esteem, depression, and anxiety. Since research has demonstrated the relationship between various mental health concerns and body image dissatisfaction, studying the psychosocial outcomes that may result from negative body image is imperative.

Compared to their heterosexual peers, youth and young adults who identify as part of a sexual minority population are at greater risk for experiencing stigma (Herek, Gillis, & Cogan, 2009), being victimized by their peers (Puhl & Luedicke, 2012), and having higher levels of body image dissatisfaction (Chabot, 2005). Altogether, these

experiences have the potential of bringing adverse psychosocial effects upon the individual. Differences within sexual orientation identification (i.e., heterosexual, bisexual, gay, lesbian, queer, questioning) and body image concerns may emerge from the different appearance ideals in heterosexual and sexual minority social environments and the level of conformity to masculine or feminine ideals (Calzo et al., 2015).

Although there are numerous studies evaluating body image among cisgender (e.g. Calogero & Thompson, 2010) and sexual minority individuals (e.g., Huxley, Clarke, & Halliwell, 2013), there is a gap in the research evaluating psychological difficulties and negative peer interactions that may arise from body image dissatisfaction. Although previous research has investigated the relationship between specific sexual minority groups (i.e., lesbian, gay), body image evaluations, and mental health outcomes, this study aims to extend the current literature in this area by examining social and mental health outcomes among a broader group of sexual minorities (i.e., heterosexual, lesbian/gay, bisexual/queer/pansexual, and questioning) and gender identity groups (i.e., male, female, and transgender).

Theoretical Framework

Several theories provide a foundation for understanding the underlying processes that may impact body dissatisfaction. An individual's body image and psychosocial functioning have a complex relationship, particularly when related to sexual orientation and gender identity minority groups. First, the tripartite influence model (Thompson et al., 1999) purports that cultural influences such as peers, family, and the media can directly and indirectly influence the development of body image dissatisfaction. In essence, the broader social environment encourages the internalization of cultural

standards of appearance ideals and influences individuals to make appearance comparisons in order to evaluate their body image. Additionally, the self-discrepancy theory and the social comparison theory explain the processes related to the development of body image. Self-discrepancy theory (Higgins, 1987) posits that individuals undergo an internal process of evaluating the discrepancy of their actual versus ideal body image. In contrast, social comparison theory (Festinger, 1954) compels the individual to evaluate their image in comparison to others. Lastly, the minority stress model (Meyer, 1995; Meyer, 2003) emphases on how minority populations may endure stressors not experienced by others that can increase victimization and heighten the negative impact on mental health outcomes.

Specifically, the tripartite influence model within the context of objectification theory (Fredrickson & Roberts, 1997) suggests gender social norms, gender roles, and sexual objectification situations construe how individuals perceive their bodies and overall appearance. In this way, peers, family, and media promote cultural standards of appearance ideals that individuals internalize and take upon their own bodies (Moradi, 2010). For the study, this theory serves as a guiding framework as it attends to issues of gender, sexual, and cultural diversity. It is important to understand the impact these societal influences can have on an individual's body image as heightened appearance comparison and body surveillance can foster body shame, increased anxiety, and reduce awareness of bodily states that, in turn, can influence psychopathological symptomatology (Moradi, 2010).

Numerous studies have been conducted on peers' influence on appearance ideals and overall body image (e.g., Lawler & Nixon, 2011; Jones, Vigfusdottir, & Lee, 2004;

de Vries, Peter, de Graaf, & Nikken, 2016; Rodgers, McLean, & Paxton, 2015; Webb & Zimmer-Gembeck, 2014). For example, adolescents who reported having repeated conversations about physical appearance with peers reported higher levels of internalization of appearance ideals, which predicted higher levels of body dissatisfaction (Jones & Crawford, 2006). However, research has found evidence that conversations about appearance ideals between peers have different gender effects. For instance, among boys, comparing their physical appearance to peers led to increased discussion of body change tactics rather than body dissatisfaction independently (Calogero & Thompson, 2010; McCabe & Ricciardelli, 2005). Additionally, greater school-level prevalence of weight-related teasing was significantly related with lower self-esteem and higher levels of body image dissatisfaction in girls, and increased depressive symptomatology in boys (Lampard, MacLehose, Eisenberg, Neumark-Sztainer, & Davidson, 2014) over and above individual-level peer influences. These findings support the importance of examining peers as a valuable source of influence on body image.

Parental figures, and family members as a whole, can also impact eating patterns and body image perceptions. Although there may be a shift in peers having considerably more influence during adolescence (Shroff & Thompson, 2006), parents have a greater influence on childhood body image development. The appearance-related teasing by paternal and maternal figures has different outcomes in children given the interaction between parental figure engaging in teasing and child's gender (Keery, Boutelle, van den Berg, & Thompson, 2006). For example, research found appearance-related teasing by family members had an association with higher levels of body dissatisfaction, lower self-esteem, depression, and eating disorder symptomatology (Keery et al., 2006); moreover,

these messages can be extremely impactful in communicating physical appearance expectations and relaying sociocultural norms for gender expectations.

Additionally, ample empirical evidence is available describing the role that media plays in the development of body image. The media portrays a dichotomous view on what meets appearance ideals and standards. Predominantly, adhering to the femininity ideal in females and the muscularity ideal in males are depicted as the standard to achieve (Calogero & Thompson, 2010). Moreover, the media displays a very limited range of body types and shapes that are seen as "acceptable." Not meeting appearance ideals being depicted by different media sources (e.g., magazines, television commercials, music videos, films, books, toys) leads to harsher appearance-related self-evaluations and lower body image satisfaction (de Vries et al., 2016).

On the other hand, the social comparison theory proposes that the individuals constantly compare themselves to others in order to form opinions about their own characteristics (Festinger, 1954). Fundamental to body image formation among children and youth, social comparison theory posits that individuals compare themselves, either negatively or positively, to established sociocultural standards or to others who closely fit these ideals (Dijkstra, Kuyper, van der Werf, Buunk, & van der Zee, 2008). However, social comparison can be a risk factor for body image dissatisfaction (Myers & Crowther, 2009). Social comparison theory explains that self-enhancement is what drives individuals to make social comparisons and this can have adverse outcomes when the individual is trying to achieve appearance-ideals that are unrealistic.

Body image can be developed by comparing oneself to others or by focusing on the discrepancy that exists between the actual and ideal self. The self-discrepancy theory

explains that individuals are motivated to attain their ideal standards and experience dissatisfaction when actual and ideal selves are not equivalent (Higgins, 1987). In order for there to be a distinction between negative and positive body image, individuals must engage in cognitive processes of comparing notions of the actual image versus the ideal image of one's self. During such comparisons, if there is a discrepancy between actual and ideal body image, the individual may experience adverse psychological, social, and health effects (Luskin & McCann, 2013). This discrepancy can be particularly detrimental when individuals place value in achieving a specific standard of physical attraction or desire to have a bodily feature look a certain way.

Particularly important for this study, the minority stress model assesses how distress can arise from the social environment when there is a discrepancy between minority and dominant culture values (Meyer, 1995). Prejudice and stigma that target gender and/or sexual minority populations bring about unique stressors that increase mental and physical health disparities relative to those that follow heteronormative standards. In addition to general stressors, minority stress processes point out prejudice that can lead to experiencing expectations of rejection, need to conceal true identity, and internalized homophobia (Meyer, 2003), which may lead to overall negative physical and mental health outcomes. These results are crucial as they demonstrate the increased pressure that those from sexual or gender minority groups (Kichler, 2016) experience in order to achieve certain standards that will counterbalance their undervalued social identity.

Body Image

Body image refers to an individual's emotional attitudes, beliefs and perceptions of their own body (Grogan, 2006). It entails both aesthetic aspects of appearance and the pressures reflected by society (Thompson et al., 1999). Social influence and comparison are implicated in the development of body image (Shroff & Thompson, 2013); however, research has yet to address the role of sexual orientation and gender identity in predicting overall body image and psychosocial functioning in youth and young adults. Research has found that while some individuals do not experience substantial distress regarding their body image besides expressing specific dissatisfaction with one or more physical features (Cash, 2008); for others, experiencing dissatisfaction with even one physical attribute can lead to a range of emotional and behavioral problems such as depression, social anxiety, eating disorders, and/or chronic dieting or exercising (Cash, 2008). Moreover, dissatisfaction with one's own body image can be due to a particular body part, general shape, or body as a whole and the individual need not be over- or under-weight as determined by body mass index (BMI) to express discontentment (Curtis & Loomans, 2014).

Multiple factors such as individual characteristics, self-esteem, support and/or pressure from family and peers, and external messages from society and the media can influence an individual's body perceptions. Within the context of body dissatisfaction, age, gender, and sexual orientation have an effect on how individuals assess their appearance and internalize messages from others. For instance, although body dissatisfaction can be present at any developmental stage, pre-adolescence and adolescence seem to be particularly vulnerable time periods that contribute to elevated

importance attributed to body image. In addition, puberty is happening during these developmental stages, which changes the individual's body and can contribute to increased body dissatisfaction and adverse psychosocial outcomes (Markey, 2010). As for gender, more is known about females reporting increased body image dissatisfaction when compared to males (McCabe & Ricciardelli, 2005). However, research examining body image for males and gender conflicted or gender nonconforming individuals is lacking. The only message that seems to be certain are the different sociocultural values in place for females to conform to the feminine ideal and males to conform to the masculine ideal (Calogero & Thompson, 2010). To date, research examining body image dissatisfaction among sexual minority groups is lacking and there is not a cohesive framework for addressing body image as it relates to sexual orientation and gender identity. However, body image dissatisfaction increases as individuals feel they need to conform to standard masculine and feminine ideals, even when appearance standards may be different based on the subculture with which the individual identifies (Calzo et al., 2015).

The Current Study

The purpose of the present study is to assess self-reported body image satisfaction and relations to mental health across individuals from diverse sexual orientation and gender identity groups. Body image satisfaction is the extent to which individuals believe their physical attributes match their ideal body image (Cash, 2008). The importance associated with reaching those appearance ideals may be predictive of negative social outcomes (i.e., victimization) and negative mental health outcomes (i.e., depression, anxiety). This study is one of the first to assess interactions between these social and mental health outcomes with age, sexual orientation, and gender identity. For example,

although previous research has investigated the relationship between specific sexual minority groups (i.e., lesbian, gay), body image evaluations, and mental health outcomes, this study aims to examine social and mental health outcomes among a broader group of sexual minorities and gender identity groups.

To address these questions, data from youth (ages 13-18) and young adults (ages 19-25) who participated in a larger, international research study examining mental health, well-being, individual empowerment, and engagement in their homes, schools, and communities were analyzed. Data were gathered electronically using Qualtrics Survey Software. Participant recruitment occurred via online sources (e.g., research partner's websites, social media outlets, email, listservs) and during community outreach events.

According to a power analysis conducted in G*Power (Faul, Erdfeldger, Buchner, & Lang, 2013) using an alpha of .05, power of .80, and .4 or larger effect sizes allows for an adequate cell size for each condition in the study, such as gender (e.g., male, female, and transgender) and sexual orientation (e.g., heterosexual, bisexual, gay, lesbian, queer, and questioning). Given the total of 4,224 participants, the current study has enough power to make appropriate analyses with the data. Previous research on body image has focused on specific subgroups (i.e., males or females) when examining body image evaluations due to small sample sizes. This current study sought to address previous methodological limitations as it examines body image differences and psychosocial outcomes, specifically anxiety, depression, and bullying victimization within a broader range of self-identified sexual orientation and/or gender subgroups. A paucity of research exists on how body image is associated with psychosocial outcomes among diverse youth and young adults and this study seeks to fill this gap.

The following chapter describes the empirical research on body image and several theoretical models used to explain the interaction between body image and psychosocial outcomes such as bullying victimization, depression, and anxiety. Additionally, these constructs will be analyzed as a function of individual characteristics such as age, gender, and sexual orientation. First, the literature on the tripartite influence model, self-discrepancy theory, social comparison theory, and the minority stress model will be examined in order to establish the guiding framework for understanding the constructs of interest. Then, the literature on body image will be reviewed, providing evidence for predictors and outcomes within each variable. Gender identity, sexual orientation, and other developmental factors will be discussed. The limited research on body image dissatisfaction and psychosocial outcomes as a function of sexual orientation will be reviewed. Lastly, two chapters will present and discuss the findings and implications for practice and future research.

Chapter Two: Literature Review and Theoretical Framework

In order to explain the impact body image has on youth and young adults, four theories provide a better understanding of the relationship between body image, mental health and social interactions. The tripartite influence model (Thompson et al., 1999) focuses on the specific sources that may impact how individuals view their body image. Specifically, the model explains how body image development can be greatly influenced by the media, parents/guardians, and peers. In addition to the importance of assessing sources of influence, theories that clarify the processes that lead to body image formation are vital. Second, social comparison theory (Festinger, 1954) provides a guiding framework for understanding how individuals are compelled to evaluate themselves by comparing themselves to others. Third, the self-discrepancy theory (Higgins, 1987) illustrates how a negative view of individuals' body image stems from the discrepancy between actual self-image perception and their ideal (i.e., actual versus ideal discrepancy). Fourth, the minority stress model (Meyer, 1995; Meyer, 2003); focusing on minority stress processes of lesbian, gay, and other sexual minority populations; explains the factors that are associated with various stressors that can lead to victimization and can have a negative impact on mental health outcomes.

Body image dissatisfaction has been defined as relating to negative evaluations of body size, shape, thinness or muscularity, and weight along with a perceived difference between one's own body and one's ideal image (Grogan, 2017). Body image dissatisfaction has emerged as a predictor of disordered eating and unhealthy eating patterns (Neumark-Sztainer et al., 2006). Additionally, it has been acknowledged as a risk factor individuals' reporting poorer physical and mental health-related quality of life and

psychosocial functioning (Wilson, Latner, & Hayashi, 2013). Research has been a driving force for social media campaigns trying to shift the focus towards a healthier, more positive body image (e.g., The Dove Campaign for Real Beauty, This Girl Can, Lane Bryant's I'm No Angel, The What's Underneath Project, Nike's Better For It), particularly for younger individuals.

A paucity of research has been conducted regarding a potential for stronger and more negative processes associated with body image satisfaction for already vulnerable groups such as gender and sexual minority individuals. Efforts to understand the complex relationship related to body image, minority groups, victimization, and mental health outcomes must start with a detailed examination of the four theories that underlie this study.

Objectification Theory as a Framework: Tripartite Influence Model

Objectification theory can serve as a framework for integrating theories that describe the role body image has across diverse populations. Objectification theory (Fredrickson & Roberts, 1997) has been influential in studying how body image and eating disorders research intersects with the psychology of women and gender. Although originally established to better describe women's experience (Moradi and Huang, 2008), Moradi (2010) details how the theory has been extended to sexual minorities, heterosexual men's experiences as well as subgroups of women such as lesbian, African American, and Deaf women. Objectification theory postulates that gender social norms and roles and sexual objectification incidents define individuals (mostly documented in women) by their bodies and appearance (Fredrickson & Roberts, 1997). In turn,

individuals internalize cultural standards of beauty as their ideal or take on an outsider's perspective upon their own body (Moradi, 2010).

Objectification theory aligns with several models such as objectified body consciousness, dual pathway model, and the tripartite influence model (Smolak & Murnen, 2001). The tripartite influence model has the most influence on the constructs being measured in this study. Hence, how the tripartite influence model, within the objectification theory framework, addresses the different sources that have an effect on body image will be described. Evidence of the promise this theory shows in attending to gender, sexual, and cultural diversity was reviewed.

The tripartite influence model proposes that three primary sources of influence: parents, peers, and media, contribute to the development of body image dissatisfaction (Thompson et al., 1999). The model focuses on how cultural, peer, and parental and/or family influences can directly and indirectly affect how the individual views their body (Thompson et al., 1999). Specifically, peer and family influences can directly influence attitudes and behaviors regarding one's physical appearance or ideal body image. Essentially, the broader social environment encourages the internalization of cultural standards of attractiveness and compels the individual to make appearance comparisons. Within the objectification theory framework, the tripartite influence model's pressures from family, peers, and media can be thought of as specific instances of sexual objectification that may translate into continual body surveillance (Moradi, 2010). As explained by Moradi (2010), heightened appearance comparison and body surveillance can foster body shame, increased anxiety, and reduce awareness of bodily states that, in turn, can promote eating disorder and depressive symptomatology.

Peers. Numerous studies have been conducted on peers' influence on eating and body image. For example, appearance-related teasing and opinions from peers is linked with negative body image for both boys/men and girls/women. In connection with appearance-related teasing, girls had more body dissatisfaction and boys demonstrated a higher drive for muscularity (Schaefer & Salafia, 2014). Adolescent boys and girls who reported having repeated conversations about physical appearance with peers reported higher levels of internalization of appearance ideals, which predicted higher levels of body dissatisfaction (Jones & Crawford, 2006). Specifically, using a sample of 215 girls and 200 boys who were in 7th or 10th grade, Jones and Crawford (2006) found that although girls reported discussing appearance more with their peers, boys perceived more teasing and pressure to look a certain way. Interestingly, among boys, comparing their physical appearance to peers led to more discussion of body change strategies rather than body dissatisfaction independently (Calogero & Thompson, 2010; McCabe & Ricciardelli, 2005).

Within a college-age sample, weight-based teasing as a child and not general appearance or competence teasing predicted body dissatisfaction in males; however, childhood teasing about weight, competence, and general appearance predicted higher levels of body dissatisfaction in females (Gleason, Alexander, & Somers, 2000; Calogero and Thompson, 2010). Weight-based teasing has been linked with low self-esteem, depressive symptoms, body dissatisfaction, and weight control behaviors in adolescents (Lampard et. al., 2014). Not only are individual-level peer influences impactful, but also a greater school-wide level prevalence of weight-related teasing was significantly related

with lower self-esteem and higher levels of body image dissatisfaction in girls, and increased depressive symptomatology in boys (Lampard et al., 2014).

Using a conceptual model to identify the indirect processes that mediate the relationship between peers as the source of influence and body dissatisfaction, van den Berg, Thompson, Obremski-Brandon, and Coovert (2002) found that peers had a direct influence on restriction that led to higher levels of body dissatisfaction. Understanding the potential for long-lasting adverse effects due to weight and/or appearance teasing by peers on body image is crucial. Peers are likely to be a greater source of influence during adolescence, as autonomy increases and peer relationships take precedence over other sources of influences such as caregivers. Altogether, there is support for the role peers play in initiating or maintaining others body image dissatisfaction as well as their role in predicting eating and weight-related behaviors.

Parents. Various studies have documented the potential impact parental influences can have on eating and body image. For instance, in a study examining mothers' messages about body appearance, exercise, and eating behaviors on preschoolers, McCabe, Ricciardelli, & Ridge (2006) demonstrated that mothers expressing concerns about their own bodies lead to communicating messages of losing weight in daughters and gaining muscles in sons and children, in turn, exhibiting concern for their physical appearance. At such a young age, children are demonstrating concerns with their appearance, especially their attires and hair (McCabe et al., 2006). Parents may play a more important role than peers in children's body image development when they are younger. As children move towards adolescence, the results of at least one study have found significant results for peers and media as stronger sources of influence (Shroff &

Thompson, 2006). Moreover, Schroff and Thompson (2006) considered that these results indicated parents have greater influence on childhood development, while peers' influence becomes considerably more important during adolescence.

When measuring the impact of parental influence, Rodgers and Chabrol (2009) found verbal messages and reinforcement have been shown to have more impact on children's body evaluations than modeling effects. Both mothers' and fathers' messages about body concerns influence children's perspectives (Rodgers & Chabrol, 2009). In a study examining parent-adolescent relationships, puberty, dieting, and body image in adolescent females, Archibald, Graber, and Brooks-Gunn (1999) found concurrent and longitudinal effects between how girls' perception of their relationship with parents impacted their thoughts and behaviors on dieting and body image. Youth who perceive their parents to be concerned about their weight are at-risk for enduring higher levels of body dissatisfaction (McCabe & Ricciardelli, 2001); moreover, lacking parental social support predicted body dissatisfaction over and above lack of peer support (Bearman, Presnell, Martinez, & Stice, 2006). Additionally, Puhl and colleagues (2013) reported that 37% of adolescents reported having been teased because of their weight or shape, and stated their parents were the main perpetrators of the weight-based victimization. In another study, Keery and colleagues (2006) found an association between higher frequency of teasing and higher levels of negative outcomes in middle school females. Controlling for BMI and maternal teasing, paternal teasing significantly predicted females body dissatisfaction, higher levels of social comparison, thin-ideal internalization, restrictive eating behaviors, bulimia, lower self-esteem, and depression (Keery et al., 2006). Interestingly, having fathers who engaged in appearance-related

teasing increased the odds of siblings engaging in teasing; being teased by at least one sibling demonstrated significantly more adverse outcomes (Keery et al., 2006). Maternal teasing, when BMI and paternal teasing were controlled for, significantly predicted depressive symptomatology (Keery et al., 2006). It is clear parents have an important role in communication physical appearance expectations and relaying sociocultural norms.

Even though the tripartite influence model focuses on parental influence, it will be important to more broadly consider family influence. For example, appearance-related teasing by parents increased the likelihood of adolescents also being teased by siblings (Schaefer & Salafia, 2014). Furthermore, adolescent girls who receive appearance-based teasing from family members are at higher risk for engaging in unhealthy weight control practices, have higher body image dissatisfaction, and are constantly pursuing the thinness ideal (Neumark-Sztainer, et al., 2010). Additionally, being teased by parents tends to have an increase in adolescent's levels of strive for muscularity and higher levels of body dissatisfaction (Smolak & Stein, 2006). Not only can other family members have an impact on body image and eating attitudes, but can also influence the message being sent to youth and young adults (McCabe et al., 2006). Appearance-related teasing, particularly by family members and peers, not only influences adolescents' perception of themselves, but the effects can potentially have long-lasting impacts (Ata, Ludden, & Lally, 2007).

Media. Ample support in the research is available for the role media plays in the development of body image and eating behaviors and attitudes. Sources of sociocultural pressures are abundant, and the media plays an important part in conveying both explicit and implicit messages on body apperceptions. The media portrays a very skewed

perspective on appearance ideals such as unrealistic body proportions that are difficult to attain and rampant approval of cosmetic surgery. Perhaps even more concerning, the media portrays a dichotomous view on appearance ideals. Thinness in females and muscularity in men are depicted as good and fatness is portrayed as bad. The media fosters fat prejudice and weight stigmatization by showing a very limited range of acceptable body types and shapes (Calogero & Thompson, 2010). Even when an individual is purposefully trying to avoid exposing themselves to sources of appearance ideals, the negative impact of these sources seem inevitable when virtually every form of media (e.g., magazines, television commercials, music videos, films, books, children's toys) communicates unachievable standards for physical appearance (Calogero & Thompson, 2010). For example, Tiggemann and Slater (2013) found there is a significant relationship between higher usage of social network sites and lower levels body image satisfaction among adolescent girls between the ages of 13-18. Moreover, de Vries and colleagues (2016) found social network sites play an adverse role in body image development for both adolescent males and females. Using structural equation modeling with 604 Dutch adolescents, social network site use predicted higher levels of body image dissatisfaction and increased peer influence in the form of appearance-related evaluations (de Vries et al., 2016).

The tripartite influence model posits that the media plays a definitive part in spreading sociocultural norms and leads to individual's internalization of media ideals (Thompson et al., 1999). However, only a single study was found examining the longitudinal relationship between internalization of media ideal and appearance comparison as predictors of body dissatisfaction (Rodgers, McLean, & Paxton, 2015).

Rodgers and colleagues (2015) study found that internalization of the media ideal precedes and predicts appearance comparison. That is, path analysis reported internalization of media ideal predicted social appearance comparison and body dissatisfaction at 8-month follow-up, and body image comparisons with others predicted body dissatisfaction at 14-month follow-up (Rodgers et al., 2015). Furthermore, a reciprocal relationship was found where body image dissatisfaction at 8 months predicted the individual's internalization of the media ideal at 14 months (Rodgers et al., 2015). Altogether, body image conceptualizations that target internalization of media ideal in conjunction with social appearance comparison are likely to be efficacious in deterring body image satisfaction from occurring.

Expansion of the Tripartite Influence Model. As shown above, there is substantial support for the tripartite influence model among young females and some support among males, mainly identifying as heterosexual. However, empirical evidence supporting how the tripartite model affects sexual and gender minorities is lacking. Two studies were found in the literature addressing sexual orientation within the tripartite influence model. First, Huxley, Halliwell, and Clarke (2014) examined if the sociocultural pressures of thinness readily applied to lesbian and bisexual women when compared to heterosexual women. Results showed pressures from the media, male romantic partners, and families were strongly associated with body satisfaction and internalization of appearance ideals for both women (Huxley et al., 2014). However, the impact of the pressures were different between groups; heterosexual women's model found these pressures were significantly tied to appearance satisfaction and restrained eating, which were not significant for lesbian and bisexual women (Huxley et al., 2014).

Second, Tylka and Andorka (2012) examined if including partners and gay community involvement could broaden the tripartite model in order to represent the experiences of gay men as sources of social influence. The structural model revealed muscularity satisfaction had a direct link to muscularity enhancement behaviors (link not evident with heterosexual men), and body fat dissatisfaction to disordered eating behaviors (Tylka & Andorka, 2012). Additionally, results showed muscularity and low body fat were intertwined for gay men (Tylka & Andorka, 2012). That is, gay men desire (or are expected to have) very lean yet muscular/toned bodies; holding themselves to a very rigid idea of appearance standards. Interestingly, Tylka and Andorka (2012) found gay men's perception of pressures to conform to the appearance ideal standard from partners and the gay community increased gay men's drive to engage in muscularity enhancement, regardless of their actual level of muscularity dissatisfaction. This demonstrated that high pressure to conform to the appearance ideal standard within the gay community irrespective of their own attitudes and perceptions of their body image influenced the masculinity ideal.

In conclusion, van den Berg and colleagues (2002), studying how appearance comparison mediated the effects of the tripartite influence model's influences on body dissatisfaction, found that comparison mediates the influence of family and media on body dissatisfaction. These results, when combined with previous research, clarifies how comparison is an important individual difference variable. The tripartite influence model main premise is that parents, peers and media play a strong role in how youth and young adults develop body image, primarily through appearance comparison (Thompson et al., 1999). When children and adolescents believe their body image does not conform to

others expectations regarding thinness or muscularity, body image satisfaction plummets and the probability of engagement in risky behaviors to change their appearance (e.g., restrictive dieting, self-induced vomiting, excessive exercising) increases.

Social comparison, internalizing appearance-related norms, and striving to conform to the ideal standards of appearance can predict body image dissatisfaction (Tiggemann, 2011). The degree to which youth and young adults' desire to be guided by the peer and sociocultural appearance culture will determine how their body image will be shaped positively or negatively (Jones et al., 2004). Shroff and Thompson (2006), using a middle-school female sample, found the relationship between physical appearance pressures from parents, peers, and the media to strive for the thin ideal and body dissatisfaction was fully or partially explained by appearance social comparisons. Social comparison, in turn, has been identified as the underlying factor between body image influences (i.e., peers, media, family) and negative body image satisfaction. Hence, individuals that purposefully do not compare themselves to others who have achieved the standard appearance ideal or refuse to be driven by the pressures to be thin or muscular lessen the odds of developing poor body image. Even though there is ample support for the internalization of appearance ideals as the driving force for developing body image, it has not always significantly predicted body dissatisfaction (Bearman et al., 2006). Alternative explanations for body dissatisfaction such as the fundamental processes for social comparison need to be examined.

Self-Discrepancy Theory

The self-discrepancy theory states that individuals are motivated to fulfill their ideal standards and experience dissatisfaction when there is a discrepancy between their

actual self and the attributes that they hope to be endowed with (i.e., ideal self; Higgins, 1987). In relating self to affect, the self-discrepancy theory posits there are four types of self-discrepancies and qualities of discomfort (Higgins, 1987). Self-discrepancy types are (a) actual/own versus ideal/own, (b) actual/own versus ideal/other, (c) actual/own versus ought/other, and (d) actual/own versus ought/own. Higgins (1987) found that discrepancies are associated with "(a) the *absence of positive outcomes* (actual or expected), which is associated with dejection related emotions (e.g., dissatisfaction, disappointment, sadness); and (b) the *presence of negative outcomes* (actual or expected), which is associated with agitation-related emotions (e.g., fear, threat, edginess; p. 322)."

According to Higgins (1987), discrepancy between actual/own versus ideal/own indicate the individual does not believe they match what they personally hope to attain; increasing an individual's vulnerability to dejection-related emotions. For example, Heider, Spruyt, and De Houwer (2015) found participants who displayed higher rates of body dissatisfaction reported higher levels of internalized desire to be thin (i.e., thin ideal body image) than women who were less dissatisfied with their bodies. Second, if the individual actual perceptions of self does not match the ideal state a significant other wants them to attain (i.e., ideal/other), the individual is also predicted to have higher levels of dejection-related emotions. For individuals comparing their actual self to the standards an agency of one or more others want them to fulfill (i.e., ought self), agitation-related emotions are expected. It is important to assess how this particular discrepancy can have an effect when individuals in minority groups do not meet the standards imposed by their affiliated minority community (e.g., gay men who do not meet muscular/lean ideal imposed by gay community; transgender individual that does not

fully meet feminine or masculine standards). Lastly, when the actual self does not meet the individual's ideal of what it is their duty to attain, the individual is more vulnerable to agitation-related emotions. For instance, Heron and Smyth (2013), in agreement with Higgins (1987), found actual versus ideal and actual versus ought discrepancies are uniquely associated with depressed and anxious affect, respectively. These discrepancies and their outcomes can have strong repercussions such as increased body image dissatisfaction and negative mood (Heron & Smyth, 2013) and higher levels of internalized body shame (Bessenoff & Snow, 2006) for individuals whose perception of actual body image does not meet criteria for their own ideal or others imposed standards.

As stated by Vartanian (2012), body image can largely be considered a visual phenomenon; thus, when comparing one's actual self with the ideal promoted by society, it is expected many will fall short of that standard. One could only expect these standards to be met via unhealthy, extreme measures such as self-starvation, steroids/supplements, and/or cosmetic surgery. As body image discrepancies between actual and ideal selves increase, they can in turn, have emotional, psychological, and behavioral consequences for the individual (Vartanian, 2012). Furthermore, negative associations were found between purpose in life and discrepancies in perceptions of actual and ideal personality and body image (Stanley & Burrow, 2015). Stanley and Burrow (2015) empirically demonstrated that individuals who reported greater differences between ideal and actual appearance-related standards had diminished self-reported sense of purpose in life than those describing similarities. Assessing self-discrepancy theory and standards for body evaluation is particularly important as it has shown to have a direct impact on individual's maladaptive eating and exercise patterns (Anton, Perri, & Riley, 2000),

eating disorder symptomatology and body image concerns about body attributes not associated with weight (Snyder, 1998; Strauman, Vookles, Berenstein, Chaikan, & Higgins, 1991).

Social Comparison Theory

The social comparison theory proposes that individuals assimilate their own abilities and attitudes and form opinions about their own characteristics by comparing themselves to established standards or to others who closely fit these ideals (Festinger, 1954). That is, individuals process social cues and information and appraise themselves by making comparisons with others. In making these appraisals, the individual is able to determine their successes or lack thereof and social standing in life. Festinger (1954) proposed two types of social comparisons: upward social comparisons that occur when individuals compare themselves to someone whom they believe are superior to them, and downward comparisons that occur when individuals make comparisons to those they believe are less proficient than they are. Collins (1996) made the argument that upward comparisons tend to be associated with negative consequences (e.g., lowered self-esteem), whereas downward comparisons tend to be associated with positive effects.

Social comparisons seem to be a fundamental aspect of body image development among individuals. The ability to make social comparisons develops as children estimate their own abilities, differences, strengths and weaknesses in contrast to others; these comparisons become more evaluative and increase in frequency after the age of seven (Dijkstra, et al., 2008). As the evaluative nature of social comparisons increases, children decline in identifying positive self-concepts and body image dissatisfaction become more apparent (Ricciardelli & McCabe, 2001). Within the social comparison theory, Festinger

(1954) stated, “a person’s cognition (his opinions and beliefs) about the situation in which he exists and his appraisals of what he is capable of doing (his evaluation of his abilities) will together have bearing on his behavior” (p. 117). As such, the theory posits that individuals compare themselves, either negatively or positively, to specific standards. Festinger (1954) explained, “the holding of incorrect opinions and/or inaccurate appraisals of one’s abilities can be punishing or even fatal in many situations” (p. 117). In essence, potential for adverse effects increases as the individual compares themselves to others and his or her own reflection does not embody such standards.

Few studies have studied the relationship between children’s social comparison practices and their body dissatisfaction. One limitation to understanding children’s social comparison practices empirically is that there are many unknowns regarding who children’s social comparison targets are and how these factors may affect their body image (Tatangelo & Ricciardelli, 2015). Research has shown that children have a stronger preference to use peers of their same gender and age as sources of comparison (Dumas, Huguet, Monteil, Rastoul, & Nezlek, 2005), but no empirical evidence was found assessing the underlying mechanisms of social comparisons for constructs other than age and gender. Holt and Ricciardelli (2002) examined the relationship between social comparison and body image dissatisfaction and found that children between the ages of eight and ten reported negative eating attitudes, higher levels of muscle concern, and lower self-esteem. Results by Holt and Ricciardelli (2002) were in agreement with the literature stating females had more thinness-related concerns and males engaged in more muscularity-related comparisons. The social comparison theory described the negative effects associated with upward social comparisons (Festinger, 1954; Collins,

1996). Studying attentional bias using eye-tracking systems, Cho and Lee (2013) found individuals who had increased body dissatisfaction displayed frequent and more sustained attention toward muscular body images in males and thin body images in females presented within the study. Thus, men and women who have higher body dissatisfaction have an attentional bias towards bodies that meet or assimilate to their appearance ideal. If this attention progresses into making social comparisons, the negative effects may be greater.

Social comparison, however, can be both a risk and a protective factor depending on the construct being evaluated; coping response to victimization (Visconti, Sechler, & Kochenderfer-Ladd, 2013) and risk factor for body image dissatisfaction (Myers & Crowther, 2009). In a meta-analytic review examining the relationship between social comparison and body dissatisfaction, Myers and Crowther (2009) found significant heterogeneity but identified the relationship may partially be explained by significant moderators such as age, gender, and object of comparison. Findings suggested that appearance-related social comparisons with images found in the media may have more adverse effects than comparisons made with peers (Myers & Crowther, 2009), as the media most typically portrays unachievable standards of appearance. The social comparison theory asserts that self-enhancement is the driving force to social comparisons (Wood & Taylor, 1991), which could be critical for individuals striving to achieve an unattainable standard of appearance ideals.

Minority Stress Model

The minority stress model works as a conceptual framework to address minority stress that can arise from belonging to a minority group. Minority stress stems from the

relationship between minority and dominant culture values and the distress that may arise from the social environment from the discrepancy between both groups (Meyer, 1995). The underlying processes of the model describe two kinds of stressors: distal and proximal stressors. They pertain to the psychological proximity the stressor has to the individual and they are found in a continuum. Namely, distal stressors are defined as objective events and conditions and proximal personal processes rely on individual perceptions and evaluations of the events (Meyer, 2003). Stressors are identified as the stigma, prejudice, and discrimination that create a hostile social environment that causes mental health problems to arise, including the experience of prejudice events, expectations of rejection, hiding and concealing, internalized homophobia, and coping processes (Meyer, 2003).

Sexual orientation and gender minority stigma relies on assumptions of the minority stress paradigm. From this model, theoretical explanations are derived for the increased rates of adverse mental health outcomes in sexual minorities and non-cisgender individuals (Hatzenbuehler & Pachankis, 2016; Sikorski, Luppa, Luck, & Riedel-Heller, 2015). Within the context of the model, proximal stressors are closely tied to an increased risk of adverse mental health outcomes (Sikorski et al., 2015), are associated with increased efforts of trying to "fit in" (Phelan, Link, & Dovidio, 2008), and persistent feelings of devaluation (Link, Struening, Neese-Todd, Asmussen, Phelan, 2001), which have the potential to promote high levels of stress. In brief, mental health concerns (i.e., loss of self-esteem, anxiety and depression symptomatology, reduced positive affect; Herek et al., 2009; Szymanski & Gupta, 2009) are more prevalent in youth and young adults who identify as part of a sexual minority group, and leads to increased efforts to

belong and a constant self-evaluation of 'fitting in-ness.' Considering the importance of minority stress processes of internalized stigma and anticipated discrimination is of need given it is linked with increased health concerns as well as psychological distress through reduced psychosocial resources such as social support, self-compassion, and self-esteem (Williams, Mann, Fredrick, 2017).

Prejudice and stigma that target sexual minority populations bring about unique stressors that highlight the serious mental health disparities relative to heterosexual peers. Researchers have associated these disparities to negative social experiences such as homophobic victimization and internalized biases like internalized homophobia (Lick, Durso, & Johnson, 2013). In addition to general stressors, distal minority stress processes point out prejudice events that lead to proximal stressors such as expectations of rejection, need to conceal true identity, and internalized homophobia (Meyer, 2003), which may lead to overall negative physical and mental health outcomes. Meyer, Schwartz, and Frost (2008) found support indicating those who identified with a disadvantaged social group (i.e., sexual orientation, gender, race/ethnicity) are allotted more stress and fewer coping resources. For instance, gay men who self-reported high levels of minority stress were two to three times more likely to self-report high levels of distress (Meyer, 1995). Moreover, minority stress moderated the relationship between social norms and gay men's engagement in risky health practices (i.e., substance use/abuse and risky sexual practices; Hamilton & Mahalik, 2009). That is, gay men's perceptions of health risk behaviors and their own risky behaviors varied given the amount of stress they have experienced from identifying with a minority sexual orientation. Specifically studying internalized heterosexism as a variable measuring

minority stress, Brewster and colleagues (2016) found internalized heterosexism was correlated positively with high appearance standards (i.e., attractiveness) and positively related to body dissatisfaction, which, in turn, yielded a significant indirect link to intention to use steroids through drive for muscularity. These results are impactful as they demonstrate the increased pressure men and women from sexual and gender minority groups (Kichler, 2016) confront in order to achieve certain standards that will counterbalance their undervalued social identity.

The aforementioned theories, tripartite influence model, self-discrepancy model, social comparison theory, and the minority stress model elucidate the pivotal factors that explain the relationship between body image dissatisfaction and negative mental health and social outcomes. Sexual minority youth and young adults are at-risk for increased levels of body dissatisfaction (Hadland, Austin, Goodenow, & Calzo, 2014) as well as peer victimization (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013). Body image is a social construct dominated by societal ideals and standards of appearance that can have detrimental effects on an individual's' mental health and social interactions. It is a complex interaction of constructs particularly when examining the effects within an already vulnerable population (i.e., sexual minority). The purpose of this chapter is to review the current literature on body image and elucidate its impact on each of these constructs, while identifying the focus of this dissertation study.

Body Image

Body image is a multifaceted concept of physical appearance based on an individual's perceptions, beliefs, emotional attitudes, and thoughts about one's own body (Cash, 2008; Grogan, 2006). In order to assess one's own satisfaction or dissatisfaction

with certain physical attributes or body image as a whole, it is essential to examine the psychological importance individuals devote to body image evaluations and appearance-related standards/ideals (Szymanski & Cash, 1995). Body image attitudes are centered around two components: (a) body image evaluation/affect, which includes cognitive assessment and emotions regarding physical appearance, and (b) body image investment, which alludes to the schematic salience of appearance norms or the individual's cognitive-behavioral attention allotted to appearance (Szymanski & Cash, 1995; Muth & Cash, 1997).

Body image encompasses (a) esthetic and attractiveness aspects and (b) is a reflection of societal pressures, social values, and body-related experiences (Thompson et al., 1999). However, body image is a not mere reflection of the individual's' biological endowment or feedback received by others (Neagu, 2015). While these factors definitely influence the individual's body satisfaction, Neagu (2015) states that it is the way the individual experiences and evaluates their own body that definitely asserts how the individual will perceive their body image. When there is a discrepancy between perceived actual versus ideal selves, individuals might not fully accept their physical attributes, which, in turn, leads to personal discomfort and increased potential for social and psychological difficulties (Gouveia, Frontini, Canavarro, & Moreira, 2014). Research has found that some individuals, although they express dissatisfaction with one or more physical features, do not experience substantial distress; however, for others, experiencing dissatisfaction with even one physical attribute can lead to a range of emotional and behavioral problems such as depression, social anxiety, eating disorders, and/or chronic dieting or exercising (Cash, 2008).

It is important to understand that dissatisfaction with one's own body image can be due to a particular body part, general shape, or body as a whole; moreover, the individual need not be over- or under-weight as determined by body mass index (BMI) to express discontentment (Curtis & Loomans, 2014). This emphasizes how body image is a multifaceted and complex construct. Important to realize, body image is central to gender and sexual identity. Feelings of masculinity (e.g., tall and muscular) or femininity (e.g., thin and delicate features) can be compromised if individuals do not feel they meet the criteria to conform to a body image ideal influenced by others and themselves (Cash, 2008).

Body image dissatisfaction. How body image ideals and expectations form within an individual can be impacted by the different sources of information within one's environment. Theoretical underpinnings of the tripartite influence model, social comparison theory, and self-discrepancy model need to be taken into account in order to understand the different systems that impact appearance ideals and perceptions. Multiple factors can affect the individual's body perception at different levels: self (e.g., ethnicity, sexual orientation, sex, age), family and peers (e.g., parents, friends, socio-economic status), and society and culture (e.g., traditional and social media, cultural norms, the era you live in).

Body image can be influenced by multiple factors such as individual characteristics, self-esteem, support and/or pressure from family and friends, and external messages from society/media. Parents and friends could act as social support but could also be increasing body dissatisfaction through teasing or placing pressures to conform to an ideal (Schaefer & Salafia, 2014). Research suggests that pressures from family and

friends to conform to an ideal (e.g., typically to gain muscle in males and to be thin among females), particularly when the perception is that one's own body is different from this ideal; low parental support; and low body esteem are important predictors of high-risk eating-related beliefs and behaviors (Ata et al., 2007). The high prevalence of body dissatisfaction among youth and young adults is incredibly worrisome, as it has been linked to increased psychopathology and unhealthy behaviors (Lanza et al., 2013). As found by Neumark-Sztainer and colleagues (2013), negative outcomes for individuals perceiving their body are discrepant from body image self or imposed appearance ideals include outcomes such as depressive symptoms, low self-esteem, disordered eating, weight gain, and reduced physical activity and healthy eating. In fact, the quality of self-image is correlated to a young person's general level of success in life. It is suggested that body image dissatisfaction is the cause of many mental and physical disorders in youth, and increases in social and sexual problems (Neumark-Szteainer et al., 2013).

Age differences and body dissatisfaction. Adolescence is a critical time period to focus on factors that contribute to body image given the increased importance attributed to appearance during this time. Heron, Smyth, Akano, and Wonderlich (2013) determined that children's body image dissatisfaction might begin as early as second grade regardless of gender or ethnic background. However, as explained by Ata and colleagues (2007), physical body changes due to pubertal development increase the odds for adolescents to have even higher levels of body dissatisfaction. Altogether, physical changes associated with puberty have a direct impact as girls' bodies naturally shift away from the thin ideal and boys' development impacts increased muscular development (Schaefer & Salafia, 2014). Thus, it was necessary to focus on factors

associated with body image concerns, particularly for youth within the study, as puberty and increased importance of peer influence may contribute to higher risks of adverse mental health and social effects. Many adolescents report some level of dissatisfaction with their body image during this developmental time period (Markey, 2010). Particularly, high levels of body image dissatisfaction is a significant risk to adolescents' social relationships and mental health such as depression, eating disorders, and low self-esteem (Markey, 2010). The early detection of body dissatisfaction is of great importance as engaging in these practices may later meet symptomatology criteria for serious disorders, such as anorexia nervosa or bulimia (Micali et al., 2015).

In examining longitudinal trends from 1999-2010 of weight-related teasing as adolescents transitioned into young adulthood, Haines and colleagues (2013) found that weight-related trends remained stable, except among males were teasing increased from 18% to 27% in early young adulthood. Compared to being in middle school or high school, young adults would be expected to have greater cognitive control of how body image messages affect them more than media, parental, or peer influences. Higher cognitive control may significantly reduce the amount of teasing. As seen by Haines and colleagues (2013), this is not always the case. However, male and female differences may be due to pubertal change timing. Physical changes given to puberty vary by age and may impact males in early young adulthood differently than females. Using data collected from 6,140 males and females aged 14 years, Micali and colleagues (2015) found childhood body dissatisfaction strongly predicted eating disorder cognitions in females, but only in interaction with BMI in males. These results suggest that studying the

differences in body image perceptions throughout adolescence and young adulthood may be beneficial.

Gender differences and body dissatisfaction. According to the tripartite influence model mentioned above, parents, peers, and media represent three influential sources on body image. Altogether, these influences impact body perceptions, body cognitions, body feelings, and body behaviors by genders differently, as the sociocultural message that boys/men and girls/women receive about their bodies are distinctly different (Calogero & Thompson, 2010). In particular, Calogero and Thompson (2010) state there is substantial evidence that would suggest sociocultural values endorse the thin ideal among women and the muscular ideal among men. Gender differences in body image have been studied predominantly with females who have reported having greater body dissatisfaction when compared to males (McCabe & Ricciardelli, 2005), yet greater empirical attention needs to be granted to males in body image research (Griffiths et al., 2016). As discussed by Caologero, Herbozo, and Thompson (2009), body image dissatisfaction in females has been most frequently explained by messages imposed by society where thinness equals physical attractiveness. Although it has been studied to a much lesser extent, for males, the message imposed by society is quite different. Contrary to females, body dissatisfaction for males seem to be tied to a greater desire to achieve society's standards of muscularity (McCabe & Ricciardelli, 2005).

As has been discussed, sociocultural influences generally were perceived by girls to relate to messages of thinness in comparison to boys that perceived the need to increase muscularity. Messages from parents, notably fathers, were strong predictors of weight loss and increase in muscularity among adolescent boys, with the media and best

male friend having a less prominent role (McCabe & Ricciardelli, 2005). However, the strongest influences for adolescent girls were mothers and best female friends; messages from fathers or the media were less impactful (McCabe & Ricciardelli, 2005). Gender can have an effect on how the individual views and internalizes body appearance messages depending on the source of the information. This idea proposes that the importance of various sociocultural influences in relation to gender be considered of relevance when examining body image interventions.

In examining pathways that evaluated types of stress (i.e., relationship, performance, education, financial, family) and body dissatisfaction, Blodgett and Lemer (2012) found stress led to body dissatisfaction in females, which then led to dieting and finally bulimic symptoms when performance, relationship, and family stress were involved. On the other hand, for males, all types of stress were associated with body dissatisfaction, which was linked to dieting; however, no significant relationship was found between dieting and bulimic symptoms (Blodgett & Lemer, 2012). Griffiths and colleagues (2016) examined how levels of body dissatisfaction were linked to mental and physical health-related quality of life. Results showed body dissatisfaction and psychological distress led to poor self-reported health-related quality of life significantly for both genders, but was stronger for males (Griffiths et al., 2016). Body surveillance and body shame may be intensified for individuals whose gender identity does not fit internalized, traditional cultural standards of physical appearance of gender norms (Moradi, 2010). For instance, Wiseman and Moradi (2010) found internalized homophobia was linked to higher levels of eating disorder symptomatology through increased body shame. Additionally, recalled childhood harassment for gender

nonconformity was related to greater eating disorder symptomatology mediated by pathways involving internalization of cultural standards of appearance ideals, body surveillance, and body same (Wiseman & Moradi, 2010).

In applying objectification theory to the study of gender conflicted individuals, body image is highlighted by Ålgars, Santtila, and Sandnabba's (2010) empirical findings. Within their study, Ålgars et al. (2010) operationally defined gender identity conflict as having wished one had been born the opposite gender. It is important to examine gender identity in the context of body image as a dissonance between anatomical sex and desired gender may increase the likelihood of having negative evaluations of one's body (Ålgars et al, 2010). Utilizing a sample of 1,142 Finnish twins and their siblings, first, Ålgars and colleagues found that individuals who self-reported gender identity conflict had greater levels of overall body dissatisfaction than non-conflicted participants. One can speculate that there are within and between group differences in the way sociocultural standards of physical appearance are internalized. Second, they found that the thinness ideal and how that is reflected in eating patterns did not vary between gender conflicted and non-conflicted men but were greater among gender conflicted women than non-conflicted women (Ålgars et al., 2010). This is important as cultural ideals vary between the emphasis of thinness for women and muscularity for men.

Detrimental Effects of Body Image Dissatisfaction

Body image dissatisfaction and internalizing mental health symptoms are distinct concepts; however, they are both highly prevalent within the general population and even more in adolescence (Patalay, Sharpe, & Wolpert, 2015). Determining the directionality

or bidirectionality that may exist between these concepts in order to determine preventative effects on mental health outcomes is important. The current study followed body dissatisfaction-driven hypothesis (Patalay et al, 2015) to examine constructs. Rooted within the socioecological model and self-discrepancy theory, a body dissatisfaction-driven hypothesis will lent itself to evaluate how body image can be a risk factor of later mental health concerns (Sharpe et al, 2017).

Mental Health Outcomes.

Depression. Depressive disorders include the presence of sad, empty, or irritable mood that is accompanied by physical and cognitive changes that alter the individual's daily life activities (American Psychiatric Association, 2013). Unlike individuals who are resilient through difficult times, those who are depressed cannot seem to readily bounce back. In children who have been diagnosed with depression, continual sadness and unhappy mood interferes with their daily routines, school performance, overall functioning, and are linked to higher rates of suicidal attempts in adolescence (Mash & Wolfe, 2016). Given depressive symptomatology results in negative changes in behavior, persists over time, and causes significant functioning impairments (American Psychiatric Association, 2013) it was important to evaluate the relationship that may exist between high levels of reported symptoms of depression and body image dissatisfaction in youth and young adults.

Research on depression has found rates are low before puberty, but rise in adolescence, especially among girls (Maughan, Collishaw, & Stringaris, 2013). However, across age, both anxiety and disruptive behaviors preceded youth depression (Maughan et al., 2013); although research has demonstrated comorbidity is common (Cummings,

Caporino, & Kendall, 2014). Depression in childhood and adolescence is associated with a risk of later mental health problems such as continued depression, anxiety, substance dependence, suicidality, problems in social functioning, and risky sexual behaviors (McLeod, Horwood, & Fergusson, 2016; Maughan et al., 2013). However, long-term trajectories into young adulthood showed that when adolescents who are depressed have increased social supports, psychological well-being increased in young adulthood (Galambos, Barker, & Krahn, 2006). Using repeated-measures over ten years with a population-based cohort of Canadian teenagers, Naicker and colleagues (2013) found the transition period from adolescence to adulthood makes individuals particularly vulnerable to the onset of depression given educational, employment, and social changes that may be occurring.

Anxiety. Anxiety disorders are those that include features of both excessive fear to different types of objects or situations that result in behavioral disturbances (American Psychiatric Association, 2013). Physiological symptoms of anxiety include muscle tension, heart palpitations, sweating, dizziness, or shortness of breath. Additionally, emotional symptoms comprise restlessness, sense of impending doom, and fear of dying, embarrassment, or something terrible happening (even when there are no rational grounds for the fear; American Psychiatric Association, 2013; Mash & Wolfe, 2016). As stated within the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM)-V (American Psychiatric Association, 2013), most anxiety disorders develop in childhood and occur more frequently in females.

Research on anxiety in childhood and adolescence has varied substantially in the prevalence rates being reported (Cartwright-Hatton, McNicol, & Doubleday, 2006).

Using meta-analytic data strategies, Costello and colleagues (2011) found that 12.3% of children going through middle childhood and 11% of adolescents met criteria for a DSM-IV anxiety disorder. It can be speculated that research varies as studies typically analyze the comorbidity of anxiety with other disorders and vary by specific anxiety disorder type (e.g., social anxiety, generalized anxiety disorder, phobias). By and large, children and adolescents having been diagnosed with an anxiety disorder is common; conflicting evidence exists denoting females are at a greater risk for being treated for anxious symptomatology (Copeland, Angold, Shanahan, & Costello, 2014). Compared to depression, when examining longitudinal data, number and severity of anxiety disorders reported in adolescence were indicative of increased risks of later anxiety disorder, depression, substance dependence, suicidality, and lower educational performance even when confounding sociocultural factors were statistically controlled (Woodward & Fergusson, 2001).

Particular to body image, Hart, Leary, and Rejeski (1989) coined the term, "social physique anxiety," which stems from social anxiety and is specifically related to the feelings of anxiety that arise when one perceives their appearance is being evaluated by others. Social physique anxiety, moderated by levels of social comparisons and body surveillance, has been found to be related to elevated levels of eating disorder symptomatology (Fitzsimmons-Craft, Harney, Brownstone, Higgins, & Bardone-Cone, 2012). That is, high levels of social physique anxiety in individuals who are continually engaging in appearance-related comparisons and body surveillance behaviors are at higher risk to utilize behaviors and cognitions that lead to eating disorders. Brunet and colleagues (2010) reported that self-esteem significantly influences social physique

anxiety, which, in turn, significantly increased adolescent males' drive for muscularity and adolescent females' drive for thinness. From a practical perspective, understanding the underpinnings anxiety and depression can have on body image and its potential bidirectional relationship could really impact future intervention strategies with youth and young adults.

Social Outcomes

Bullying Victimization. Bullying and peer victimization are serious problems that affect children and adolescents involved either as bullies, victims, or bystanders (or a combination of these roles). This phenomenon is increasingly recognized as a pervasive problem with recent research finding that approximately 30% of youth reported being victims of bullying behaviors (DeVoe & Murphy, 2011). Bullying has been defined as complex social interactions that comprise an unwanted, intentional aggressive act that is repeated or highly likely to be repeated by any individual or group that includes an observed or perceived power imbalance; not involving siblings or current dating partners (Gladden, Vivolo-Kantor, Hamburger, & Lumpkin, 2014). Additionally, bullying can occur in both overt and covert forms. As described by the CDC (Gladden et al., 2014), overt/direct bullying is a somewhat exposed aggressive act on the target individual while cover/indirect bullying is done in a concealed, mostly anonymous manner. Different forms of bullying have been acknowledged. Specific bullying behaviors can be classified into physical (e.g., hitting, shoving, punching), verbal (e.g., name calling, threatening), relational (e.g., spreading rumors, posting negative images/comments in physical/electronic domains without the individual's authorization), and/or damage to property (e.g., destroying victim's property, tampering personal electronic information;

Gladden, et al., 2014). Bullying needs to be assessed as a complex social phenomenon that is influenced by individual, peer, school, family, and community factors (Swearer, Espelage, Vaillancourt, & Hymel, 2010).

Being involved in any role within the bullying-victimization continuum can be associated with a multiplicity of negative outcomes such as depression, anxiety, lack of belongingness, negative self-concept, and poor body esteem (O'Brennan, Bradshaw, Sawyer, 2009). However, frequent victims of peer aggression are more likely than less victimized peers to experience short- and long-term adjustment problems; establishing then that peer victimization is a risk factor for developing internalizing symptomatology (e.g., depression and anxiety; Storch, Zelman, Sweeney, Danner, & Dove, 2002). Particularly for youth and young adults, the peer group can serve as a protective factor to the harmful effects of victimization (Cuadros & Berger, 2016; Hodges, Boivin, Vitaro, & Bukowski, 1999) or prolong the cycle by victimizing those within their group (Schwartz, Lansford, Dodge, Pettit, & Bates, 2015). In studying the potential negative outcomes the relationship between body image and sexual orientation may have, appearance-related and sexual-minority related victimization have to be addressed. Ultimately, for individuals self-identified as part of a sexual minority group, the effects of victimization can be exponential.

Research examining peer victimization found moderate effect sizes when assessing the role appearance-related victimization played on body image dissatisfaction, dietary restraint, and bulimic behaviors (Menzel et al., 2010). One form of appearance-related victimization is targeting an individual for his weight. Pervasive teasing and bullying for children and adolescents who are overweight is a serious issue. Children who

are overweight face higher levels of body dissatisfaction than peers who are not overweight (Lombardo, Battagliese, Pezzuti, & Lucidi, 2013), suggesting a larger body size has adverse effects on how children perceive their bodies and experience more peer victimization. Puhl and colleagues (2013) assessed 361 adolescents who have sought out weight-loss treatment. Sixty-four percent of study participants, even when they were no longer overweight, reported weight-based victimization at school by peers and friends (Puhl et al., 2013). Additionally, Pryor and colleagues (2016) found overweight development in middle childhood is associated with internalizing (i.e., depression, anxiety) symptomatology in adolescence; moreover, this effect was partly mediated by peer victimization and body dissatisfaction (i.e., reported desire to be thinner). Females who were frequently victimized at age 10 had lower weight-esteem at age 13; males who were targeted for their appearance, in contrast, held more negative beliefs about others perception of their body image (Lunde, Frisén, & Hwang, 2007). Degree of weight-based victimization was significantly related with poor body image, higher weight concerns, maladaptive eating behaviors, depressive symptomatology (i.e., loneliness, suicidality), negative perceptions of body image, and avoidance of physical activity over and above weight status alone and demographics (Puhl & Luedicke, 2012; Hayden-Wade et al., 2005). Lastly, using meta-analytic data strategies, Fedewa and Ahn (2011) found the odds of sexual minority youth of being victimized by peers were, on average, 124% higher than for their heterosexual counterparts, and these experiences lead to a myriad of negative outcomes. For youth who self-identified as part of a sexual minority group, experiencing sexual minority-specific victimization significantly mediated between sexual minority status on depressive symptoms, suicidality (Burton et al., 2013), and

educational outcomes (Aragon, Poteat, Espelage, & Koenig, 2014). These results demonstrate targeted victimization is partially responsible for potentially dangerous symptomatology for sexual minority youth supporting the minority stress model. Not only are there detrimental mental health effects, but also physical health disparities exist between sexual minority and heterosexual youth. Andersen and colleagues (2015) using mediation analyses found sexual minority youth's higher rates of victimization in childhood explained the physical health differences between the groups. Psychosocial and health outcomes associated with peer victimization related to appearance and/or sexual orientations were presented. It will be essential to understand the how peer victimization related to sexual orientation is also associated with body image and other mental health outcomes.

Effects of Body Image on Diverse Youth and Young Adults

Sexual orientation and body image formation. Establishing relationships within a community can be particularly protective for individuals who are marginalized or identify themselves with a stigmatized population. Notwithstanding, more than just providing support, subcultural groups can facilitate identity formation and shape values, mindsets, and behaviors deemed important for group membership (Markowe, 2002). Group norms surrounding appearance ideals serve as a framework for a shared social identity and cognitively represent a model to adhere to for appropriate group belonging (Huxley et al., 2013). Exploring evidence of body dissatisfaction that may arise from not meeting appearance-related ideals for one's own social identity group is vital.

Although diversification of style and appearance norms is evident within different social identities, general expectations seem to be consistent for each group. For instance,

Huxley and colleagues (2013) drawing on qualitative data found the 'lesbian look' to be predominantly described as 'butch', 'boyish', and 'androgynous.' If lesbian women deviate from those descriptors, they are often misread to be heterosexual females, as they adhere to more feminine roles and styles (Levitt, Gerrish, & Heistand, 2003). Comparatively, the gay male subculture has critical expectations to become (and remain) muscular and lean in order to belong within the community (Tylka & Andorka, 2012; Tiggemann, Martins, & Kirkbride, 2007). Those that do not adhere to the mesomorphic ideal are at risk for being classified as 'fats', 'femmes', or 'trolls' (Tylka & Andorka, 2012, Wood, 2004). In contrast, most individuals could not identify distinct bisexual appearance norms (Huxley et al., 2013). Taub (1999) found that bisexual women are more likely to adhere to appearance norms associated with heterosexual or lesbian appearance standards were dependent on the gender of their partners. As for heterosexual individuals, women are expected to adhere to a feminine, sexualized look that often are portrayed in the media as unnourished, yet large-breasted figures; in contrast, media representations of heterosexual males consist of tall, muscular bodies that display muscular arms, chest, and abdominals (Holmqvist & Frisén, 2012). To date, there are no studies examining differences between subgroups of sexual orientation identities altogether and assess health and social outcomes. It will be important to evaluate if, just like with body image identity, body image evaluation is different for each sexual orientation subgroup when compared to each other.

Adverse effects for sexual minorities. Body image dissatisfaction disparities may emerge in diverse sexual orientation groups given (a) different appearance ideals in heterosexual and sexual minority social environments or b) level of conformity to

masculine or feminine ideals (Calzo et al., 2015). Results examining data from 12,984 adolescents showed sexual minority youth misconstrue their weight status and about one-third of sexual minority youth reported partaking in risky weight control behaviors (e.g., fasting, purging, using dietary supplements) in the past month (Hadland et al., 2014). Such high prevalence of these behaviors is alarming, particularly when sexual minority males were four times more likely and sexual minority females two times more likely to engage in these potentially dangerous behaviors than their heterosexual same-gendered peers (Hadland et al., 2014). Although social influence and comparison are implicated in the development of body image (Schroff & Thompson, 2013), research has yet to address the role of sexual orientation by subgroup in predicting overall body image in youth and young adults. Equally important, societal pressures seem to have a higher impact on the LGBQQ population as they feel forced from hetero- and homosexual populations to look like one or the other (Chabot, 2005). Coming to terms with the intersection between one's own body image and sexual orientation is vital in order to reduce the gap between body image dissatisfaction and acceptance of oneself. However, in order for this to occur, research must understand the implications body image dissatisfaction can have on youth and young adults.

To date, no study has examined the relationship between body image dissatisfaction and psychosocial outcomes across sexual orientation and gender identity subgroups. Nevertheless, a few studies have examined other body image outcomes as a function of sexual orientation. For example, Owens and colleagues (2002) found the lesbian subculture served as a protective factor against societal demands toward thinness for women, but likely does not counter the effects of society at large as they still

experiences negative attitudes toward eating and weight. Additionally, studying reported disordered eating behaviors, Watson and colleagues (2016) found sexual minority youth reported disproportionately higher disordered eating than heterosexual peers (approximately one in four sexual minority youth report risky weight-restricting behaviors). Ehlinger and Blashill (2016) aimed to assess the interaction of subjective and objective appearance with sexual orientation. Results found higher negative subjective appearance evaluation was tied to increased reports of depressive symptoms, with a stronger positive association found among sexual minority versus heterosexual youth. That is, holding to societal appearance stereotypes and evaluating one's self against it may be a robust predictor of depression, especially for sexual minority youth and young adults.

Specifically related to sexual minority men, Watson and Dispenza (2015) reported body surveillance significantly mediated the link between masculine appearance norms and body shame. That is, sexual minority males may be experiencing higher levels of appearance-related anxiety that stems from body surveillance which then can contribute to the degree societal norms of masculinity affect sexual minority men's body image dissatisfaction. Furthermore, Blashill and colleagues (2016) found that body image dissatisfaction significantly predicted elevated depressive symptoms, lower sexual self-efficacy, and elevated sexual anxiety in self-identified gay and bisexual men. Examining sexual minority women within the context of minority stress and body shame, Mason and Lewis (2016) found lesbian women's body image satisfaction and eating behaviors were adversely affected, finding discrimination and sexual minority stress to be associated with increased rates of social anxiety. Lastly, Ramseyer Winter and colleagues (2015) reported

that women's body evaluation may be affected by specific sexual orientation subgroup (e.g., lesbian, bisexual).

Given that sexual orientation is one aspect of identity that may intersect with body image, the purpose of this study is to assess self-reported body image satisfaction. Body image satisfaction is the extent to which individuals believe their physical attributes match their ideal body image (Cash, 2000). The importance associated with reaching those appearance ideals may be predictive of negative social outcomes (i.e., victimization) and negative mental health outcomes (i.e., depression, anxiety). This study is one of the first to assess interactions between these social and mental health outcomes with age, sexual orientation, and gender identity. For example, although previous research has investigated the relationship between specific sexual minority groups (i.e., lesbian, gay), body image evaluations, and mental health outcomes, this study aims to examine social and mental health outcomes among a broader group of sexual minorities and gender identity groups.

Gender identity and body image formation. In a qualitative study, McGuire and colleagues (2016) assessed body dissatisfaction and satisfaction in transgender youth. Not surprisingly, self-criticism and social distress related to body dissatisfaction whereas self and social acceptance were related to body image satisfaction (McGuire, Doty, Catalpa, & Ola, 2016). More importantly, McGuire and colleagues (2016) found developmental differences that provided evidence for participants who were closer in consolidating their gender identity described increasing rates of social awareness, self-acceptance, and body image satisfaction. In identifying areas where mental health intervention may be needed in order to promote wellbeing, differentiating transgender

individuals from cisgender individuals is of importance in order to address the knowledge gaps that currently exist. Per Wanta and Unger (2017), mental health work on transgender research tend to be descriptive rather than studying risk factors for psychiatric comorbidities that could lead to tailored intervention. This study aims to elucidate the relationship between body image and more expansive gender categories versus cisgender only within a quantitative format.

Adverse effects for gender minorities. Although not all individuals who identify as transgender face distress or have an increased desire for surgical intervention (Beek, Kreukels, Cohen-Kettenis, & Steensma, 2015), some do as there is incongruence between their body image and their identity. What is more, the DSM-5 has qualified distress due to incongruence between body image and identity as Gender Dysphoria. van de Grift and colleagues (2016) reported that when there is genital dissatisfaction there is limited connection with one's own body and increased body image dissatisfaction. Additionally, research as determined body areas that are more centrally involved in discussing body satisfaction among birth sex and identified gender. In trans women van de Grift and colleagues (2016) found these characteristics were related to voice and hair, while muscularity and posture have increased importance for trans men.

Research Questions and Hypothesis

Based on a thorough examination of the minority stress model, tripartite influence model, self-discrepancy model, social comparison theory and empirical research examining body image satisfaction among sexual minority and transgender individuals, this study will address the following research questions and hypotheses:

1. Are there differences in subjective body image satisfaction ratings among participants who self-identify as lesbian/gay, bisexual/queer, or questioning and cisgender or transgender participants?

Hypothesis 1: Participants who self-identify as questioning their sexual orientation, would report lower body image satisfaction than self-identified heterosexual participants and gay/lesbian participants.

Hypothesis 2: Participants who self-identify as transgender would report less body image satisfaction than self-identified cisgender participants.

Hypothesis 3: Adolescent participants would report less body image satisfaction than young adult participants.

2. Does lower body image satisfaction predict the likelihood that an individual would experience mental health symptomatology?

Hypothesis 4: Body image satisfaction would be negatively associated with depressive symptomatology. That is, lower body image satisfaction would be associated with elevated depressive symptomatology.

Hypothesis 5: Body image satisfaction would be negatively associated with anxious symptomatology. That is, lower body image satisfaction would be associated with elevated anxious symptomatology.

3. Does lower body image satisfaction predict the likelihood that participants would have negative social outcomes?

Hypothesis 6: Body image satisfaction would be negatively associated with bullying victimization. That is, lower body image satisfaction would be associated with higher ratings of being bullied.

4. Does sexual orientation affect the way body image satisfaction predicts the likelihood that an individual would experience mental health symptomatology?

Hypothesis 7: The effect of body image dissatisfaction on anxiety would be stronger for sexual minority individuals than heterosexual individuals.

Hypothesis 8: The effect of body image evaluation on depression would be stronger for sexual minority individuals than heterosexual individuals.

Hypothesis 9: The effect of body image evaluation on anxiety and depression would be stronger for questioning individuals.

Chapter 3: Methods

Participants

Participants for this study include youth and young adults who participated in a larger, international research study investigating the factors that promote individual empowerment and engagement. Data were gathered via a web-based survey administered by Qualtrics Survey Software. During the current phase of the study, launched in 2016, quantitative data assessed participants' responses in the context of online experiences, physical health, mental health, and what supports individuals need in order to create a kinder and braver world. The research study received approval by the University of Nebraska-Lincoln Institutional Review Board for ethical research (IRB# 20121213052EP, see Appendix A).

Participants were recruited through several individuals, organizations, and social media platforms that appeal to youth and young adult participants. Some of the recruitment sources were Born This Way Foundation volunteers, website, listserv, Twitter, and Facebook accounts; Life is Good; TextTalkAct: Creating Community Solutions email listserv; Random Acts of Kindness Foundation; Intel; and Mattel (i.e., Monster High). In order to address potential issues with the representativeness of the sample as well as study participants' demographics, Born This Way Foundation teamed up with other community partners such as Intel, Life is Good; TextTalkAct: Creating Community Solutions email listserv; Random Acts of Kindness Foundation; and Mattel in order to get a more diverse sample and not solely youth and young adults that Born This Way Foundation may have appealed to. Additionally, postcards with information to

access the study were distributed across community events hosted by the partners mentioned above across the United States.

A power analysis was conducted in G*Power to determine a sufficient sample size using an alpha of .05, a power of .80, and a large effect size (f = .40; Faul et al., 2013). Based on the aforementioned assumptions, the desired sample size was 400. A total of 4,224 participants completed all necessary measures and were retained for analysis, which is in agreement with the recommendations from the power analysis. This amount of participants allowed for an adequate cell size for each condition in the study, such as gender (e.g., male, female, and transgender) and sexual orientation (e.g., heterosexual, homosexual [gay + lesbian], other [bisexual + queer + pansexual], and questioning).

A total of 4,224 international participants consented or assented to participate in this study. Participants' age ranged from 13-25 years old with the largest percentage being within the ages of 19-21 (n = 1,798, 42.6%). In the total sample, sexual orientation was 27.4% heterosexual (n = 1,157), 5.4% lesbian (n = 228), 31% gay (n = 1,309), 19.1% bisexual (n = 808), 2.2% queer (n = 92), 4.7% questioning (n = 197), 6.2% pansexual (n = 260) and 4.1% as other/prefer not to disclose (n = 173). Gender and/or sex was 42.4% male (n = 1,790), 48.6% female (n = 2.054), 2.6% as transgender (n = 110), 3.3% genderqueer (n = 139), .7% pangender (n = 29), and 2.5% as other/prefer not to disclose (n = 102). Participants who reported other or preferred to not disclose within gender or sexual orientation demographic assessment were not included within the analysis. The majority of the participants identified as White (n = 2,817, 66.7%). Additionally, 28.5% of participants (n = 1,205) identified as having a Hispanic or Latino origin. Lastly, the

majority of participants stated currently being in school (*n* = 2,366, 56%). Detailed frequencies and demographic characteristics for the participants are provided in Table 1.

Research on body image has primarily focused on specific subgroups of the population. For example, studies predominantly focus on studying one specific group such as body image among gay men, among lesbian women, among men, or among women; but none have examined body image differences and psychosocial outcomes within a broader range of subgroups. Given the large and diverse sample size, it is of great empirical benefit to be able to compare how body image as a construct manifests across and within subgroups. Additionally, this study allowed for age differences to be assessed between youth and young adults. Few studies have been found in the literature assessing how youth and young adults may differ when measuring body image and other psychosocial functioning concepts (Holsen, Jones, & Birkeland, 2012; Rodgers, & Chabrol, 2009; Simis, Verhulst, & Koot, 2001). Understanding the complex relationships between sexual orientation, gender identity, and age differences increases the fields understanding of the underlying characteristics of body image and its outcomes, making great advances for research and evidence-based interventions particularly valuable.

Instrumentation

Demographic variables. Demographic variables include age, gender and/or sex, sexual orientation, ethnicity, race, and country of origin. Additionally, information about school or work status, grade or level of schooling, and educational accommodations and services were gathered. Demographic information all described in the aforementioned table. Demographic information were obtained through self-report as were completed at the beginning of the survey.

Body image. To measure participants' evaluations of their physical appearance, the Body-Image Ideals Questionnaire (BIQ; Cash, 2000**)** was used. The BIQ is an 11-item questionnaire that assessed the importance participants place on their physical appearance, as well as how much the evaluation of their physical appearance deviated from their ideal physical appearance (see Appendix C). For each item, participants were asked to respond to two statements regarding a specific physical attribute. The first statement (Part A) of the item addressed how they perceived their physical attribute aligned with the ideal (e.g. "My ideal height is…," "My ideal skin complexion is…") using the response options: "Exactly as I am," "almost as I am," "fairly unlike me," and "very unlike me." The second part of the item (Part B) asked participants how important it is for a specific physical attribute to match their ideal (e.g. "How important to you is your ideal height?" "How important to you is your ideal skin complexion?") while using the response options: "Not important," "somewhat important," "moderately important," and "very important." The scoring of the 22-items involved calculation of a mean of the item-by-item cross-products of discrepancy by importance ratings (Cash, 2000).

In order to assess body image in a different way, the BIQ was developed deriving from a self-discrepancy theory framework (Cash & Szymanski, 1995). Utilizing this framework, Cash and Szymanski (1995) posits an individual's appearance self-evaluations are based on congruent or discrepant results between perceived self-appearance and internalized standards or ideals. That is, body image satisfaction will depend on the individual's perceptions of how their appearance matches their ideal (Part A) followed by the importance with reaching those appearance ideals (Part B).

Technical data for the BIQ were gathered from analyses conducted by Cash (2000). Most analyses have been done with college samples that reflect reasonable ethnic diversity. However, the psychometric properties are done mostly on female samples; there is a need to have additional validation data on sexual minority groups and other non-female gender identities. Analyses of internal consistency across several studies (n = 192 across 2 samples for men and n = 896 across 5 samples for women) have found mean coefficient alpha of .81 for men and .76 for women. Excellent convergent validity has been reported with the following: the BASS (-.72), the MBSRQ Appearance Evaluation subscale (-.61), SIBID index of body-image dysphoria (.64), and body-image avoidance (.52; Cash, 2000). Additionally, Cash (2000) reported significant associations with social-evaluative anxiety (.43), depression (.47), and eating disturbance (.49). For the present study, the BIQ scale yielded a good internal consistency of α=.85. Total scores ranged for the body image scale ranged from 0 to 9 (M=2.35, SD=1.66) for young adults and 0 to 9 (M=2.63, SD=1.78) for youth.

Depression. To measure participants' levels of depression, the Beck Depression Inventory—Second Edition (BDI-II; Beck, Steer, & Brown, 1996) was used. The BDI-II is a 21-item measure that provides a unidimensional assessment of depression (see Appendix D). For each question, participants are provided four statements, from which they must select one that best reflects their thoughts, feelings, or behavior over the previous two weeks. Total depression scores are calculated by summing the numerical equivalent of the statement selected; items range from 0-3, with statements more indicative of depressive systems having higher point values. Depressive symptoms are interpreted based on total scores and categorized into four categories: Minimal depression

(0-13), mild depression (14-19), Moderate depression (20-28), and severe depression (29-63).

Technical data for the BDI-II were gathered from the BDI-II manual (Beck, Steer, & Brown, 1996). Analyses of internal consistency indicated the BDI-II has an approximate coefficient alpha of .92 when administered to both outpatient and college student samples. Analyses of test-retest reliability indicate a coefficient of .93. Additionally, analyses of concurrent validity indicate the BDI-II is correlated with the Beck Hopelessness Scale (r = .68), Scale for Suicide ideation (r = .37), and the Beck Anxiety Inventory (r = .60).

Internal consistency in the current study was excellent for both youth (α=.95) and young adults (α=.93). A factor analysis was not conducted due to previous literature suggesting the presence of only one factor. Total scores ranged from 0 to 63 (M=19.33, SD=13.91) for young adults and 0 to 63 (M=21.68, SD=14.62) for youth.

Anxiety. The current study used two measures to assess participants' levels of anxiety; measure completed was dependent on participants' age. For participants aged 19 and above, the Beck Anxiety Inventory (BAI; Beck & Steer, 1993) will be administered. The BAI is a 21-item measure that requires participants to indicate their experiencing of anxiety symptomatology (e.g. "Numbness or tingling," "feeling hot," "unable to relax") over the past week (see Appendix E). For each symptom, participants indicate the level of discomfort they felt from each symptom on a 4-point Likert-type scale with options ranging from "not at all" to "severely (I could barely stand it). A total scale score is calculated by summing the numerical equivalent for each item and categorizes

participants into four levels of anxiety: minimal anxiety (0-7), mild anxiety (8-15), moderate anxiety (16-25) and severe anxiety (26-63).

Technical properties of the BAI are documented in the technical manual (Steer & Beck, 1997) and indicate the BAI has a high internal consistency of .94 amongst clinical samples, and test-retest reliability of .75. Additionally, concurrent validity of the BAI has been established through co-administration with the *Hamilton Anxiety Rating Scale—Revised* (r = .51), the anxiety subscale of the *Cognition Check List* (r = .51), and the State (r = .47) and Trait (r = .58) subscales of the *State-Trait Anxiety Inventory.* Finally, the BAI has been validated through correlation comparisons with depression (*Beck Depression Inventory:* r = .61).

For the present study, excellent internal consistency was found (α=.93). A factor analysis was not conducted due to previous literature suggesting the presence of only one factor. Total scores ranged from 0 to 63 (M=20.06, SD=13.78).

For participants between the ages of 13-19, anxiety was measured using the Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997). The MASC is a 39-item measure that requires participants to indicate the frequency to which they experience anxiety symptomatology, experience thoughts related to anxiety, or engage in anxiety-related behaviors (e.g. “I feel tense or uptight,” “I worry about other people laughing at me,” “I keep my eyes open for danger”; see Appendix F)). For each statement, participants are to respond using a 4-item Likert-type scale with options ranging from “never true about me” to “often true about me.” A total score is calculated by summing the numerical equivalent for each item. In addition to a total scale score, the MASC has four subscales: Physical Symptoms, Harm Avoidance,

Social Anxiety, and Separation/Panic. Levels of anxiety for the total scale, as well as for each subscale, are interpreted by converting scale scores to T-scores and fall into eight categories: very much below average (T-score below 30), much below average (T-score between 30-34), below average (T-score between 35-30), slightly below average (T-score 40-44), average (T-score between 45-55), slightly above average (T-score between 56-60), above average (T-score between 61-65), and much above average (T-score between 66-70).

Technical Properties for the MASC have been demonstrated in various publications. For example, all main factors have demonstrated acceptable internal consistency with a total score coefficient alpha of .90 (March et al., 1997). Additionally, studies of test-retest reliability have found the MASC to be satisfactory (March, Sullivan & Parker, 1999).

Internal consistency in the current study was good for youth (α=.83). A factor analysis was not conducted due to previous literature suggesting the presence of only one factor. Total scores ranged from 1 to 153 (*M*=99.35, *SD*=20.22) for youth.

Bullying Victimization. The current study only utilized Part A of the Verbal and Physical Bullying Scale (VPBS; Swearer, 2001). This 13-item Likert-type scale inquired about participants' involvement in bullying as a victim during the previous school year (see Appendix G). Four items assessed physical victimization (e.g. "People attacked me," "people broke my things"), eight items assessed verbal victimization (e.g. "I was made fun of," "I was called bad names"), and one item assessed cyber victimization ("People posted mean things or made things up online about me [i.e., Facebook, Instagram, Twitter, etc.]). In addition, participants were asked to rate their frequency of victimization

for each item on a 5 point Likert-type scale with options ranging from "never happened" to "always happened." A total victimization score was determined by summing the numerical equivalent for each response; higher scores indicate greater frequency of victimization.

The technical properties of the VPBS have been documented in various publications. For instance, examining adolescent males' perceptions of being bullied, internal consistency of .87 for the VPBS total score (Swearer, Turner, Given, & Pollack, 2008) was found. A factor analysis of this data was also conducted and generated a two-factor solution with expected items loading on the Physical Bullying (α = .79) and Verbal Bullying (α = .85) factors with no cross-loadings (Swearer et al., 2008).

Additionally, studying victimization and bystander status, Werth and colleagues (2015) found the principal components analyses yielded a two-factor solution with items loading onto the Physical (α = .68; .83) and verbal (α .81; .82) bullying factors for victims and bystanders, correspondingly. Similarly, good internal consistency (alpha = .83) for the perpetration subscale and strong internal consistency (alpha .86) for the victimization subscale using coefficient alpha were found when using a 12-item scale (cyber bullying factor included; Strawhun, 2016).

Internal consistency in the current study was good for both youth (α=.84) and young adults (α=.85).

Procedures

Given that participants and data were part of a larger study, procedures were reviewed and approved by the IRB (Appendix A). This process assured participants' safety, appropriate consent and assent processes, and appropriate management of data

collection and storage of participant information. Furthermore, the Collaborative Institutional Training Initiative (CITI) trained all research assistants and investigators involved with data collection and analyses.

Data for the study were gathered electronically. Young adults (ages 19-25) were able to access the electronic link to the survey via the Born This Way Foundation website. Participants were then directed to the electronic young adult consent form (see Appendix H). Participants that were under the age of 19 required active parental consent to participate. Once parents accessed the electronic link to the survey via the Born This Way Foundation, they consented to their child's participation (see Appendix I) and provided their child's email address. Youth (ages 13-18) then received an email message with an electronic link to access the assent form (see Appendix J). Once the youth filled out the assent form, they were directed to participate in the study. Included in the consent form were information describing the purpose of the study, its approximate duration, and potential risks and benefits.

Questionnaires were delivered using Qualtrics Survey Software. It is estimated it took participants approximately 40 minutes to complete the survey. After agreeing to participate in the study, via consent or assent form, participants were first directed to the demographic data collection page. Participants then completed several questionnaires were randomly selected from a larger battery of surveys. Before every new survey, participants read brief instructions on how to complete the measure. Participants responded to questions about their experiences with the Born This Way Foundation, school/work environment, school/work engagement, support systems, involvement in bullying/victimization, cognitions, body image, kindness and bravery, sexual and gender

identity acceptance and “outness”, and internalizing concerns, such as anxiety and depression. Lastly, participants were asked if they are interested in being involved in a follow-up phase of the study. If so, participants were required to provide their contact information and were informed they might be invited (via phone, email, or Twitter) to participate in an in-person or over-the-phone interview.

Chapter Four: Results

Preliminary Analyses

All statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS) Version 25 software. Prior to completing analyses, a series of Pearson product-moment correlations were calculated to determine the strength of the relationship between the independent variables of depressive symptomatology, anxious symptomatology, and bullying victimization and the dependent variable of body image, providing support for using regression analyses in order to address the study's research questions. There was a significant positive correlation between participants' scores on the bullying victimization scale VPBS and participants' scores on the body image scale (r = .191). Additionally, there was a significant positive correlation between participants' scores on the depression scale BDI and participants' scores on the body image scale (r = .495). Lastly, there were significant positive correlations between participants' scores on the anxiety scales MASC and BAI and participants' scores on the body image scale for youth (r = .425) and young adults (r = .319) respectively. Means and standard deviations for each measure by age are presented in Table 2.

Research Question One

The aim of the first research question was to assess differences in subjective body image satisfaction scores among participants who self-identify as lesbian/gay, bisexual/queer, or questioning as well as evaluating gender by assessing differences between transgender versus cisgender participants. Additionally, differences in self-reported body image satisfaction scores among youth and young adult was assessed. A factorial ANOVA was conducted to compare the main effects of sexual orientation,

gender identity, and age and the interaction effect between the independent variables on body image dissatisfaction scores. Sexual orientation included four levels (heterosexual, homosexual, questioning, and bisexual/queer/pansexual, gender orientation consisted of 5 levels (male, female, transgender, genderqueer, other), and age consisted of two levels (youth, young adults). All main effects were significant at the .05 significance level. The main effect for sexual orientation yielded an F ratio of $F(3, 3103) = 5.614$, $p < .001$, indicating a significant difference between individuals who identify as heterosexual ($M = 2.27$, $SD = 1.62$), homosexual ($M = 2.44$, $SD = 1.69$), questioning ($M = 2.81$, $SD = 1.76$), and bisexual/queer/pansexual ($M = 2.49$, $SD = 1.72$). The main effect for gender identity yielded an F ratio of $F(4, 3103) = 5.251$, $p < .001$, indicating a significant difference between individuals who identify as male ($M = 2.39$, $SD = 1.68$), female ($M = 2.41$, $SD = 1.65$), transgender ($M = 3.26$, $SD = 2.02$), genderqueer ($M = 2.46$, $SD = 1.63$), and other ($M = 2.57$, $SD = 1.96$). The main effect for age yielded an F ratio of $F(1, 3103) = 10.375$, $p < .001$, indicating a significant difference between youth ($M = 2.61$, $SD = 1.76$) and young adults ($M = 2.36$, $SD = 1.66$). The interaction effects were non-significant. Tukey's HSD post hoc tests were conducted and interpretations for analysis are found below for each hypothesis.

Hypothesis one. Hypothesis one predicted that participants who self-identified as questioning their sexual orientation reported lower body image satisfaction than self-identified heterosexual and gay/lesbian participants. For sexual orientation, individuals who identified as questioning their sexual orientation ($M = 2.81$, $SD = 1.76$) had higher levels of body image dissatisfaction and were significantly different from those who identified as heterosexual ($M = 2.27$, $SD = 1.62$; $p = 0.001$) and homosexual ($M = 2.44$,

SD = 1.69; *p* = 0.042). Thus, hypothesis one was supported. Individuals who identified as questioning were not significantly different than those who identified as bisexual, queer, or pansexual (*M* = 2.49, *SD* = 1.72; *p* > 0.05).

Hypothesis two. Hypothesis two predicted participants who self-identify as transgender would report lower body image satisfaction than self-identified cisgender participants. For gender, individuals who identified as transgender (*M* = 3.26, *SD* = 2.02) reported higher levels of body image dissatisfaction and were significantly different to those who identified as female (*M* = 2.41, *SD* = 1.65; *p* < 0.001), male (*M* = 2.39, *SD* = 1.68; *p* < 0.001), and genderqueer (*M* = 2.46, *SD* = 1.63; *p* = 0.005). Thus, hypothesis two was supported. No other significant differences were found among gender.

Hypothesis three. Hypothesis three predicted adolescent participants would report less body image satisfaction than young adult participants. Youth (*M* = 2.61, *SD* = 1.76) were significantly different than young adults (*M* = 2.36, *SD* = 1.66; *p* = 0.001) reporting higher levels body image dissatisfaction. Therefore, hypothesis 3 was supported.

Research Question Two

The aim of the second research question was to assess if lower body image satisfaction predicted the likelihood that an individual would experience higher levels of anxious or depressive symptomatology.

Hypothesis four. Hypothesis four predicted that participants with lower body image satisfaction would be associated with elevated depressive symptomatology. A simple linear regression was calculated to predict depression scores based on body image scores. Body image dissatisfaction significantly predicted depression scores, *b* =

4.1490, $t(3285) = 32.63$, $p < .001$. A significant regression equation was found ($F(1,3285) = 1064$, $p<.001$), with an r^2 of 0.2447. Thus, hypothesis four was supported.

Hypothesis five. Hypothesis five predicted that participants with lower body image satisfaction would be associated with elevated anxious symptomatology. Given anxiety measures are different for youth and young adult, separate analyses were conducted by age group. A linear regression established that body image scores could statistically significantly predict anxiety scores in youth, $b = 4.5969$, $t(879) = 13.92$, $p < .001$. Body image scores accounted for 18% of the explained variability in anxiety scores, $F(1, 879) = 193.8$, $p <.001$. Similarly, body image dissatisfaction significantly predicted anxiety scores, $b = 2.6351$, $t(2404) = 16.53$, $p < .001$ for young adults. Body image scores statistically significantly predicted anxiety scores in young adults, $F(1, 2404) = 273.2$, $p <.001$ and body image scores accounted for 10% of the explained variability in anxiety scores. Thus, hypothesis five was supported for both youth and young adults.

Research Question Three

The goal of the third research question was to evaluate if lower body image satisfaction predicted the likelihood that an individual would experience higher levels of victimization.

Hypothesis six. Hypothesis six predicted that participants with lower body image satisfaction would be associated with higher victimization scores. A simple linear regression was calculated to predict victimization scores based on body image scores. A significant regression equation was found ($F(1,1358) = 51.3$, $p<.001$), with an r^2 of 0.04. Body image dissatisfaction significantly predicted victimization scores, $b = 1.3641$, $t(1358) = 7.162$, $p < .001$. In order to examine potential differences for youth and

young adult, separate analyses were conducted by age group. A linear regression established that body image scores could statistically significantly predict victimization scores in youth, $F(1, 454) = 17.91$, $p < .001$, and body image scores accounted for 4% of the explained variability in victimization scores. Similarly, body image scores statistically significantly predicted victimization scores in young adults, $F(1, 902) = 29.63$, $p < .001$ and body image scores accounted for 3% of the explained variability in victimization scores. Thus, hypothesis 6 was supported for both youth and young adults.

Research Question Four

The aim of the fourth research question was to assess if sexual orientation affected the way body image satisfaction predicted the likelihood that individuals would experience increased levels of mental health symptomatology. Multiple linear regression was calculated to predict body image dissatisfaction based on anxiety and depression by sexual orientation.

Hypothesis seven predicted that the effect of lower levels of body image satisfaction on anxiety would be stronger for sexual minority individuals than heterosexual participants. Given two different assessment instruments were used to measure anxiety based on age, two separate multiple regressions were conducted in order to assess the effect of body image on anxiety based on sexual orientation. The overall model was significant with the omnibus $F(7, 2298) = 45.44$, $p < .001$, for young adults. There was a significant interaction between the effects of sexual orientation and body image scores on anxiety, $F(3, 2298) = 3.248$, $p < .021$, for young adults. Body image dissatisfaction on anxiety was evaluated with the following formula: $Anxiety\ Score = 11.56 + 3.42 BodyImageScore + 4.16 BisexualQueerPansexual + 2.03 Homosexual +$

6.13*Questioning* - .71*BodyImageScore*BisexualQueerPansexual* - 1.26*BodyImageScore*Homosexual* - .7 *BodyImageScore*Questioning*. The interaction effect was only significant for individuals who identify as homosexual when compared to those who identified as heterosexual. The effect of body image scores on anxiety scores for individuals who identified as homosexual was as follows: Anxiety Score = 11.56 + 3.42*BodyImageScore* + 4.16*BisexualQueerPansexual* + 2.03*(1) + 6.13*(0) - .71 *BodyImageScore**(0)-1.26*BodyImageScore* *(1) - .7*BodyImageScore**(0) = 11.56 + 3.42*BodyImageScore* -1.26*BodyImageScore* = 11.56 + 2.16*BodyImageScore*. Results demonstrated body image scores have a larger effect on anxiety scores for homosexuals as compared to heterosexuals. Detailed presentation of the results can be found in Tables 3 and 4. For youth, overall model was significant with an omnibus $F(7, 832) = 27.75$, $p < .001$. However, there was not a significant interaction between the effects of sexual orientation and body image scores on anxiety, $F(3, 832) = 0.621$, $p = .602$. Results for youth are presented on Tables 5 and 6. Thus, hypothesis seven was partially supported, as the interaction effect was only significant for young adults.

Hypothesis eight predicted that the effect of lower levels of body image satisfaction on depression would be stronger for sexual minority individuals than heterosexual participants. Overall model was significant with an omnibus $F(7, 3138) = 171.9$, $p < .001$. There was a significant interaction between the effects of sexual orientation and body image scores on depression, $F(3, 3138) = 8.16$, $p < .001$. Body image dissatisfaction on depression was evaluated with the following formula: *Depression Score* = 8.24 + 4.68*BodyImageScore* + 3.95*BisexualQueerPansexual* + 1.75*Homosexual* + 2.48*Questioning* - .32*BodyImageScore*BisexualQueerPansexual* –

1.31*BodyImageScore*Homosexual* - .67*BodyImageScore*Questioning*. The interaction effect was only significant for individuals who identify as homosexual when compared to those who identified as heterosexual. Detailed presentation of the results are displayed in Tables 7 and 8. Thus, hypothesis eight was supported.

Hypothesis nine predicted that the effect of lower body image satisfaction on anxiety and depression would be stronger for questioning individuals. Given the results presented above, there was not a significant interaction between the effects of questioning individuals and the effects of body image on depression or anxiety. Therefore, hypothesis nine was not supported.

Chapter Five: Discussion

The purpose of this study was to examine the relations between self-reported body image satisfaction and bullying victimization, depression, and anxiety among youth and young adults. Importantly, this study aimed to examine differences across a broad range of self-identified sexual orientation and gender identity subgroups as understanding these interactions have not been well studied among diverse sexual orientations and gender identities. While previous research on body image dissatisfaction has studied its effects on mental health and victimization for individual genders (i.e., mostly male/female); age characteristics; and sexual orientation (i.e., mostly heterosexual versus "other"); the evidence is limited in how body image dissatisfaction is related to psychosocial outcomes among diverse youth and young individuals. Thus, the current study contributes to the literature by examining the interactions between body image satisfaction with anxiety, depression, and victimization within subgroups of sexual orientation, gender identity, and age.

Ultimately, the results of the current study further explain the importance of examining body image concerns, particularly during adolescence. These results extend the broader literature on body image satisfaction in youth and young adults across more expansive demographic characteristics, which may have implications for early clinical intervention and prevention work with diverse populations. In addition, the results from the current study emphasize the need to continue to break from the norm and include broad ranges of gender identities and sexual orientation identification in research on youth and young adults. Moreover, the results from this study underscore the importance of studying body image dissatisfaction conjointly with broader groups of sexual orientation and gender identity groups. In doing so, applied research will continue to

make strides toward full inclusion while making between group comparisons in order to provide tailored versus generic evidence-based interventions across groups. Within this chapter, the results of each hypothesis and their implications for research are discussed. Additionally, study limitations, future directions, and clinical implications are considered.

Body Image Satisfaction and Age, Sexual Orientation, and Gender Identity

The purpose of the first research question was to assess differences in subjective body image satisfaction ratings among participants by age, sexual orientation, and gender identity. Three specific hypotheses were made. The hypotheses predicted that certain groups, specifically individuals questioning their sexual identity, those identifying as transgender, and adolescents, would have significantly lower body image satisfaction. The hypothesis related to sexual orientation was made given previous research findings, suggesting individuals who identified as questioning their sexual orientation would present with higher levels of body image dissatisfaction (Gonzalez, Swearer, Mosher, Tebbe, & Zweifel, 2016). The second hypothesis was generated following evidence, which elucidated how transgender individuals experience gender-related discrimination, harassment, and violence that, taken together with the minority stress theory, increase the likelihood of an individual experiencing lower self-esteem, higher levels of suicidal ideation, and mental health symptomatology (Schulman & Erickson-Schroth, 2017; Testa et al., 2017; Mizock, 2017). More specifically, Vocks, Stahn, Lownser, and Legenbauer (2009) reported that transgender individuals had more body image dissatisfaction than cisgendered individuals. Since less is understood about the cognitive processes that influence body image dissatisfaction such as concerns for thinness or muscularity, gender incongruence, or personal expectations for meeting stereotypical gender norms (McGuire

et al., 2016) this study aimed to expand our knowledge in this area by examining transgender individuals ratings of body image satisfaction. Lastly, it was hypothesized that youth (individuals ranging from age 13-19) would experience lower body image satisfaction given body image dissatisfaction tends to increase with the onset of puberty (Bucchianeri, Aikian, Hannan, Eisenberg, & Neumark-Sztainer, 2013), increased rates of peer pressure related to conforming to appearance-related norms (Helfert & Warschburger, 2013), and a heightened sense of competition and comparison within peers (Muñoz & Ferguson, 2012).

All hypotheses for research question one were supported, as significant differences were found in body image satisfaction between age, sexual orientation, and gender identity groups. Given the findings from this study, individuals who identified as questioning their sexual orientation, those who identified as transgender, and participants aged 13-18 reported lower body image satisfaction based on identity group belonging. Particularly when examining body image satisfaction in individuals who identified as questioning, results from this study expand the existing literature by finding that questioning individuals have significantly lower body image satisfaction than heterosexual and homosexual peers. This study also found that individuals who identify as transgender reported lower levels of body image satisfaction than their cisgender peers. These results align with the findings of Murray, Rieger, and Byrne (2013) that identified there is significant societal emphasis for individuals to adhere to stereotypical gender identity expectations which, in turn, increased body image dissatisfaction. Lastly, this study found body image satisfaction was lower for adolescents versus young adults. These results are consistent with results from previous studies (e.g, Eisenberg, Neumark-

Sztainer, & Paxton, 2006; Tiggemann & Lynch, 2001); however, other studies have revealed no change in dissatisfaction or suggested that body image dissatisfaction continued to increase into young adulthood (Bucchianeri et al., 2013). Taken together, findings from the current study point to specific group belonging as potential fruitful targets of prevention and intervention efforts to reduce body image concerns and, in turn, mitigate the likelihood of negative outcomes that will be described below.

Body Image Satisfaction and Mental Health

The purpose of the second research question was to examine if body image dissatisfaction would predict the likelihood that an individual would experience mental health symptomatology. Two specific hypotheses (Hypothesis 4 and Hypothesis 5) were made in regards to the relationship between body image satisfaction and mental health outcomes. Hypothesis 4 predicted a negative association between the variables such that lower body image satisfaction would be associated with elevated depressive symptomatology. This hypothesis was generated based on evidence provided by Tiggemann's (2005) study linking body image dissatisfaction with increased likelihood of experiencing depressive symptoms along with lower self-esteem. This hypothesis was supported as self-reported lower body image predicted elevated levels of depressive symptomatology. Results from this study are consistent with Flores-Cornejo, Kamego-Tome, Zapata-Pachas, and Alvarado (2017) finding that adolescents between the ages of 13-17 years who had higher levels of body image dissatisfaction were 3.7 times more likely to report depressive symptoms. Furthermore, Solomon-Krakus and colleagues (2017) reported depressive symptoms were more frequently reported when the perception between actual and ideal body image is increasingly different. In addition, Jung and

colleagues' 2017 meta-analysis found individuals' whose BMI fell in the underweight and obese range had increased risk of depression. These findings along with the current results underscore the importance of the relationship between body image and depressive symptomatology. Furthermore, these results urge mental health and healthcare providers to assess for body image concerns as these concerns can increase the likelihood of developing depressive symptomatology even when the individual may not fall into a category stereotypically identified as having body image dissatisfaction.

In addition to examining the relationship between body image satisfaction and depression, this study sought to examine body image satisfaction and anxiety. Hypothesis five predicted that lower body image satisfaction would be associated with elevated anxious symptomatology. The results from the current study are in agreement with those found by Vannucci and McCauly (2017) as their findings suggest body image dissatisfaction is associated with symptoms of multiple anxiety disorders. More specifically, Vannucci and McCauly (2017) stated higher body image dissatisfaction was significantly related to reporting of higher rates of symptoms of generalized anxiety disorder, panic disorder, social anxiety disorder, and significant school avoidance. Additionally, Stefano and colleagues (2016) found that even in non-clinical populations, individuals with lower body image satisfaction show increased rates of body checking behaviors. Body checking behaviors have been tied to anxiety (White & Warren, 2014), eating pathology (Nikodijevic, Buck, Fuller-Tyszkiewicz, Paoli, & Krug, 2018; Suda et al., 2013), and are defined as excessive focus on body dislike and cause inordinate amounts of vigilance and worry over discrepancies between expected or ideal body image and current body image. Therefore, body-checking behaviors along with the documented

relationship between body image and social influences supports the finding from the current study that body image satisfaction is negatively related to anxious symptoms. Consequently, taken together, these results not only underline the relationship between anxiety and body image satisfaction, but they call attention to the importance of assessing for body image concerns when identifying individuals at risk for anxiety disorders.

Body Image Satisfaction and Bullying Victimization

The purpose of the third research question was to examine if self-reported body image satisfaction would predict the likelihood of experiencing bullying victimization. One specific hypothesis (Hypothesis six) predicted a negative association between the variables such that lower body image satisfaction would be associated with increased rates of self-reported bullying victimization. Hypothesis six was generated given body image has been correlated to being a victim of bullying victimization by peers (e.g., Frisen et. al., 2014; Lunde & Frisen, 2011). Moreover, there is a reported association suggestion those who were dissatisfied with their bodies were also more likely to report poor social relationships (Tiggemann, 2005) as they seem to be increasingly dependent on peer acceptance and approval. The current study confirmed the predictive relationship between body image dissatisfaction and bullying victimization. In agreement with the results from this study, Duarte, Pinto-Gouveia, and Stubbs (2017) found that not only is there a relationship between bullying victimization and body image dissatisfaction, but that it creates an added layer of body shame that mediates the link between bullying experiences and significant disordered eating. Given the relationship between body image dissatisfaction and bullying victimization and constructs that mediate the relationship such as body shame, which increase the complexity of the relationship, it is imperative to

examine the individual processes and constructs involved in body image evaluation and bullying victimization. Lastly, findings from the current study create a call to action to educators to address body image differently in school settings as it can relate to bullying victimization and the sequelae of negative outcomes that can arise from both being a victim of bullying victimization and having body image concerns.

Relationship between Body Image Satisfaction, Mental Health, and Sexual Orientation

The purpose of the fourth research question was to assess if sexual orientation affected the way body image satisfaction predicted the likelihood than an individual would experience mental health symptomatology. Given the literature evidence discussed in support of the individual hypotheses, hypotheses seven, eight, and nine were generated in order to assess for the possible interaction within the constructs. Hypothesis seven predicted that the effect of body image dissatisfaction on anxiety would be stronger for sexual minority individuals than for those who identify as heterosexual. This hypothesis was partially supported as the interaction effect between body image and sexual orientation on anxiety was significant only for young adults. These results can be interpreted as adolescents, regardless of sexual orientation, are experiencing a significant relationship between body image dissatisfaction and anxiety. Not finding a statistically significant difference between body image dissatisfaction and anxiety for youth who identified as heterosexual versus part of a sexual minority solidifies adolescence as a critical period in body image development. These results are in agreement with the holistic perspective presented by Voelker, Reel, and Greenleaf (2015) within their review of the literature that stated adolescence is a pivotal stage in body image for all individuals

that increases the likelihood of negative body perceptions and its harmful effects. However, there was a statistically significant difference between sexual orientation groups when examining the relationship between body image satisfaction and anxiety in young adults. These results emphasize the need to continue to study the relationship between sexual orientation, body image, and anxiety; particularly, why the experience is significantly different for individuals belonging to a sexual minority group as they transition from adolescence to adulthood.

In addition to examining the effect of body image dissatisfaction on anxiety based on sexual orientation, this study sought to examine these constructs interaction effects with depression. Hypothesis eight predicted that the effect of body image dissatisfaction on depression would be stronger for sexual minority individuals than for those who identified as heterosexual. In addition to the findings from this study that lower body image satisfaction is significantly related to elevated levels of depression, body image dissatisfaction has previously been found to be associated with depression independent of BMI, sex, and age (Richard, Rohrmann, Lohse, & Eichholzer, 2016). The current study, however, sought to expand the current literature on body image by assessing the interaction between the effects of body image dissatisfaction and sexual orientation on depression. Findings from the current study suggest there is a significant interaction between the effects of sexual orientation and body image scores on depression. Results from this study are in agreement with the findings of Ehlinger and Blashill (2016) that sexual orientation significantly moderated the relationship between body image subjective evaluations and depression, with a stronger positive association between body image dissatisfaction and depression scores observed among sexual minority versus

heterosexual participants. Findings suggest that body image dissatisfaction is a strong predictor of depression, particularly for sexual minority individuals.

Lastly, this study sought to examine the effect of body image dissatisfaction on anxiety and depression based on identification as questioning one's sexual orientation. Hypothesis nine predicted the effect of body image dissatisfaction on depression and anxiety would be stronger for questioning individuals. This hypothesis was not supported. The lack of significant results highlights the complex relationship between sexual orientation, body image, and mental health as well as establishes the need to continue to explore the appropriate relationships between them.

Implications and Clinical Significance

Body image dissatisfaction is a predictor of frequent dieting (e.g., Rodgers, McLean, Marques, Dunstan, & Paxton, 2016), restrictive food intake behaviors and disordered eating (e.g., MacNeill, Best, & Davis, 2017), and weight gain (e.g., Voelker et al., 2015). The current study adds to the literature on body image dissatisfaction by finding that lower levels of body image satisfaction increase the likelihood of experiencing anxiety and depression. Increasing efforts to urge therapists and primary care providers to appropriately assess for body image concerns is imperative given it is a risk factor for negative health outcomes and increased levels of anxiety and depression. Moreover, the current study adds to the literature by examining these relations among a diverse sample.

The present study points to a number of implications for clinical practice with sexual and gender minority populations. Specifically, results suggest that prevention efforts aimed at a systems-wide level, including education, community mental health

agencies, and primary care medical providers, are needed to appropriately monitor and decrease the levels of body image dissatisfaction experienced by individuals. Efforts to decrease body image satisfaction are important as they increase awareness toward the negative outcomes that may arise. The present findings suggest that these efforts may also help reduce anxious and depressive symptomatology in sexual minority populations. Interventions to reduce body image dissatisfaction and increase acceptance of gender and sexual minority identities can attenuate negative mental health outcomes and peer victimization.

Informed by these findings, clinicians and primary care medical providers can start by understanding the larger context of minority stress, discrimination, and prejudice that may interfere with individuals being forthcoming in disclosing not only their identities but also their thinking behind their body image dissatisfaction. For example, taking the results of the present study indicating body image dissatisfaction predicts the likelihood of an individual experiencing mental health symptomatology, clinicians and medical professionals can engage in advocacy efforts by reducing societal assumptions of heterosexuality (e.g., openly asking about sexual orientation, changing intake forms to be inclusive). Additionally, the present study calls for providers to increase their standards of care by appropriately and consistently assessing for body image satisfaction and sexual orientation as the present findings state individuals who experience lower body image satisfaction are at increased risk based on identity group belonging that can, in turn, signify increased likelihood to experience anxiety and depression. Building on the foundation of prevention, clinicians and medical providers can help individuals explore experiences that have shaped their body image conceptualization. Moreover, practitioners

can move towards intervention by encouraging individuals to resolve negative thoughts and behaviors that may stem from body image dissatisfaction and its interplay with their identity.

Results from the present study emphasize the need for intervention efforts tailored specifically for gender and sexual minority youth and young adults, as variables such as minority stress, group belonging, and self-acceptance may be compounding the negative outcomes of body image dissatisfaction for this population. For instance, it is noteworthy that a decline in body image satisfaction and its relationship with mental health outcomes was not observed in sexual minority individuals when transitioning to young adulthood. Regardless of sexual orientation, the concerns that arise from body image satisfaction remain worrisome, given its association with a plethora of negative outcomes (e.g., Rodgers et al., 2016; MacNeil et al., 2017; Voelker et al., 2015) and the increased likelihood of anxiety and depression that was also found in this study. Altman, Zimmaro, and Woodruff-Bordern (2017) found evidence for body-focused mindfulness and 1acceptance-based cognitive behavioral therapies as the most effective in increasing body compassion and body image flexibility. Taking the findings from this study, intervention efforts can be directed at targeting the thoughts and feelings that are maintaining or exacerbating body image dissatisfaction regardless of sexual orientation given body image dissatisfaction alone increased the likelihood of mental health concerns.

The historic discriminatory, biased, and stereotypic perceptions regarding sexual orientation and gender identity minority individuals lead the fields of psychology, counseling, and psychiatry to conceptualize sexual and gender minorities as representative of psychopathology or social deviancy (Biddell, Milton, Chang,

Watterson, & Deschler, 2015). Even though clear efforts are being implemented in various disciplines to reverse such conceptualizations, provided competent mental and physical healthcare services continues to be a significant barrier. The results from this study establishing that sexual orientation affected the way body image satisfaction predicted the likelihood that individuals would experience increased levels of anxiety and depression provides a unique opportunity to address mental health disparities. Given the established relationship between body image dissatisfaction and mental health, primary care providers are encouraged to discuss body image concerns as a gateway to other conversations that can be increasingly complex such as identity, mental health, and bullying victimization. Given the findings from the present study, mental health and physical healthcare providers should provide psychoeducation regarding the potential negative effects of body image dissatisfaction as well as the increased likelihood individuals who identify as gender nonconforming and those from sexual minority groups have of experiencing body image concerns. Altogether, providing appropriate psychoeducation that normalizes body image concerns raises awareness regarding its detrimental effects can aid individuals' comfort in increasingly sharing information that is important for conceptualization and treatment planning beyond body image concerns.

Future Directions and Limitations

Further research in the area of body image satisfaction is warranted to help inform interventions designed to provide tailored interventions to address body image concerns in various sexual orientation and gender identity groups. Additional work is needed to address how specific group belonging can change how one conceptualizes one's own body and, ultimately, how this might have a negative effect on mental health and

psychosocial outcomes. Studying different constructs that may mediate the relationship between sexual orientation, gender identity and body image satisfaction such as self-acceptance, sense of belonging, and perceived social support would potentially elucidate gaps in the literature that may further explain mental health disparities. As this current study highlights significant interactions between sexual orientation, mental health outcomes, and body image dissatisfaction, future research should assess the interaction between sexual orientation and racial/ethnic identities as well as sexual orientation and gender identities. Discussing the possibility of cumulative risk as the result of coping with multiple marginalized identities would point to increasingly targeted and effective interventions in relation to mental health outcomes.

With bullying victimization it is difficult to distinguish all the different variables that may influence why a particular individual is victimized. However, results from the current study confirm that there is a statistically significant relationship between body image dissatisfaction and higher rates of reported victimization. An area for future research is whether there exists a difference between types of victimization (i.e., physical, verbal, relational, or cyber) and the relationship with body image dissatisfaction (Ramos Salazar, 2017). As described previously, the current study follows a body image dissatisfaction-driven hypothesis and supports the assertion that lowered body image satisfaction predicts higher self-reported victimization. However, continuing to examine the bidirectionality of this construct will be important as Ramos Salazar (2017) found evidence suggesting that cyber bullying victimization was a predictor of cyberbullying perpetration, body image dissatisfaction, dieting behaviors, and lowered life satisfaction.

No study is without limitations and there are several limitations to be discussed regarding the current study. First, sampling is a limitation of this study given that recruitment of participants occurred primarily through Born This Way Foundation website, public events, and social media. Data sources as well as the recruitment process raise potential problems with the representativeness of the sample. However, recruitment also occurred through several other community partners in order to recruit participants beyond Born This Way Foundation (i.e., Intel Corporation, Life is Good; TextTalkAct: Creating Community Solutions; Random Acts of Kindness Foundation; and Mattel) in order to enhance the representative of the sample. Additionally, with participants from this study being from different countries and cultural backgrounds, the potential for inherent differences in how the constructs, particularly related to body image ideals, may vary across cultures. Evaluating these differences were out of the scope of this study; however, future research should continue to examine the impact of culture and nationality on body image perceptions.

Additionally, the generalizability of these results can be questioned. By the nature of its mission, Born This Way Foundation may appeal to a population that may have distinct individual characteristics, given Lady Gaga's fan base. While the diversity of the current sample across sexual orientation and gender identify is a strength, the demographic characteristics cannot be compared against a nationally representative sample. Currently, most research does not assess non-binary gender identity and diverse sexual orientations with the exception of the Center for Disease and Control Prevention (CDC) Behavioral Risk Factor Surveillance System (2014) and GLSEN's National School Climate survey (2015). Current literature highlights the inability to assess current

diverse sampling in any formal way given the lacking US population data (e.g., census data) to compare national findings (Meyer, Brown, Herman, Reisner, & Bockting, 2017). The current study calls on researchers and policymakers to include alternative methods that include multiple items to assess for gender identity (e.g., sex at birth, current gender identity) and sexual orientation (i.e., beyond heterosexual and homosexual) in future studies to continue to enhance our knowledge about diverse individuals.

Lastly, another limitation of this study centers on the measurement of anxiety since this construct was measured using two different assessment tools for youth and young adults. However, the two assessment tools are widely used in the clinical literature and have been found to reliably assess symptoms of anxiety. However, using two different assessments may not equally assess anxiety across the full sample. Additionally, given the data for predictor and criterion variables were obtained under the same contextual influences at one point in time, concern is raised for common method bias.

Concluding Remarks

Despite the aforementioned limitations, the current study adds to our understanding of how body image can interact with gender identity, sexual orientation, age, and can affect mental health. This study emphasizes the importance of a comprehensive assessment of body image related concerns as it appears to be efficacious in exploring potential risk factors towards experiencing depressive and anxious symptomatology as well as bullying victimization. In addition, exploring body image related concerns could also serve as a platform for discussing how identity group belonging can exacerbate or maintain negative body image perceptions in youth and young adults.

The results from the current study encourage researchers and clinicians to examine constructs that have an impact on mental health within a broader assessment of sexual orientation and gender identity beyond hetero- or gender-normative models. In a qualitative study, Gordon, Austin, Krieger, White Hughto, and Reisner (2016) found four themes emerged when examining the perspective of disordered eating in gender nonconforming individuals. Gordon and colleagues (2016) found gender socialization and the development of body image ideals, experiences of stigma and discrimination, biological processes, and sources of strength and resilience are all involved in increased body image and eating concerns. These emergent themes stress the complexity that underlies body image concerns. Furthermore, it emphasizes the need to continue to tease apart the underlying processes that may alter body image perceptions across more expansive subgroups of gender identity and sexual orientation.

Additionally, results further support interventions or preventions strategies that incorporate assessing for body image concerns and the level of distress individuals may experience. Evidence from the current study suggests that appropriately assessing for body image satisfaction, particularly in youth, can be enlightening in determining prevention and early intervention efforts to promote positive body image perceptions and psychological well-being. Simply asking an individual "how satisfied are you with the appearance of your body on a scale from one to 10 with 10 meaning ‘a lot’ and one ‘not at all’?” can lead to open conversations regarding the elevated risk for anxiety, depression, or bullying victimization if the individual reports higher levels of dissatisfaction with their body. Adding clinical questions about body image satisfaction

as common practice within mental health, school, and medical professionals may uncover mental health or social stressors that may be a source of distress.

It is of great importance that there is a shift in overall research and clinical strategies towards assessing a broader range of individual characteristics that can impact body image dissatisfaction to better determine its influence on mental health. Results from the current study solidify the need to assess for body image satisfaction as higher dissatisfaction increases the likelihood of experiencing increasingly significant depressive and/or anxious symptomatology and bullying victimization. Taken together, these results not only underlie the relations between anxiety, depression, bullying victimization, and body image dissatisfaction within the context of a diverse sample, but calls attention to the importance of assessing for body image concerns when identifying individuals at risk for negative psycho-social outcomes.

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Tables

Table 1

Descriptive Statistics

Characteristic	*n*	%
Age		
20-25	2,369	56
13-19	1,855	44
Race		
White	2817	66.7
Multiple (2 or more races)	567	13.4
Other	408	9.7
Asian	230	5.4
Black or African American	157	3.7
American Indian or Alaska Native	41	1
Native Hawaiian or Pacific Island	4	.1
Gender and/or Sex		
Female	2054	48.6
Male	1790	42.4
Genderqueer	139	3.3
Transgender	110	2.6
Other	103	2.4
Prefer Not to Disclose	28	.7
Sexual Orientation		
Homosexual	1537	36.4
Bisexual, Queer, Pansexual	1160	27.5
Heterosexual	1157	27.4
Questioning	197	4.7
Total	4224	100

Table 2

Means and Standard Deviation by Age for Each Measure

Measure	Depression: BDI	Anxiety: BAI	Anxiety: MASC	Victimization
Youth				
M	21.68		99.35	47.84
SD	14.62		20.22	13.49
Young Adult				
M	19.33	20.06		45.03
SD	13.91	13.78		14.02

Table 3

Summary of Effects for Anxiety (BAI) on Body Image Scores (BIQ) by Sexual Orientation

	df	*SS*	*MS*	*F*
BIQ	1	44790	44790	271.380***
Sexual Orientation	3	6095	2032	12.311***
BIQ:Sexual Orientation	3	1608	536	3.248*
Residuals	2298	379278	165	

*Note. *p < .05 ***p< .001*

Table 4

Main and Interaction Effects for Anxiety (BAI) on Body Image Scores (BIQ) by Sexual Orientation

Variable	***B***	***SE B***	***t***
Intercept	11.5479	0.8650	13.351***
BIQ	3.4198	0.3205	10.671***
Sexual Orientation: BQP	4.1626	1.2346	3.372***
Sexual Orientation: Homosexual	2.0253	1.1373	1.781
Sexual Orientation: Questioning	6.1271	2.8099	2.181*
BIQ x BQP	-0.7117	0.4428	-1.607
BIQ x Homosexual	-1.2605	0.4049	-3.113**
BIQ x Questioning	-0.6990	0.9233	-0.757
$R^2 = 0.1216$			
F = 45.44***			

*p < .05, **p<.01, ***p<.001

Table 5

Summary of Effects for Anxiety (MASC) on Body Image Scores (BIQ) by Sexual Orientation

	df	*SS*	*MS*	*F*
BIQ	1	51966	51966	174.95***
Sexual Orientation	3	5187	1729	5.82***
BIQ:Sexual Orientation	3	553	184	0.62
Residuals	832	247128	297	

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

Table 6

Main and Interaction Effects for Anxiety (MASC) on Body Image Scores (BIQ) by Sexual Orientation

Variable	***B***	***SE B***	***t***
Intercept	86.31668	1.96699	43.883***
BIQ	4.99092	0.63748	7.829***
Sexual Orientation: BQP	5.35262	2.71547	1.971*
Sexual Orientation: Homosexual	-0.05413	2.77401	-0.020
Sexual Orientation: Questioning	7.81386	4.27104	1.829
BIQ x BQP	-1.13796	0.85045	-1.338
BIQ x Homosexual	-0.85327	0.93264	-0.915
BIQ x Questioning	-0.73226	1.22727	-0.597
$R^2 = 0.1893$			
F = 27.75***			

*p < .05, **p<.01, ***p<.001

Table 7

Summary of Effects for Depression (BDI) on Body Image Scores (BIQ) by Sexual Orientation

	df	*SS*	*MS*	*F*
BIQ	1	156812	156812	1082.00***
Sexual Orientation	3	14055	4685	32.33***
BIQ:Sexual Orientation	3	3548	1183	8.16***
Residuals	3138	454783	145	

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

Table 8

Main and Interaction Effects for Depression (BDI) on Body Image Scores (BIQ) by Sexual Orientation

Variable	***B***	***SE B***	***t***
Intercept	8.2374	0.6950	11.853***
BIQ	4.6762	0.2484	18.828***
Sexual Orientation: BQP	3.9472	0.9831	4.015***
Sexual Orientation: Homosexual	1.7513	0.9292	1.885
Sexual Orientation: Questioning	2.4815	1.9364	1.281
BIQ x BQP	-0.3186	0.3386	-0.941
BIQ x Homosexual	-1.3129	0.3242	-4.049***
BIQ x Questioning	0.6746	0.5932	1.137
$R^2 = 0.2772$			
F = 171.9***			

*p < .05, **p<.01, ***p<.001

Appendix A

NUgrant

University of Nebraska-Lincoln
Institutional Review Board (IRB)
402-472-6965
irb@unl.edu

FOR OFFICE USE ONLY
IRB #: 20121213052EP
IRB Decision Date: 12/07/2015
Date Received: 12/01/2015
NUgrant Project ID: 13052
Form ID: 25195
Status: Approved by the IRB

Investigators

Listed below is the current PI and SI. Please update these people if needed.

*** 1. Principal Investigator's Status:**
Faculty

*** Principal Investigator is:**
Susan M Swearer - sswearernapolitano1@unl.edu - 4024721741

*** Principal Investigator's Department**
Department of Educational Psychology

2. Secondary Investigator is:
Michelle Howell Smith - mhowellsmith@unl.edu - 4024721821

Secondary Investigator's Department
Nebraska Center for Research on Children, Youth, Families and Schools

Section I

Note: If the project is complete, please submit the protocol Final Report form. Do not complete the Continuing Review Form.

If your project has been approved for 5 years you must select the status of "5-year Renewal of active project." If you are unsure of how long your project has been approved for, you may reference the original application approval date but viewing the Original Form tab.

*** 3. Status of Study**
Active with ongoing recruitment of subjects

Section II

*** 1. When did the study begin?**
12/21/2012

*** 2. What is the estimated completion date of the study?**
12/31/2017

3. How many subjects (or subject files) have completed the study?

NUgrant

Appendix B

Demographic Variables

D2. What is your age?

D11. The following questions are about your gender and/or sex. When a person's sex and gender do not match, they might think of themselves as transgender. Sex is what a person is born. Gender is how a person feels. Which one response best describes you?

1 = I am male

2 = I am female

3 = I am transgender and identify as a boy or man

4 = I am transgender and identify as a girl or woman

5 = I am transgender and identify in some other way

6 = I am genderqueer

7 = I prefer not to disclose

8 = Other (please specify)

9 = I am pangender

“Genderqueer” includes androgynous, agender, bigender, both, gender blind, pangender, and any other terms that imply fluid or multiple gender identities.

D15. What is your sexual orientation?

1 = Straight

2 = Lesbian

3 = Gay

4 = Bisexual

5 = Queer

6 = Questioning

7 = I prefer not to disclose

8 = Other (please specify)

9 = Pansexual

"Bisexual/Queer" includes terms such as pansexual, pomosexual, polysexual, free sexual, homoflexible, demisexual, and any other terms that imply fluid or multiple sexual orientations. Also include any terms such as asexual and aromantic.

Appendix C

Body-Image Ideals Questionnaire (BIQ)

Measure is copyrighted and was used for this study with permission by the author.

Appendix D

Beck Depression Inventory- II (BDI-II)

Measure is copyrighted and was used for this study with permission from the publisher.

Appendix E

Beck Anxiety Inventory (BAI)

Measure is copyrighted and was used for this study with permission from the publisher.

Appendix F

Multidimensional Anxiety Scale for Children (MASC)

Measure is copyrighted and was used for this study with permission from the publisher.

Appendix G

Verbal and Physical Bullying Scale (VPBS)

Measure is copyrighted and was used for this study with permission from the author.

Appendix H

University of Nebraska Lincoln

COLLEGE OF EDUCATION AND HUMAN SCIENCES
Educational Psychology

Young Adult Consent Form

The Born Brave Experiences Research Study

Dear Born Brave Experiences Participant:

You are invited to participate in this research study. The following information is provided in order to help you make an informed decision whether or not you want to participate. You are being asked to complete this consent form because you are over 18 years of age. If you have any questions please do not hesitate to ask. The long-term goal of this research project is to better understand the factors that support individual empowerment and engagement, and to develop effective mental health interventions for youth and young adults. Also, we hope to gain a better understanding of the psychological and social functioning of individuals who participate in the Born This Way Foundation experiences. Overall, this project will help answer the question, "What do people need in order to create a kinder and braver world?"

You are eligible to participate in this study because you are between 19 and 25 years old and have accessed the link on the Born This Way Foundation website. The research project will take place using your computer or tablet and accessing the Young Adult Survey link on http://bornthisway.foundation/.

This study will take approximately 30-40 minutes of your time, and will be completed one time during 2016. You will be asked to complete several questionnaires that are randomly selected from a larger battery of questionnaires. You might be asked questions about your demographics (e.g., grades, gender, age), experiences with the Born This Way Foundation activities, school/work climate, school/work engagement, empathy, peer and family support, involvement in bullying/victimization, cognitions, hope for the future, self-concept, sexual and gender identity acceptance and outness, and internalizing issues, such as anxiety and depression. In a follow-up phase of the study, you may be invited (via phone, e-mail, or Twitter) to participate in an in-person or over-the-phone interview. If you are interested, you will be asked to provide your contact information so researchers can contact you for the interview phase of the study.

You may experience mild discomfort when completing the questionnaires (for example, it is possible that this will cause psychological discomfort for some participants who are experiencing problems with bullying or who feel at risk for psychological or health problems). If problems should arise, please click on the "Get Help Now" link on the Born This Way Foundation website: http://bornthisway.foundation/get-help-now.

Participant's Initials_____

114 Teachers College Hall / P.O. 880345 / Lincoln, NE 68588-0345
(402) 472-2223 / FAX (402) 472-8319

However, it is possible that you may appreciate being asked about these experiences. Also, answering questions about your experiences often helps people process them.

Any information obtained during this study that could identify you will be kept strictly confidential. Any identifiable, sensitive data will be replaced with a numerical value to protect your anonymity. Your e-mail address will be stored temporarily in a secure location in the event that you are chosen to be invited to participate in an interview. The information obtained in this study may be published in scientific journals, books, or presented at scientific meetings, but your identity will be kept strictly confidential and responses will be aggregated. Study records will be kept for seven years on a password-protected website (i.e., Qualtrics) or secure computer file, which will only be accessed by the investigators of this study.

If you choose to participate, you will be entered into raffles for Lady Gaga merchandise (determined by Haus of Gaga). If you win, you will receive the prize at the completion of data collection (approximately December 2016). Odds of winning are based on the number of participants. Additionally, a 20% promo code off your entire order (excluding sales) at www.lifeisgood.com will be provided at the end of the surveys.

Your participation is completely voluntary. You are free to decide not to enroll in this study or to withdraw at any time without adversely affecting your relationship with the investigators, the University of Nebraska-Lincoln, or The Born This Way Foundation. Your decision will not result in any loss of benefits to which you are otherwise entitled.

Your rights as a research participant have been explained to you. If you decide to participate in this study, please sign this form and complete the remaining online forms. If you have any questions about this study, please contact Dr. Susan Swearer at (402) 472-1741. If you have any questions concerning your rights as a research participant that have not been answered by the investigator, or to report any concerns about the study, you may contact the University of Nebraska-Lincoln Institutional Review Board (UNL IRB), telephone (402) 472-6965.

DOCUMENTATION OF INFORMED CONSENT

YOU ARE VOLUNTARILY MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS RESEARCH STUDY. YOUR ELECTRONIC SIGNATURE CERTIFIES THAT YOU HAVE DECIDED TO PARTICIPATE HAVING READ AND UNDERSTOOD THE INFORMATION PRESENTED. YOU MAY PRINT OUT A COPY OF THIS FORM FOR YOUR RECORDS.

_____ _____

SIGNATURE OF PARTICIPANT **DATE**

_____

PRINT YOUR NAME

IDENTIFICATION OF PRIMARY INVESTIGATOR(S)

Susan M. Swearer, Ph.D. Office: 402-472-1741

Appendix I

University of Nebraska Lincoln

COLLEGE OF EDUCATION AND HUMAN SCIENCES
Educational Psychology

Parental/Guardian Consent Form
The Born Brave Experiences Research Study

Dear Parent or Guardian:

Your child is invited to participate in this research study. The following information is provided in order to help you make an informed decision whether or not you want to allow your child to participate. You are being asked to complete this consent form because your child is less than 19 years of age. If you have any questions please do not hesitate to ask. The long-term goal of this research project is to better understand the factors that support youth empowerment and engagement, and to develop effective mental health interventions for youth and young adults. Additionally, we hope to gain a better understanding of the psychological and social functioning of youth who participate in the Born This Way Foundation experiences. Overall, this project will help answer the question, "What do youth need in order to create a kinder and braver world?"

You and your son or daughter are eligible to participate in this study because your child is between 13 and 18 years old and has accessed the link on the Born This Way Foundation website. The research project will take place using your computer or tablet and accessing the Youth Survey link on http://bornthisway.foundation/.

This study will take approximately 30-40 minutes of your child's time, and will be completed one time during 2016. Your child will be asked to complete several questionnaires that are randomly selected from a larger battery of questionnaires. Specifically, he or she may be asked questions about his or her demographics (e.g., grades, gender, age), experiences with the Born This Way Foundation activities, school climate, school engagement, empathy, peer and family support, involvement in bullying/victimization, cognitions, hope for the future, self-concept, sexual and gender identity acceptance and outness, and internalizing issues, such as anxiety and depression. Additionally, your son or daughter may be selected to be invited (via phone, e-mail, or Twitter) to participate in an in-person or on-the-phone interview. If your son or daughter is interested, he or she will be asked to provide your contact information and your consent will be obtained prior to your child participating in any interviews.

Your child may experience mild discomfort when completing the questionnaires (for example, it is possible that this will cause psychological discomfort for some participants who are experiencing problems with bullying or who feel at risk for psychological or health problems). If problems should arise, please click on the "Get Help Now" link on the Born This Way Foundation website: http://bornthiswayfoundation.org/help.

Parent/Guardian's Initials_____

114 Teachers College Hall / P.O. 880345 / Lincoln, NE 68588-0345
(402) 472-2223 / FAX (402) 472-8319

However, it is possible that participants may appreciate being asked about these experiences. Also, answering questions about their experiences often helps people process them.

Any information obtained during this study that could identify you and your son or daughter will be kept strictly confidential. Any identifiable, sensitive data will be replaced with a numerical value to protect the anonymity of your child. Your child's e-mail address will be stored separately in a secure location in the event that they are chosen to be invited to participate in an interview. The information obtained in this study may be published in scientific journals, books, or presented at scientific meetings, but your child's identity will be kept strictly confidential and responses will be aggregated. Study records will be kept for seven years on a password-protected website (i.e., Qualtrics) or secure computer file, which will only be accessed by the investigators of this study.

If your child chooses to participate, he or she will be entered into raffles for Lady Gaga merchandise (to be determined by Haus of Gaga). If your child wins, he or she will receive the prize at the completion of data collection (approximately December 2016). Odds of winning are based on the number of participants. Additionally, a 20% promo code off your entire order (excluding sales) at www.lifeisgood.com will be provided at the end of the surveys.

Your child's participation is completely voluntary. You are free to decide not to enroll your child in this study or to withdraw at any time without adversely affecting your child's or your relationship with the investigators, the University of Nebraska-Lincoln, or The Born This Way Foundation. Your decision will not result in any loss of benefits to which your child is otherwise entitled.

Your child's rights as a research participant have been explained to you. If you decide to participate in this study, please sign this form and have your child complete the remaining online forms. If you have any questions about this study, please contact Dr. Susan Swearer at (402) 472-1741. If you have any questions concerning your or your child's rights as a research participant that have not been answered by the investigator, or to report any concerns about the study, you may contact the University of Nebraska-Lincoln Institutional Review Board (UNL IRB), telephone (402) 472-6965.

DOCUMENTATION OF INFORMED CONSENT

YOU ARE VOLUNTARILY MAKING A DECISION WHETHER OR NOT TO ALLOW YOUR CHILD TO PARTICIPATE IN THIS RESEARCH STUDY. YOUR ELECTRONIC SIGNATURE CERTIFIES THAT YOU HAVE DECIDED TO ALLOW YOUR CHILD TO PARTICIPATE HAVING READ AND UNDERSTOOD THE INFORMATION PRESENTED. YOU MAY PRINT OUT A COPY OF THIS FORM FOR YOUR RECORDS.

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**

_____
PRINT YOUR CHILD'S NAME

IDENTIFICATION OF PRIMARY INVESTIGATOR(S)
Susan M. Swearer, Ph.D. Office: 402-472-1741

Appendix J

University of Nebraska Lincoln

COLLEGE OF EDUCATION AND HUMAN SCIENCES
Educational Psychology

Youth Assent Form
The Born Brave Experiences Research Study

Dear Born Brave Experiences Participant:

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This study will take approximately 30-40 minutes of your time, and will be completed one time during 2016. You will be asked to complete several questionnaires that are randomly selected from a larger battery of questionnaires. You might be asked questions about your demographics (e.g., grades, gender, age), experiences with the Born This Way Foundation activities, school climate, school engagement, empathy, peer and family support, involvement in bullying/victimization, cognitions, hope for the future, self-concept, sexual and gender identity acceptance and outness, and internalizing issues, such as anxiety and depression. In a final phase of the study, you may be invited (via phone, e-mail, or Twitter) to participate in an in-person or over-the-phone interview. If you are interested, you will be asked to provide your contact information and your parent or guardian's consent will be obtained prior to you participating the interview phase of the study.

You may experience mild discomfort when completing the questionnaires (for example, it is possible that this will cause psychological discomfort for some participants who are experiencing problems with bullying or who feel at risk for psychological or health problems). If problems should arise, please click on the "Get Help Now" link on the Born This Way Foundation website: http://bornthisway.foundation/get-help-now.

Participant's Initials_____

114 Teachers College Hall / P.O. 880345 / Lincoln, NE 68588-0345
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_____ _____
SIGNATURE OF PARTICIPANT **DATE**

_____
PRINT YOUR NAME

IDENTIFICATION OF PRIMARY INVESTIGATOR(S)

Susan M. Swearer, Ph.D. Office: 402-472-1741