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Doctoral thesis

**Examining the Relationship Between Men's Body Concerns, Health-Related
Quality of Life, and Self-Compassion Among Young and Older Iranians
Living in Iran and Europe**

by

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Abstract

Body image represents a significant psychological dimension of well-being that can affect individuals' health, social functioning, and health-related quality of life (HRQOL). While body-image research has predominantly focused on women and younger populations, body-related concerns are also pertinent among men and may vary across the lifespan and cultural settings. Self-compassion has been identified as a psychological resource that may enable individuals to respond more adaptively to body-related concerns. This doctoral study investigated the relationships among multidimensional body-self relations, self-compassion, and health-related quality of life in young and older Iranian men residing in Iran and Europe, with particular emphasis on the potential mediating and moderating roles of self-compassion, as well as the effects of age and country of residence.

A cross-sectional, comparative design was employed. The total sample consisted of 640 Iranian men, including 300 participants residing in Iran and 340 Iranian migrants residing in Europe, specifically Germany and Sweden. Participants were divided into younger men aged 22–35 years and older men aged 60 years and above. The European sample comprised 233 younger men and 107 older men. Data were collected using the Multidimensional Body-Self Relations Questionnaire (MBSRQ), the Persian Self-Compassion Scale (SCS), and the World Health Organization Quality of Life Questionnaire–BREF (WHOQOL-BREF). Descriptive statistics, reliability analyses, correlation and regression analyses, moderation analyses, and structural equation modelling (SEM) were used to examine the proposed relationships.

The results revealed a significant association between multidimensional body-self relations and health-related quality of life (HRQOL). More positive body-self relations correlated with higher overall HRQOL, as well as improved physical, psychological, social, and environmental quality of life. Self-compassion was also positively associated with overall HRQOL and each of the four WHOQOL-BREF domains. Mediation analyses showed that self-compassion partially mediated the relationship between multidimensional body-self relations and HRQOL, indicating that self-compassion may account for part of the association between body-related perceptions and quality of life. Structural equation modeling (SEM) analyses identified a significant interaction between body-self relations and self-compassion. Simple-slope analyses showed that the strength of the association between body-self relations and HRQOL varied by level of self-compassion, supporting a moderating or buffering effect of self-compassion.

The age-related findings were less consistent. Neither age group nor the Age $\times$ MBSRQ and Age $\times$ Self-Compassion interactions were statistically significant in the age-focused model, and age did not significantly mediate the relationship between body-self relations and health-related quality of life (HRQOL). In contrast, the model including country of residence identified a significant Age $\times$ MBSRQ interaction, indicating that the association between body-self relations and HRQOL may depend on broader contextual conditions. Country of residence also emerged as a significant predictor of HRQOL. Participants residing in Europe reported substantially higher HRQOL compared to those living in Iran. However, this difference should be interpreted as an observed distinction between the study populations, rather than as evidence of a direct causal effect of culture, since country of residence encompasses multiple cultural, socioeconomic, environmental, healthcare, and institutional factors.

The findings support an integrated perspective in which men's health-related quality of life is associated with both their perceptions and evaluations of their bodies, as well as their psychological responses to body-related concerns. Self-compassion is particularly relevant, functioning as both a potential explanatory mechanism and a moderating factor in the relationship between body-self relations and health-related quality of life (HRQOL).

This study contributes to the literature by simultaneously examining body image, self-compassion, quality of life, age, and cultural context among Iranian men across various stages of adulthood and residential settings. The results underscore the potential value of culturally sensitive interventions that address body image in conjunction with self-compassion and broader psychological well-being. Because this study used a cross-sectional, observational design, causal interpretations are not justified. Longitudinal and experimental research is recommended to further elucidate the temporal and causal relationships among body-self relations, self-compassion, and HRQOL.

Keywords: Body image, Health-related quality of life, Self-compassion, Men, Intergenerational differences

Streszczenie

Obraz własnego ciała stanowi istotny psychologiczny wymiar dobrostanu, który może wpływać na zdrowie, funkcjonowanie społeczne oraz jakość życia związaną ze zdrowiem (HRQOL). Choć badania nad obrazem ciała koncentrowały się głównie na kobietach i młodszych grupach wiekowych, obawy dotyczące wyglądu ciała dotyczą mężczyzn i mogą zmieniać się w zależności od etapu życia oraz kontekstu kulturowego. Współczucie wobec samego siebie (ang. *self-compassion*) zidentyfikowano jako zasób psychologiczny, który może pozwalać jednostkom na bardziej adaptacyjne reagowanie na obawy związane z własnym ciałem. Niniejsza praca doktorska analizowała zależności między wielowymiarowymi relacjami z własnym ciałem, współczuciem wobec samego siebie a jakością życia związaną ze zdrowiem u młodszych i starszych mężczyzn irańskich zamieszkujących Iran oraz Europę, ze szczególnym uwzględnieniem jako mediatora współczucia wobec samego siebie, a także różnicowania tych współzależności przez dwie kolejne zmienne: wiek (młodzi i starsi dorośli) i kontekst życia (Iran i nie Iran).

Zastosowano schemat badania przekrojowego o charakterze porównawczym. Łączna próba badawcza obejmowała 640 mężczyzn irańskich, w tym 300 uczestników mieszkających w Iranie oraz 340 migrantów irańskich mieszkających w Europie (konkretnie w Niemczech i Szwecji). Uczestników podzielono na grupę mężczyzn młodych (w wieku 22–35 lat) oraz starszych (w wieku 60 lat i więcej). Próba europejska składała się z 233 młodych mężczyzn i 107 starszych. Dane zebrano przy użyciu perskich adaptacji kwestionariuszy: Multidimensional Body-Self Relations Questionnaire (MBSRQ), Self-Compassion Scale (SCS) oraz kwestionariusza jakości życia Światowej Organizacji Zdrowia WHOQOL-BREF. Do analizy badanych zależności wykorzystano statystyki opisowe, analizy rzetelności, analizy korelacji i regresji, analizy moderacji oraz modelowanie równań strukturalnych (SEM).

Wyniki wykazały istotny związek między wielowymiarowymi relacjami z własnym ciałem a jakością życia związaną ze zdrowiem (HRQOL). Bardziej pozytywne relacje z własnym ciałem korelowały z wyższą ogólną jakością życia (HRQOL), a także z lepszą jakością życia w wymiarach: fizycznym, psychicznym, społecznym i środowiskowym. Współczucie wobec samego siebie również wiązało się pozytywnie z ogólną jakością życia (HRQOL) oraz z każdym z czterech wymiarów kwestionariusza WHOQOL-BREF. Analizy mediacyjne wykazały, że współczucie wobec samego siebie częściowo pośredniczyło w relacji między wielowymiarowymi relacjami „ciało–ja” a jakością życia związaną ze zdrowiem (HRQOL), co wskazuje, że współczucie to może

wyjaśniać część związku między postrzeganiem własnego ciała a jakością życia. Analizy z wykorzystaniem modelowania równań strukturalnych (SEM) ujawniły istotną interakcję między relacjami „ciało–ja” a współczuciem wobec samego siebie. Analizy prostych nachyleń (simple-slope analyses) wykazały, że siła związku między relacjami „ciało–ja” a HRQOL różniła się w zależności od poziomu współczucia wobec samego siebie, co potwierdza buforujący wpływ tego ostatniego.

Wyniki dotyczące wieku były mniej spójne. Ani grupa wiekowa, ani interakcje Wiek $\times$ MBSRQ oraz Wiek $\times$ Współczucie wobec samego siebie nie okazały się istotne statystycznie w modelu uwzględniającym wiek; wiek nie pełnił również istotnej funkcji mediatora w relacji między relacjami „ciało–ja” a jakością życia związaną ze zdrowiem (HRQOL). Z kolei w modelu uwzględniającym kraj zamieszkania stwierdzono istotną interakcję Wiek $\times$ MBSRQ, co sugeruje, że związek między relacjami „ciało–ja” a HRQOL może zależeć od szerszych uwarunkowań kontekstowych. Kraj zamieszkania okazał się również istotnym predyktorem HRQOL. Uczestnicy mieszkający w Europie deklarowali znacznie wyższy poziom HRQOL w porównaniu z osobami mieszkającymi w Iranie. Różnicę tę należy jednak interpretować raczej jako zaobserwowaną odrębność między badanymi populacjami niż jako dowód na bezpośredni związek przyczynowo-skutkowy z kulturą, ponieważ kraj zamieszkania wiąże się z wieloma czynnikami kulturowymi, społeczno-ekonomicznymi, środowiskowymi, a także tymi dotyczącymi opieki zdrowotnej i instytucji.

Uzyskane wyniki przemawiają za podejściem integrującym, zgodnie z którym jakość życia mężczyzn związana ze zdrowiem wiąże się zarówno z postrzeganiem i oceną własnego ciała, jak i z psychologicznymi reakcjami na obawy dotyczące ciała. Szczególne znaczenie ma tu współczucie wobec samego siebie, które pełni funkcję zarówno potencjalnego mechanizmu wyjaśniającego, jak i czynnika moderującego w relacji między relacjami „ciało–ja” a jakością życia związaną ze zdrowiem (HRQOL).

Niniejsze badanie wnosi wkład do literatury przedmiotu poprzez jednoczesną analizę obrazu ciała, współczucia wobec samego siebie, jakości życia, wieku oraz kontekstu kulturowego w grupie irańskich mężczyzn na różnych etapach dorosłości i w różnych warunkach zamieszkania. Wyniki te podkreślają potencjalną wartość interwencji uwzględniających uwarunkowania kulturowe, które łączą kwestie obrazu ciała z rozwijaniem współczucia wobec samego siebie oraz szerszym dobrostanem psychicznym. Ze względu na przekrojowy i obserwacyjny charakter

niniejszego badania, wyciąganie wniosków dotyczących związków przyczynowo-skutkowych jest nieuzasadnione. Wskazane jest prowadzenie badań podłużnych i eksperymentalnych w celu dalszego wyjaśnienia zależności czasowych i przyczynowych pomiędzy relacjami z własnym ciałem, współczuciem wobec samego siebie a jakością życia związaną ze zdrowiem (HRQOL).

słowa kluczowe: obraz ciała, jakość życia związana ze zdrowiem, współczucie wobec samego siebie, mężczyźni, różnice międzypokoleniowe

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Introduction

Globalisation and the Internet have significantly reshaped everyday life in Iran, reflecting dynamics found in many other societies (Hashemzadegan & Gholami, 2022; Azadi et al., 2022). With more than 82 million Iranians having access to the Internet as of 2022, a 96% penetration rate, modern Iran is becoming more and more at odds with its traditional roots (Hashemzadegan and Gholami 2022). According to surveys, 73% of people utilize social media, with the most widely used platforms being Instagram, Telegram, and WhatsApp (ISPA 2021). Exposure to global trends and content influences how individuals perceive themselves and their relationships with the world around them. This shapes expectations and perceptions regarding the body and health – issues of significance to men that affect their quality of life in both early and later adulthood. While a focus on the individual and their well-being is widely accepted in European culture, the situation is more complex in Muslim countries. In many everyday situations, conservative legal or religious frameworks clash with modern, progressive social changes disseminated (i.e., popularized and promoted, especially among younger generations) via social media. Increasing unemployment or underemployment – combined with limited opportunities for independent living and a prolonged period of residing with parents – typically undermines the sense of autonomy and agency, even though living with parents can provide emotional and financial support (Jafarzadeh, 2019). Thus the Iranian context necessitates a nuanced understanding of its traditional and religious framework.

Traditional Iranian culture, deeply intertwined with Islamic values, often prescribes specific roles and expectations for men, their bodies, and the aging process, which can differ markedly from Western perspectives on individualism. A rigid adherence to these traditions can paradoxically function as a mechanism of exclusion for the elderly. Moreover, older adults face "digital divide" that isolates them from the global digital community – a community that constitutes an increasingly important point of reference for young people (International Telecommunication Union, 2022).

The generational gap between the oldest generation and those entering adulthood and the migration of young people are occurring alongside the global phenomenon of an aging population and the growing need for care for aging generations. Over the past four decades, Iran has undergone substantial demographic transformation. Following a period of elevated fertility rates in the early post-revolutionary years, the country experienced one of the most rapid fertility

declines globally during the 1990s and 2000s (Erfani & McQuillan, 2007). As a result, Iran is transitioning from a predominantly young population to an aging society. Census projections suggest that the proportion of individuals aged 60 years and older is steadily increasing and is anticipated to accelerate in the coming decades (Statistical Center of Iran, 2025; Farzianpour et al., 2004). According to the Statistical Center of Iran, the proportion of individuals aged 60 and over has risen from 7.4% in 2006 to over 10% in 2022, a figure projected to reach 21% by 2050 (Statistical Center of Iran, 2023). Iran has also experienced substantial epidemiological transformations. Non-communicable diseases have replaced infectious diseases as the leading causes of morbidity and mortality, particularly among older adults (Esteghamati et al., 2006). Concurrently, the imperative to enhance Iranian older adults' health-related quality of life (HRQOL) have become salient.

Indigenous cultural traditions are increasingly intersecting with and being reconfigured by pervasive globalising influences (Hashemzadegan & Gholami, 2022). Within this milieu, there is an intensified focus on the body and embodiment, and emergent behaviours such as self-compassion are gaining traction. Satisfaction with body image and positive attitudes toward the body are key indicators of mental health.

Social, cultural, and media pressures regarding beauty and body monitoring have contributed to evaluation and investment in body image (Cash et al., 2004; Frisén & Holmqvist, 2010). Numerous studies demonstrate that body concerns in men, regardless of age, have significant psychological consequences (i.e. also on wellbeing and health related quality of life; Cash et al., 2004; Grogan et al., 2008). Young men spend considerable time and energy altering their physical appearance (Green et al., 2003), while with advancing age, elderly men's focus shifts from appearance to bodily functionality (Sánchez-Cabrero et al., 2019). Contrary to common assumptions, body dissatisfaction remains prevalent among older adults; for instance, studies on community-dwelling older adults show 92.5% of individuals over 65 were dissatisfied with their body image (Farias et al., 2018).

The discrepancy between the actual and ideal self has regulatory value (Raghibi et al., 2013). In men, physical appearance impacts self-esteem and self-evaluation, while in social relationships, body image can mediate and moderate fear of negative evaluation by others (Cash et al., 2004), the pursuit of approval from others (Rosen et al., 1998), and social anxiety

(Mohammadpour et al., 2019); moreover, the perception of attractiveness or unattractiveness is culturally determined (Skandnejad et al., 2014).

Self-compassion plays a crucial role in fostering self-acceptance and managing these body concerns. This construct, as a healthy form of self-acceptance, correlates with reduced self-criticism, depression, and anxiety, and enhanced quality of life and resilience (Neff et al., 2003; MacBeth et al., 2012). In contemporary society, where the body serves as a primary means of identity expression, generational differences significantly shape body attitudes and satisfaction levels (Fardouly et al., 2017).

Because the socio-political environment in Iran imposes constraints on individual freedom and self-determination, potentially influencing how individuals internalize constructs like self-compassion. Therefore, a research design that encompasses both men residing within Iran and those in the diaspora is essential to disentangle the effects of indigenous cultural norms from those of a more liberal, individualistic society. Concurrently, Iran has one of the most significant diaspora populations globally, with over 1.4 million Iranian nationals residing in the European Union, including substantial communities in Germany and Sweden (Statista, 2023). This confluence of factors marks a pivotal moment for investigating how body image, self-compassion, and quality of life are experienced across cultural contexts such as Iran versus liberal European democracies like Sweden and Germany and generations. The study will assess whether the living environment fundamentally shapes the co-variation of the examined variables.

The current study proposes an integrative framework linking three constructs: body perception, self-compassion, and health-related quality of life, in order to elucidate generational differences (younger versus older cohorts) as well as the influence of differing sociocultural contexts (Iranian domestic versus diasporic settings). Given the distinct sociocultural characteristics of Iranian society, the research specifically centres on men, a group that while culturally privileged remains under-represented in scientific literature. This focus therefore offers a novel dimension of scholarly contribution for the present doctoral dissertation.

This doctoral thesis is structured across seven chapters. The first three chapters contain the theoretical basis for the research. They systematise knowledge about key concepts of the body, self-compassion, and quality of life (i.e. health-related quality of life). Each concept is discussed on the basis of current reports from global studies and those conducted on a sample of Iranians.

The complex nature of the interdependence of these three variables is placed in various contexts of life in Iran and in Europe. In addition, their characteristics are developed taking into account the specifics of two periods of male development, youth and old age. Chapter four presents the methodology of the author's own research. It presents the aim of the research and its justification, the research model, problems, questions, and research hypotheses, as well as the operationalization of variables, a description of the research tools, and a discussion of the organization and course of the author's own research. Chapter five presents a statistical verification of the hypotheses. This is followed by a discussion of the results obtained regarding the significance of generational differences and culturally distinct life contexts for the co-variability of body perception, self-compassion, and health-related quality of life. This section also points out the limitations of the author's own research. The last part of the thesis presents the conclusions from the author's own research and practical implications. In addition, the thesis includes a bibliography, a list of tables and figures, and also the Persian version of questionnaires along with the sample consent form of participants.

Chapter 1

Definitions, Determinants, and Significance of Body Image

Across Generations and Cultural Contexts

1.1. Definitions and Conceptualization of Body Image

Body image constitutes a multifaceted and intricate psychological construct, encompassing an individual's self-perception and evaluative attitudes toward their physical self, which manifest in thoughts, emotions, beliefs, and resultant behaviors (Cash et al., 2004; Merino et al., 2024). Paul Schilder (1935) first systematically introduced this concept, defining it not merely as a cognitive representation of the body but as the dynamic interplay of emotional and attitudinal relationships one maintains with it. Building upon this foundational framework, the scope of body image research expanded considerably, leading to the differentiation of numerous interrelated constructs, including body satisfaction, weight satisfaction, appearance evaluation, body esteem, body concern, body surveillance, and body dysmorphic disorder (Thompson, 2003; Rollero et al., 2017). From a theoretical perspective, body image is understood as a tripartite structure comprising interdependent components: perceptual, cognitive-affective, and behavioral (Cash, 2002). The perceptual component pertains to the precision of an individual's estimation of their bodily dimensions and morphology. The cognitive-affective component encompasses the evaluative thoughts and feelings directed toward the body, including judgments of its attractiveness and the resultant satisfaction or dissatisfaction with its appearance. The behavioral component involves the actions enacted in response to body image perceptions, such as body checking, avoidance behaviors, or appearance-modification practices (Cash, 2004).

A pivotal concept in understanding body image dissatisfaction is the perceived discrepancy between one's "actual body image" (the subjective perception of one's physical self) and one's "ideal body image" (the internalized standard of desired appearance) (Grogan, 2021). This gap serves as a significant predictor of negative affective states, maladaptive behaviors, and clinical symptomatology (Cash & Fleming, 2002). The experience of body image is further shaped by the complex interplay of personal experiences, social comparison processes, and prevailing sociocultural ideals concerning beauty and physical attractiveness (Cohen et al., 2019). From a sociocultural perspective on body image, individuals may experience dissatisfaction with their appearance due to constant social comparison - a phenomenon prevalent on social media (Fardouly

et al., 2015) – that imposes a greater burden than comparisons made in the real world (Appel, Gerlach, & Crusius, 2016). Consequently, young men face the repercussions of constant exposure to idealized images of others in the digital realm. Body image also presents a challenge for men in later adulthood, a time when redefining masculinity becomes necessary. As the body loses its natural strength and agility, men must adapt to these changes by focusing on physical capabilities and independence in daily functioning (Błachnio, Śluzek, 2026). This shifts the focus of body appreciation toward functionality, encompassing a wide range of capabilities such as: internal processes (e.g., immunity or susceptibility to infection), physical functioning (e.g., walking, bending), sensory functioning (e.g., smell, sight), creativity (e.g., drawing), self-care (e.g., sleeping, washing, etc.), and others (Alleva & Tylka, 2021).

Although body image dissatisfaction affects individuals of all genders, the particular ideals and concerns related to body image often differ significantly between men and women. Whereas the thin-ideal predominantly characterizes body image concerns, the muscular ideal (McCreary & Sasse, 2000; Pope et al., 2000) underscores the gender-specific nature of body image experiences and necessitates theoretical frameworks sensitive to male experiences. In present research, particular interest focus on male populations and the pursuit of a muscular physique. Consequently, this construct and its associated measures will form the central focus of this doctoral dissertation.

1.2. Body Image in Generation and Culture

The range of concerns, ambivalence, and strengths associated with body image has undergone a significant transformation. Historically, studies related to the body were primarily examined within neurological and clinical contexts, where the human body was examined primarily through the lens of neurological and physical disorders. This limited view offered a one-sided and incomplete understanding of the complexities of the human relationship with their body (Sattin et al., 2023). Later, the study of body image was moved beyond the exclusive domain of neuropathology by foundational scholars like Paul Schilder (1935), and Seymour Fisher (1935, 1958), whose innovative perspectives transcended the knowledge of their time and laid the foundation for modern body image studies.

Paul Schilder, an Austrian neurologist who turned to psychiatry, played a central role in shifting the study of body image beyond the narrow focus of neuropathology (Schilder, 1935; Grogan, 2021). In his seminal 1935 work, "The Image and Appearance of the Human Body,"

Schilder presciently argued for a biopsychosocial approach to body image, emphasizing the need to simultaneously examine its neurological, psychological, and sociocultural elements (Abdoli et al., 2024). This revolutionary perspective opened new doors for scientists, demonstrating that our experience of our body is not merely the product of a neurological system or an anatomical structure but is profoundly influenced by beliefs, emotions, social relationships, and cultural norms. Schilder, with this work, transformed the body from a passive object into an active agent in the process of identity and personality formation.

Following Schilder, another influential figure in this field was Seymour Fisher who, along with his colleague Sidney Cleveland, published two editions of "Body Image and Personality" in 1958 and 1968. Their work reflected the then-pervasive psychodynamic perspectives of the era (Abdoli et al., 2024). By focusing on the construct of "body image boundaries," they explored the relationship between bodily experience and personality. Their unique methodology involved the use of projective methods like the Rorschach Inkblot Test. Based on psychoanalytic theories, these methods assumed that individuals unconsciously project their desires, fears, and personality traits onto ambiguous stimuli like inkblots (Abdoli et al., 2024). By analyzing responses, Fisher and Cleveland attempted to access unconscious understandings of the body, the boundaries between self and the world, and related personality traits. Although projective methods are criticized today for low reliability and validity, they represented a novel approach at the time for uncovering deeper layers of the individual's relationship with their body (Schilder, 1935; Fisher, 1958).

The research both scientists conducted has transformed the understanding of body image – shifting it from a static construct to a dynamic process shaped by individual experiences, social relationships, cultural norms, and even new technologies. This historical progression established the body as a canvas upon which identity, self-esteem, quality of life and mental health are projected and shaped. Body image, extending beyond a simple evaluation of physical appearance, is a psychological construct with significant consequences for the individual whose a negative evaluation of body size, shape, appearance, or weight can lead to a wide range of psychological and behavioral problems (Mills et al., 2022). Body dissatisfaction often stems from the conflict between unattainable beauty ideals promoted by society and the individual's actual image of their body (Aparicio-Martinez et al., 2019). This gap between the "ideal" and the "real" can become a constant source of stress, anxiety, and depression. Research has consistently shown a strong link between body dissatisfaction and mental health problems. For example, a large national study on

Danish adolescents showed that both feeling "too fat" and feeling "too thin" were associated with symptoms of depression (Thorup et al., 2024). Interestingly, this association was even stronger in individuals whose self-perception of their body differed from their actual Body Mass Index (BMI) (Thorup et al., 2024). This finding highlights the importance of subjective perception of the body, beyond objective measures. Other studies have also confirmed the link between body dissatisfaction and anxiety, depression, self-harm, and low self-esteem (Tekola, 2024; Abdoli et al., 2024). Adolescents are particularly vulnerable to these negative consequences due to the rapid physical changes of puberty and increased sensitivity to others' opinions. While these processes are frequently identified during adolescence, comparable mechanisms continue to shape body image concerns among adult men, especially regarding muscularity and physical appearance.

Body dissatisfaction in childhood and adolescence can predict negative health outcomes in adulthood, including risky weight-control behaviors and general psychological distress (Abdoli et al., 2024). Among men, these consequences may manifest specifically through muscularity ideals and body modification behaviours. One of the most dangerous outcomes of body dissatisfaction is the emergence of risky weight-control behaviors. Individuals dissatisfied with their bodies may resort to extreme dieting, self-induced vomiting, or the misuse of laxatives and appetite-suppressing drugs (Tanguay et al., 2025). These behaviors can lead to serious eating disorders like anorexia nervosa or bulimia nervosa, which have severe consequences for physical and psychological health. In men, this dissatisfaction sometimes manifests differently in a condition known as "muscle dysmorphia," a type of body dysmorphic disorder where, despite having a muscular body, the individual sees themselves as small and scrawny and obsessively continues to exercise and use supplements or drugs to increase muscle mass (Ganson et al., 2025). This condition can lead to the use of dangerous drugs called "appearance- and performance-enhancing drugs (APEDs)". These drugs, which are used illegally to achieve an ideal body, have serious and sometimes life-threatening side effects (Kanayama et al., 2001). The use of anabolic-androgenic steroids (AAS) to increase muscle mass (Mallaram et al., 2023), can lead to cardiovascular and liver problems, hormonal disorders, infertility, and psychological issues such as aggression and depression (AlShareef et al., 2023). Interestingly, the use of these drugs is no longer limited to professional athletes (Hoseini & Hoseini, 2024) but has spread to the general male population, many of whom have no intention of pursuing professional sports but simply turn to these substances for a more muscular appearance (Abdoli et al., 2024). General population estimates

indicate prevalence rates ranging from approximately 1% to 5%, and up to 6.4% among men (AlShareef et al., 2023). This phenomenon, indicative of the immense social pressure to achieve a specific type of male body, constitutes a serious public health issue.

Concurrently, the development of research on body perception revealed its dual role: while a positive body image can be a source of psychosocial strength (Matera et al., 2024; Manomenidis et al., 2025), a negative one can lead to the pathologization of an individual functioning. Understanding these consequences helps us recognize the importance of promoting a healthy and positive body image. This requires efforts at individual, family, educational, and societal levels to create a culture where individuals are not valued solely based on their appearance and where a diversity of body shapes and sizes is accepted (Ricciardelli et al., 2015).

The Tripartite Influence Model explains how the social and cultural environment in which an individual grows up influences the perception and evaluation of their own body (Thompson et al., 1999). According to this model, parents, peers, and the media constitute three primary sources of influence on body image and related behaviors, operating through two key mechanisms: the "internalization of appearance ideals" and "appearance comparison" (van den Berg et al., 2002). Internalization refers to the acceptance and belief in the beauty standards promoted by society, turning them into a personal criterion for evaluating one's own body. Appearance comparison is the process by which individuals compare their appearance to others (who are often idealized). These two mechanisms, particularly during the sensitive period of adolescence when the tendency for social comparison increases, can lead to intense body dissatisfaction (Tanguay et al., 2025). Recent research continues to affirm the model's validity (Tanguay et al., 2025; Choukas-Bradley et al., 2022).

Parents, as the first and most important socializing agents, play an important role in shaping their children's body image. This influence can be direct (through comments or jokes about weight and appearance) or indirect (through modeling their own behaviors and attitudes toward their bodies) (Tanguay et al., 2025; Montenido, 2025). Young people learn about their parents' attitudes toward food, exercise, and physical appearance by observation and internalize these attitudes (Montenido, 2025). Studies indicate that appearance pressure from parents often operates indirectly through processes of self-evaluation and the internalization of ideals (Tanguay et al., 2025).

Peers, especially during adolescence, are also a powerful source of appearance pressure. Interactions with friends, discussions about appearance and fashion, and even teasing or exclusion based on looks can have a profound impact on an adolescent's body image. Research shows that pressure from peers is often directly linked to eating behaviors, as peers model dietary norms and reinforce ideals through appearance-related conversations (Tanguay et al., 2025). Appearance-focused activities within peer groups can also increase body dissatisfaction by heightening body awareness, reinforcing the internalization of ideals, and changing personal attitudes toward beauty standards.

However, in today's world, the third, and perhaps most powerful factor, the media, particularly digital social media plays an unprecedented role in shaping body image. By presenting manipulated and idealized images of beauty (thinness for women, muscularity for men see: Abdoli et al., 2024), the media promotes unattainable standards (Tanguay et al., 2025). The unique features of social media its visual nature, quantifiability (e.g., likes), constant availability, and publicness intensify the pressure on appearance (Demaria et al., 2024). Adolescents are constantly capturing and posting images of themselves and seeking social validation through comments and likes (Demaria et al., 2024). This process places them in a state of continuous comparison and self-evaluation based on appearance, which can lead to severe body dissatisfaction. Research indicates that excessive social media use is associated with greater body image concerns, internalization of ideals, and symptoms of depression and anxiety (Demaria et al., 2024). Ultimately, the Tripartite Influence Model demonstrates that body image is not an isolated construct but is deeply rooted in the network of our relationships and in societal messages.

On the one hand, the Internet fosters global homogenization, while on the other – at the level of individual perception – it intensifies messages regarding "desirable standards of attractiveness, popularity, and physical appearance." This phenomenon, which can be termed the "globalization of ideals," is spreading with particular force through social networks, creating new challenges for young men across different cultural contexts (Rodgers et al., 2023). Platforms such as Instagram and TikTok, with their highly visual nature and global reach, rapidly disseminate Western beauty standards across different societies (Öztunç et al., 2025). Through continuous exposure to curated and manipulated images, individuals are increasingly confronted with Westernized appearance standards, including thinness for women and muscularity for men. As a result, many individuals begin to internalize these ideals and evaluate their own bodies in relation

to these global standards (Öztunç et al., 2025; Durante, 2026). This situation, sometimes described as “appearance culture,” encourages constant comparison with others and contributes to the internalization of unattainable body ideals (Demaria et al., 2024).

This environment exerts immense pressure on **men**, particularly younger men, to conform to often unrealistic ideals of attractiveness and physical fitness. The visibility of highly muscular bodies in digital media environments intensifies social comparison and encourages men to assess their own appearance against these idealized images. While much of the existing literature centres on adolescents, comparable mechanisms of appearance comparison and internalisation also affect body image concerns among both young and older adult men. Evidence suggests that exposure to idealised body representations in media and online platforms contributes to the internalisation of muscular appearance standards among older men, thereby increasing the likelihood of social appearance comparison and dissatisfaction with personal body image. Empirical research demonstrates that the internalisation of media-driven body ideals correlates with heightened concerns regarding muscularity and physical attractiveness among men, especially when these ideals intersect with traditional masculine norms that prioritise strength and physical dominance. Furthermore, exposure to “fitspiration” and other appearance-oriented content on social media is associated with reduced body esteem and greater pressure to attain a lean and muscular physique, underscoring the significant influence of media environments on body image perceptions among young adults (Czubaj et al., 2025; Reddy, 2013).

The constant exposure to curated and idealized images of the human body – often digitally altered – foster a culture of constant comparison; although unrealistic, they are by no means devoid of significance, leading to the development of destructive behaviors and psychological distress (Vuong et al., 2021; Merino et al., 2024). The internalization of these appearance ideals, facilitated by social comparison, is a primary mechanism through which socio-cultural factors impact body image. While these pressures are widespread, their expression and the specific ideals themselves are heavily mediated by cultural context. For instance, research has shown that men in Western cultures like the United States and France tend to idealize a significantly more muscular physique than men in East Asian cultures like Taiwan, highlighting the profound role of cultural values in shaping body ideals (Rodgers et al., 2023; Yang et al., 2005).

Understanding body image is incomplete without considering the culture, as a set of shared values, beliefs, and norms, that play a significant role in defining beauty, attractiveness, and bodily

norms (Abdoli et al., 2024). At the same time, culture – especially when comparing the distinct cultural heritages of East and West – involves interesting differences. In Western countries like Europe and North America, the male ideal revolves around physical power and symmetry. The ideal physique is described as a "V-shape body" with broad shoulders and a narrow waist, reinforced by Hollywood and the fitness culture (Chukwuma, 2025). In East Asian cultures like China, Japan, and South Korea, softer and more androgynous appearances are preferred for men. The K-pop and J-pop industries have introduced men with a slim, youthful, and fashion-conscious look as the pinnacle of attractiveness, where smooth skin, neat hair, and delicate features are preferred over excessive muscularity (Chukwuma, 2025). This difference was clearly demonstrated in a study where men in the United States, Austria, and France chose an image of a man with about 10 kg more muscle than their community average as the most attractive option for women, while men in Taiwan chose an image with much less muscle and correctly identified that women are not attracted to very muscular bodies (Abdoli et al., 2024). Beyond Western and East Asian contexts, body ideals are also shaped by religious and cultural traditions in other regions, particularly within Islamic societies. In contrast to Western culture, which emphasizes youth and physical beauty, traditional Islamic culture assigns different meanings to the body and masculinity. In many Arab-Muslim societies, the concept of masculinity is defined by classical patriarchal definitions of the man as the head of the household and the breadwinner (Khelif, 2023). However, these concepts are not static and are influenced by different interpretations, history, and politics. Some patriarchal interpretations of the Quran, formed in specific historical contexts, define the man as having a leadership role in the family, which can lead to a form of masculinity where the man must be the provider and the authority of the family to fulfill himself (Khelif, 2023). However, there are modern and feminist Islamic readings that emphasize the Quranic principle of equality between men and women and seek to offer new models of masculinity. For example, the Prophet Muhammad's marriage to Khadijah, an older, wealthy woman, is sometimes cited in contemporary discussions of Islamic masculinity as an illustration of cooperative and non-hierarchical gender relations (Khelif, 2023). In the Middle East and North Africa (MENA) region, male standards emphasize maturity, strength, and grooming. The beard is highly valued as a symbol of masculinity, religious commitment, and authority (Chukwuma, 2025). A solid muscular build, sharp facial features, and a neat appearance often signify both cultural pride and adherence to Islamic traditions that emphasize personal grooming. This suggests that, within Islamic culture,

the physical body holds significance, although its importance is defined by a specific spiritual and cultural framework (Hirsch, 2011). An important question concerns whether adherence to Islamic traditions which forms the bedrock of Iranian society (Taheri et al., 2023), and presents a distinct perspective on body image, where cultural norms lean heavily toward modesty and functionality can serve among older generations as a protective factor against global pressures to conform to Western body ideals. Islamic culture, which shapes Iranian Islamic identity, views the body as a trust (*amanah*) bestowed by the Divine, rather than as an object intended for public display or aesthetic modification. In this context, masculinity may be more closely tied to qualities such as responsibility and piety rather than solely to muscularity or physical appearance. However, this traditional framework is not static. The rapid influx of global media and the rise of social media have introduced competing discourses, particularly among younger generations, creating a complex negotiation between traditional values and modern, globalized image cultures (Honarbin-Holiday, 2013; Ozer et al., 2021). This cohort may be redefining the concepts of the body and masculinity within a hybrid cultural space. These issues are directly related to the broader discussion of the interaction between tradition and modernity in the context of globalization (Inhorn & Wentzell, 2011). The younger generation in Islamic societies is situated at a complex cultural crossroads; on one hand, they are in contact with religious values and family traditions, and on the other, they are increasingly influenced by global media that promote different ideals. This interaction can lead to tension but, at the same time, to creativity and the formation of new identities (Bayat & Herrera, 2010).

Beyond cultural variation across societies, body image ideals are also shaped by generational differences within the same cultural context. The passage of time, combined with the rapid pace of technological advancement, has led to a distinct generational divide. Older generations often remain the guardians and champions of tradition, while the young - immersed in digital communication - seem to be losing their sense of rootedness. This cultural and generational interplay leads to critical questions for this research. It prompts an inquiry into how strongly the older generation in Iran adheres to traditional views of the body and whether this adherence constitutes a genuine protective factor against body image dissatisfaction. One's life context – specifically, place of residence – also plays a significant role in shaping behavioral patterns and body image. To what extent do traditions internalized during childhood influence an individual living in a vastly different socio-cultural environment? For this reason, the study focused on aging

Iranians living in the European diaspora. Does the culture of origin exert a stronger influence on one's perception of self and the world than the culture in which one currently resides, or is it the other way around? Conversely, it raises the question of the extent to which younger Iranians, both within Iran and in the diaspora, are influenced by the global image culture propagated through social media. These developments prompt critical questions about whether younger Iranian men are reassessing the significance and function of the body and shifting from traditional norms toward more appearance-focused ideals. Among Iranian men, particularly those undergoing migration or acculturation in European contexts, exposure to Westernized body ideals may intensify appearance-related pressures. Acculturative stress and the negotiation of bicultural identity can further complicate body image processes, as individuals attempt to reconcile traditional masculine norms with new sociocultural standards. Empirical evidence suggests that migration and globalization may increase body dissatisfaction among men by intensifying exposure to hegemonic Western muscular ideals (Griffiths et al., 2013). Understanding these dynamics is essential for explaining how body image concerns differ between younger and older Iranian men and how cultural and media influences shape these differences.

1.3. Assessment Tools for Measuring Body Image

Over the past decades, research on body image assessment has produced a large number of psychometric tools, reflecting both the multidimensionality of the construct and the methodological challenges involved in its measurement (Thompson, 2004). Even a selective review of the literature reveals the complexity of the issue of body image and the diverse dimensions in which it can undergo change across various stages of development throughout the lifespan. It also indicates that an analysis of available research – particularly regarding discrepancies in findings – highlights the persistent problem of inconsistent operationalization of measures and a lack of precision in reporting them. Among body image instruments, certain measures have become more dominant due to their psychometric soundness, conceptual clarity, and frequency of use in empirical studies.

1.3.1. Multidimensional Body-Self Relations Questionnaire (MBSRQ)

The Multidimensional Body-Self Relations Questionnaire (MBSRQ), developed by Thomas F. Cash in 1990, is most widely referenced through its psychometric evaluation published in 2000

(Cash, 2000). This instrument operationalizes body image as a multidimensional construct, incorporating evaluative, cognitive, and behavioral components of body-related self-attitudes. In contrast to unidimensional measures, the MBSRQ evaluates self-attitudinal aspects of the physical self across multiple domains.

The original MBSRQ consists of 69 items, rated on a 5-point Likert-type scale ranging from 1 (definitely disagree) to 5 (definitely agree). The instrument yields multiple subscales, including: Appearance Evaluation, Appearance Orientation, Fitness Evaluation, Fitness Orientation, Health Evaluation, Health Orientation, Illness Orientation, Body Areas Satisfaction Scale (BASS), Overweight Preoccupation, Self-Classified Weight. These subscales cluster into broader dimensions reflecting evaluative (e.g., Appearance Evaluation), cognitive-investment (e.g., Appearance Orientation), and behavioral aspects of body image.

Cash (2000) reported strong psychometric properties based on large U.S. samples. Internal consistency coefficients (Cronbach's α) ranged from 0.70 to 0.90 across subscales. Factor analytic procedures supported the multidimensional structure. Test–retest reliability over several weeks was acceptable ($r \approx 0.70$ – 0.90 depending on subscale).

Shemshadi et al. (2020) validated the Persian version of the instrument, confirming its factorial validity in Iranian samples. The study reported satisfactory internal consistency, with Cronbach's alpha coefficients generally above 0.70 across subscales. Construct validity was established through correlations with related constructs, including self-esteem and body dissatisfaction. The findings indicate that the Persian MBSRQ possesses adequate psychometric properties for both research and clinical applications in Iranian populations.

1.3.2. Body Appreciation Scale (BAS)

The Body Appreciation Scale (BAS) was developed by Avalos, Tylka, and Wood-Barcalow (2005) to assess positive body image. Unlike traditional deficit-focused measures, the BAS evaluates acceptance, respect, and favorable opinions toward one's body.

The original BAS contains 13 items, rated on a 5-point Likert scale from 1 (never) to 5 (always). It measures a unidimensional construct reflecting: Body acceptance, Respect for the body, Resistance to unrealistic media ideals, Appreciation of body functionality.

Avalos et al. (2005) reported high internal consistency (Cronbach's $\alpha = 0.94$) and strong construct validity. Confirmatory factor analysis supported a single-factor structure. Positive correlations

with self-esteem and negative correlations with body dissatisfaction provided evidence of convergent and discriminant validity.

Although the Iranian cultural adaptation of the tool is satisfactory in certain respects regarding its psychometric properties (e.g., reliability - Cronbach's alpha coefficients of 13-item and 10-item (excluding items 8, 9, and 12) BAS were 0.898 and 0.924 respectively, see: Atari et al., 2015), it requires revision concerning its factor structure; specifically, it contains items reflecting investment with one's body that, within the Iranian cultural context, do not load onto the body appreciation factor.

1.3.3. Body Esteem Scale for Adolescents and Adults (BESAA)

The Body Esteem Scale for Adolescents and Adults (BESAA) was developed by Mendelson, Mendelson, and White (2001) as a revision of the original Body Esteem Scale (Franzoi & Shields, 1984). The BESAA is intended to assess body esteem in both adolescent and adult populations.

The BESAA comprises 23 items rated on a 5-point Likert scale ranging from 1 (never) to 5 (always). It includes three subscales: Appearance, Weight, and Attribution, the latter reflecting perceptions of how others evaluate an individual's body.

Mendelson et al. (2001) reported satisfactory internal consistency, with Cronbach's alpha coefficients ranging from 0.81 to 0.94 across subscales. Confirmatory factor analyses supported the three-factor structure. Convergent validity was demonstrated through associations with global self-esteem and depressive symptoms.

Sharif-Nia et al. (2024) conducted a psychometric evaluation of the Persian version of the Body Esteem Scale among Iranian adults. In this study, the authors administered the Persian translation to 500 adults in Tehran and examined its construct validity and reliability using factor-analytic methods. Maximum Likelihood exploratory factor analysis with Promax rotation identified a three-factor structure consisting of 21 items, accounting for 43.4% of the total variance. The factor structure was further examined through confirmatory factor analysis, and the final model was supported following necessary modifications. Additionally, Cronbach's alpha, Composite Reliability, and Maximal Reliability coefficients exceeded .70 for all constructs, indicating satisfactory internal consistency and construct reliability. These findings suggest that the Persian version of the Body Esteem Scale possesses a valid factor structure and acceptable reliability for use among Iranian adults (Sharif-Nia et al., 2024).

1.3.4. Drive for Muscularity Scale (DMS)

The Drive for Muscularity Scale (DMS), developed by McCreary and Sasse (2000), measures the desire for increased muscularity, with a primary focus on male populations.

The DMS consists of 15 items rated on a 6-point Likert scale, with anchors ranging from 1 (always) to 6 (never) or similar frequency descriptors, depending on scoring direction. It evaluates two primary components: Muscularity-Oriented Body Image Attitudes and Muscularity-Oriented Behaviors.

McCreary and Sasse (2000) reported strong internal consistency for the DMS (Cronbach's $\alpha \approx 0.84-0.91$). Factor analysis supported a two-factor structure. The DMS demonstrated construct validity through its associations with body dissatisfaction, exercise behaviors, and disordered eating symptoms.

The cultural adaptation of the tool for the Iranian population was successful; exploratory factor analysis revealed a three-factor structure – comprising attitudes toward a muscular physique, muscle-building behaviors, and the use of muscle-enhancing agents – characterized by acceptable internal consistency and convergent validity (Molodi et al., 2012); the Persian version reports a Cronbach's alpha of 0.84 for males and 0.81 for females (Raeisian et al., 2026).

1.3.5. Body Shape Questionnaire (BSQ)

The Body Shape Questionnaire (BSQ), developed by Cooper, Taylor, Cooper, and Fairburn (1987), assesses concerns related to body shape, with a particular focus on fear of fatness. The original BSQ consists of 34 items rated on a 6-point Likert scale ranging from 1 (never) to 6 (always). It measures body shape dissatisfaction, preoccupation with weight and shape, fear of weight gain, and avoidance behaviors.

Cooper et al. (1987) reported high internal consistency (Cronbach's $\alpha = 0.97$) and strong test-retest reliability ($r = 0.88$). Convergent validity was demonstrated through correlations with eating disorder symptomatology and depression.

The cultural adaptation of the questionnaire was conducted on a sample of Iranian students, and the scale demonstrated satisfactory psychometric properties (i.e. Cronbach's alpha, split-half and test-retest reliability were 0.95, 0.93 and 0.82, respectively; see: Sadekhi et al., 2014).

Research on body image among Iranian (especially) youth is relatively augmenting. Recent studies have focused on refining methods for measuring body image-related constructs within the Iranian context. One example is the development and validation of the Iranian Body Image Scale (IBIS) for adolescents; this tool has demonstrated sound psychometric properties and significant associations with weight status. Reliable and culturally adapted measurement tools are essential for accurately assessing body image dimensions across developmental stages and for investigating age-related differences in body perception and body dissatisfaction (Jalali-Farahani et al., 2021b).

1.4. Body Image among Men

The examples of questionnaires frequently used in research cited above illustrate body image as comprising perceptual, cognitive, affective, and behavioral dimensions (Cash & Smolak, 2011). Furthermore, studies indicate that concerns regarding one's appearance (i.e. body dissatisfaction, typically focusing on muscularity, leanness, and physical strength; Pope et al., 2000) are very common among men. A systematic review by Fiske et al. (2014) reported rates ranging from 8% to 61% among men.

The muscular ideal, perpetuated by global media and transnational consumer culture, emphasizes a mesomorphic physique characterized by low body fat and pronounced musculature. Social comparisons (see Festinger, 1954) with celebrities, athletes, and actors often equate the “male ideal” with a muscular and lean physique—an aesthetic standard that is unattainable for many (AlShareef et al., 2023). Empirical evidence has associated this ideal with heightened drive for muscularity, increased body surveillance, and engagement in potentially harmful behaviors, including excessive exercise and anabolic steroid use (Griffiths et al., 2013; Pope et al., 2000). Research has shown that men who read fitness magazines report higher levels of eating disorders and body dissatisfaction than those who do not, and even short-term exposure to idealized male figures can induce body dissatisfaction. Interestingly, adolescent males are often evenly divided between a desire to lose weight, typically among those with higher body fat, and a desire to gain weight and increase muscle mass (Abdoli et al., 2024). As men transition into adulthood, the desire to lose weight tends to increase (Abdoli et al., 2024), however one study found that men experienced greater psychological distress when they perceived their bodies as too thin rather than overweight (Swiatkowski, 2016; Barnes et al., 2020). On average, men tend to aspire toward a

mesomorphic body type, characterized by a high degree of lean muscle mass and a low level of body fat, reflecting the prevailing cultural ideal (Chukwuma, 2025).

Moreover, research suggests that tolerance for a wider range of acceptable body sizes may increase with age. A study by Milton et al. (2021) found that body image distress among young Australians aged 16 to 25 increased significantly by 33% between 2009 and 2015, while levels of distress decreased with advancing age. A linear regression analysis indicated that factors such as gender, age, dieting status, weight perception, psychological distress, alcohol and substance use, and overall well-being explained approximately 24% of the variance in body image distress.

Although research has historically focused on women, a growing body of evidence indicates that body image concerns remain a persistent issue for men (Abdoli et al., 2024) whose negative body image typically fall into two distinct categories: those who wish to gain weight and muscle mass, and those who wish to lose body fat. The behavioral manifestations of body dissatisfaction also differ. Men are more likely to engage in exercise to achieve a lean and muscular physique, whereas women are more likely to engage in dieting behaviors aimed at weight loss (Abdoli et al., 2024). Men, however, may be less likely to disclose body dissatisfaction due to the pervasive stereotype that such concerns are primarily a “female” issue. As a result, many men experience body image distress silently, which may delay help-seeking and increase the risk of developing serious health problems (AlShareef et al., 2023). These findings highlight the importance of examining body image concerns across different stages of adulthood, as the meanings and pressures associated with male appearance may differ between younger and older men.

1.5. Body Image and Quality Of Life

The World Health Organization (WHO) defines quality of life as “an individual’s perception of their position in life within the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns” (The World Health Organization, 1998). Both social and health-related factors significantly influence quality of life, encompassing the multidimensional aspects of human well-being – including physical, psychological, social, and spiritual dimensions (Pedret-Llaberia et al., 2025). Consequently, the relationship observed in empirical studies between body image, dietary behaviors, and the sense of health competence, on the one hand, and perceived quality of life, on the other, is fully justified. Excessive weight loss – or, conversely, obesity – limitations in physical function, and other aspects of how changes in one's

own body are perceived play a significant role in the sense of quality of life (Goodrose-Flores et al., 2022). Other factors, including health issues and societal expectations, often play a role in the dynamics of these interdependencies as well (Rueda & Perez-Garcia, 2006; Śluzek, Szorc, Błachnio; 2026).

Sanftner (2011) identified a significant relationship between perceptions of body image, eating behavior, and quality of life among American participants. The findings suggested that gender plays an important role in the development of psychosocial risk variables, with men generally reporting lower levels of such risks compared to women. Gender was also found to moderate the relationship between quality of life and objective body awareness (Sanftner, 2011).

Body image concerns and eating disorders have consistently been associated with lower levels of psychological and physical quality of life also among men (Da Silva et al., 2018). In a study conducted by Da Silva et al. (2018), perceived health competence and educational variables were found to contribute significantly to individuals' quality of life, while body mass index (BMI), and medication use played important roles in shaping body image perceptions. Among men, quality of life was more closely related to overall body appearance and cognitive aspects of body evaluation. Poorer evaluations of physical appearance were linked to lower quality of life among men (Da Silva et al., 2018). Moreover, individuals with negative body image are more likely to engage in unhealthy behaviors such as dieting, skipping meals, developing eating disorders, avoiding social interactions, and even delaying or avoiding medical care (Levine & Smolak, 2018). Whereas, the eating disorders have been linked to reduced quality of life. For instance, binge eating disorder has been associated with depressive symptoms and has been shown to mediate the relationship between binge eating behaviors and quality of life among male and female students (Singleton et al., 2019).

It has been shown that a positive body image has a beneficial effect on health and quality of life. A positive body image protects against the development of disordered eating patterns, regardless of whether they involve restrictive dieting or episodes of binge eating (Sharif-Nia et al., 2024a). Research indicates that individuals with a positive body image are less susceptible to social pressure and unrealistic beauty standards (Rostampour et al., 2022). Furthermore, Cash and Fleming (2002) indicated that positive body image contributed to several aspects of well-being, including feelings of competence, happiness, perceived control over body weight, social interactions with friends, and acceptance by romantic partners (Cash & Fleming, 2002). The

positive body image is also positively associated with higher self-esteem, greater social support, optimism, and overall quality of life (Tylka & Wood-Barcalow, 2015). Therefore, measuring various dimensions of body image – regardless of whether the assessments are negative or positive – is crucial for explaining differences in individuals' quality of life.

1.6. Body Image and Self-Compassion

A positive body image has been defined as accepting, appreciating, and respecting one's body while attending to the body's needs, protecting oneself from unrealistic body ideals, maintaining broader definitions of beauty, and processing appearance-related information in a body-protective manner (Tylka & Wood-Barcalow, 2015). The individuals with a positive body image are more likely to critically evaluate and reject unrealistic media portrayals of appearance in order to protect their body image (Frisén & Holmqvist, 2010; Wood-Barcalow et al., 2010).

An increasing number of studies point to the analogous functions of self-compassion, which can serve as a protective factor for the individual across various areas of functioning, including body image. Self-compassion has been shown to moderate the media pressure on the internalization of thin ideals (Tylka & Wood-Barcalow, 2015). Higher levels of self-compassion are associated with reduced body image distress and body dissatisfaction, lower levels of rumination, and greater body appreciation (Albertson et al., 2015; Toole & Craighead, 2016). Homan and Tylka (2015) reported that individuals with higher self-compassion were better able to maintain positive body appreciation even when engaging in body-related social comparisons. These findings suggest that cultivating self-compassion may help mitigate the negative consequences of body image concerns and promote a more positive body image.

Self-compassion-based interventions aim to foster attitudes of self-kindness, mindfulness, and a sense of shared human experience when individuals encounter body image concerns. Rather than attempting to directly change individuals' perceptions of their bodies, these approaches focus on transforming the way individuals respond to distress related to body image (Albertson et al., 2015; Toole & Craighead, 2016). For example, self-compassion meditation and reflective writing exercises have been shown to decrease body dissatisfaction and body shame while simultaneously increasing self-compassion and body appreciation (Albertson et al., 2015). A randomized controlled trial conducted by Toole et al. (2021) found that self-compassion and dissonance-based interventions were more effective than a wait-list control condition in reducing body image

distress. Further, self-compassion practices may contribute to improvements in weight management, nutritional choices, eating behaviors, and overall body image (Toole & Craighead, 2016). Thus, self-compassion represents a promising approach for improving psychological well-being and health outcomes among individuals experiencing body image concerns.

1.7. Body Image Among Young and Older Adults in Iran

Body image concerns are prevalent among young adults in Iran (Shoraka et al., 2019) and encompasses both aesthetic (i.e. perceived facial characteristics, body size and shape) and functional (i.e. physical fitness, capacity) dimensions of the self (Jalali-Farahani et al., 2021). Population-based studies indicate that the dissatisfaction with body shape and appearance is strongly associated with societal norms, media portrayals, peer comparisons, and perceived discrepancies between actual and ideal body forms (Malekshahi et al., 2020).

Cross-sectional studies have consistently reported elevated levels of body dissatisfaction among Iranian students and the general population. In a community-based survey involving approximately 1,200 participants ranging from adolescents to adults, a considerable proportion reported body dissatisfaction and engagement in body-change behaviors such as dieting, exercising, substance use, and cosmetic procedures. Furthermore, the internalization of culturally idealized body images and social comparison processes were found to mediate the relationship between sociocultural exposure and body dissatisfaction (Garrusi & Baneshi, 2017). Socio-cultural influences also exert gender-specific pressures. While girls more frequently report a desire for thinness, boys often express concerns related to muscularity and masculinity. These findings indicate that gendered appearance ideals play an important role in shaping body image during adolescence and early adulthood (Garrusi et al., 2013).

Youth who are frequently exposed to idealized body types through television, magazines, and films tend to report higher levels of body dissatisfaction and are more likely to engage in weight-control behaviors compared with peers who have lower levels of media exposure. These findings illustrate the influence of globalized beauty standards and the increasing incorporation of Western aesthetic ideals into Iranian society, despite traditional cultural norms that emphasize modesty and alternative conceptions of appearance (Garrusi et al., 2013). In the Iranian cultural context, emerging evidence suggests that the persistent societal emphasis on youthfulness and physical attractiveness may continue to shape body perceptions even among older individuals.

These influences may be reflected in concerns about changes in appearance, such as weight gain and skin aging, as well as concerns regarding physical ability and vitality (Shoraka et al., 2019).

Although research on body image among Iranian youth is relatively extensive, scholarly investigation of body image among older adults in Iran remains limited. Older individuals experience distinct body image concerns influenced by aging, functional changes, and evolving social expectations. While direct epidemiological data on older Iranian adults are scarce, international literature suggests that with increasing age, aesthetic concerns often become more closely associated with perceptions of physical functioning, health status, and social roles. Age-related changes in body composition and mobility may challenge body ideals formed during earlier stages of life, leading to unique patterns of body dissatisfaction (Jankowski et al., 2014). Comparative analyses within the broader Iranian literature suggest that body image dissatisfaction is not limited to a particular life stage but rather reflects a complex interaction between traditional cultural values and contemporary aesthetic standards. For younger individuals, peer evaluation and media exposure represent major sources of influence, whereas older adults often experience body image concerns more closely linked to health, self-worth, and social identity (Sharif-Nia et al., 2024b; Shoraka et al., 2019). These age-specific experiences highlight the importance of considering both developmental and sociocultural factors when examining how individuals in Iran perceive and evaluate their bodies.

Existing evidence from Iran therefore indicates widespread body image concerns among youth while also revealing emerging and complex patterns among older adults. These findings highlight the importance of examining body image across different stages of adulthood in Iran, as the meanings, pressures, and sociocultural expectations surrounding appearance may vary substantially between younger and older individuals. Future research should therefore systematically compare body image across age groups using validated measurement tools, explore underlying psychosocial mechanisms such as social comparison and internalization of appearance ideals, and examine how age-related changes in physical health and social roles shape body perceptions across the life course.

1.8. Body Image Among Young and Older Adults in Sweden and Germany

Studies on body image in Sweden and Germany demonstrate alignment with broader Western patterns, such as a high prevalence of appearance concerns among youth and gendered ideals,

while also revealing distinct local characteristics, including specific population-level risk behaviors, age-related trends, and unique measurement methodologies (Krause et al., 2023; Burén et al., 2025). Empirical research utilizing large, population-based cohorts, as well as recent clinical and epidemiological studies, demonstrates that body dissatisfaction and distorted body-size perception are prevalent among young adults in both countries. In Europe, equality campaigns have challenged the dominance of the gender binary, creating space for the free self-definition and shaping of one's identity, body, and bodily functions. Research indicates that this sociocultural shift entails certain costs. Comparisons between heterosexual and gay cultures reveal that gay men place greater importance on physical appearance (Morrison et al., 2004) and often experience greater body dissatisfaction than heterosexual men (Harvey & Robinson, 2003), even though their physiques were closer to dominant ideals. Furthermore, the significance and prominence of body-related concerns evolve with age, as functional and psychosocial issues become increasingly important in later life (Krause et al., 2023; Bergström et al., 2000).

An analysis of the Stockholm Public Health Cohort, comprising 30,245 adults aged 30 to 66 in Sweden, found that body-image discrepancy frequently co-occurs with risk behaviours such as disordered eating, smoking, and indoor tanning. Body mass index (BMI) and loss-of-control eating emerged as the strongest explanatory factors for perceived body discrepancy. The study identified only modest gender differences in body-image perception among adults, indicating that appearance concerns in Sweden extend beyond young women (Strand et al., 2021).

Research focusing on younger Swedish males demonstrates that male body ideals, particularly muscularity, significantly influence disordered eating and related behaviors. An anonymous national survey of Swedish males aged 15 to 30 identified notable levels of disordered eating, exercise behaviors, and drive for muscularity. Notably, drive for muscularity was correlated with disordered eating indices, indicating that body concerns among Swedish males often emphasize muscularity rather than thinness (Ghaderi et al., 2022).

Population-cohort data from Germany indicate a high prevalence of body-image disturbances and body-size misperceptions across genders and weight categories. The findings associate body-image dissatisfaction with behavioural and emotional difficulties, such as hyperactivity, conduct problems, and emotional problems. Age, gender, and weight status moderate these associations; older adolescents exhibit greater dissatisfaction, while boys more frequently desire increased size, specifically greater muscularity, compared to girls. This large

longitudinal cohort supports the developmental vulnerability of adolescence to body-image problems and underscores related mental-health correlates relevant for prevention (Krause et al., 2023).

Several consistent findings emerge from Swedish and German studies regarding youth: (1) body-image disturbance is prevalent and multifaceted, encompassing thinness, muscularity, and body-size misperception; (2) socio-cultural influences, including media, peers, and family, are significant, although objective weight status (BMI) remains the primary correlate; and (3) body dissatisfaction frequently co-occurs with other health-risk behaviours and emotional or behavioural problems, indicating a need for integrated prevention strategies within schools and primary care (Strand et al., 2021; Ghaderi et al., 2022; Krause et al., 2023).

Research on body image among older adults is less prevalent in national public health studies. In Western populations, the significance attributed to appearance generally decreases with age, yet dissatisfaction with specific characteristics such as weight, skin aging, and body composition may persist and continue to have psychological effects (Rocha & Terra, 2014). Hannah L. Quittkat et al. noted (2019) that there is little research on the importance of appearance for men. The results showed that this importance varied by age group, reaching its highest level among those aged 75 and older. Furthermore, the evaluative component of body image, defined as satisfaction with one's appearance, may remain relatively stable even as the importance placed on appearance decreases. Comprehensive reviews of the older-adult body image literature support these conclusions and indicate that aging modifies the significance of body concerns rather than eliminating them (Tiggemann, 2003).

Country-level evidence from Sweden and Germany demonstrates that body concerns among older adults frequently intersect with functional health and social roles. While population studies in Sweden, such as the Stockholm cohorts, and in Germany, including broader aging surveys, have not primarily examined late-life body image, related research on adults indicates that behavioral factors such as smoking, disordered eating, and physical activity, as well as overall health status, continue to be significant correlates of perceived body discrepancy in middle and later adulthood (Strand et al., 2021). Therefore, interventions targeting body concerns in older adults are best structured to emphasize physical functioning, healthy aging, and social participation rather than focusing solely on appearance (Rocha & Terra, 2014).

In research comparing body concerns among younger and older men, literature from Sweden and Germany identifies three operational priorities. First, both thinness- and muscularity-oriented concerns should be measured to capture gendered and age-dependent ideals. Second, behavioral and emotional correlates, such as disordered eating indices, activity and exercise patterns, and measures of behavioral or emotional difficulties, should be included, as these factors are consistently associated with body dissatisfaction in national samples. Third, for older cohorts, it is important to emphasize functional health and the psychosocial significance of bodily change as key outcomes, alongside standard appearance measures. Collectively, the Swedish and German evidence base offers a rigorous empirical foundation for age-sensitive and gender-informed investigations of body image across the adult life course (Strand et al., 2021; Ghaderi et al., 2022; Krause et al., 2023).

1.9. Conclusion

This chapter has provided a solid theoretical basis for understanding body image as a complex psychological construct shaped by a person's developmental stage, social environment, and cultural values. Body image is a combination of how people perceive, feel, think, and act about their bodies. These aspects are shaped by personal experiences, social connections, and cultural ideas about appearance and masculinity.

The reviewed literature demonstrated that body image concerns among men constitute a significant yet historically underexplored phenomenon. Male body dissatisfaction is typically organized around muscularity, leanness, and physical strength rather than thinness, and is closely linked to self-esteem, mental health, and behavioral regulation. Importantly, these concerns are not confined to adolescence or early adulthood but persist across the lifespan, although their meaning evolves with age. While younger men are more strongly influenced by appearance-based social comparison and media ideals, older men tend to appraise their bodies increasingly in terms of functionality, health, and social roles.

Sociocultural frameworks emphasize the influence of family, peers, and media in shaping body ideals through processes of internalization and social comparison. Globalization and digital media have increased exposure to standardized Western body ideals, which have contributed to heightened body concerns among men in various cultural contexts. In Iran, these global influences converge with traditional and religious values that prioritize modesty, responsibility, and bodily

functionality. This interaction results in generational differences in body perception, especially between younger men who navigate hybrid cultural identities and older men whose body image is more closely associated with health, dignity, and social status. Among Iranian men residing in European societies, additional processes of acculturation and identity negotiation further complicate body image experiences.

The chapter also underscored the strong association between body image and health-related quality of life. Negative body image is consistently linked to reduced psychological well-being, social withdrawal, and maladaptive health behaviors, whereas positive body image is associated with higher life satisfaction, resilience, and psychosocial functioning. Within this framework, self-compassion emerged as a key psychological resource that mitigates body dissatisfaction, reduces self-criticism, and supports adaptive coping with appearance-related distress. Rather than altering the body itself, self-compassion reshapes individuals' relationships with their bodies and with themselves, making it particularly relevant across both aging and cross-cultural contexts.

This chapter establishes the conceptual rationale for integrating body image, self-compassion, and health-related quality of life within a unified analytical framework. It emphasizes the need to adopt an approach that takes into account gender, the life course, and situational context – specifically, the difference between living in Iran and functioning within the diaspora in Europe – in order to understand men's concerns regarding their bodies.

Chapter 2

Quality of life

2.1. Quality of Life: A Historical Perspective

The concept of quality of life (QoL) has undergone substantial development within the social sciences, particularly in psychology, necessitating a clear understanding of its historical and philosophical foundations. Early conceptualizations can be traced to ancient Greek philosophy, most notably Aristotle's notion of eudaimonia, or human flourishing. Within this framework, well-being is not merely defined by material success, but by the realization of human potential through the cultivation of virtue. Aristotle established a fundamental relationship between quality of life, happiness, and human functioning, emphasizing that a meaningful life requires the integration of psychological, social, and moral dimensions (Akranavičiūtė & Ruževičius, 2007; Ruževičius, 2012).

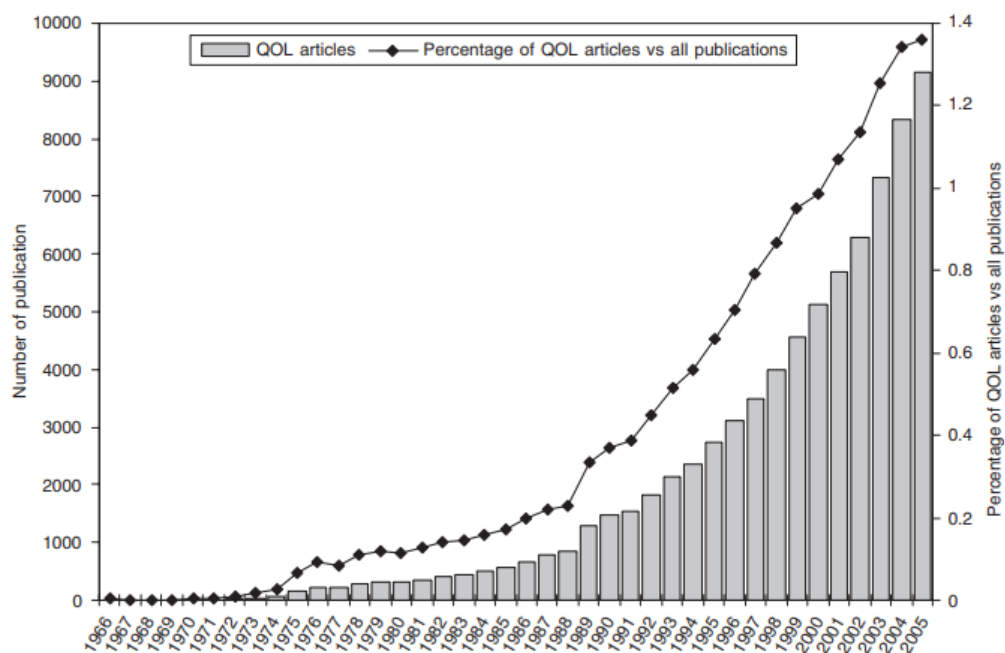
A central aspect of Aristotle's philosophy, which remains relevant to contemporary QoL research, is his differentiation among categories of goods. He distinguished between goods necessary for survival and those that contribute to a meaningful life, arguing that material resources are essential but insufficient for achieving true well-being. Instead, intellectual and moral virtues are central to life satisfaction (Kraut, 2022). This distinction is particularly important in the context of aging, as individuals often shift their priorities over time, placing greater emphasis on functional capacity, social relationships, and psychological meaning rather than purely material outcomes. Moreover, in most of the world's economies, older people are viewed as being in the post-productive stage of life; in today's reality, they grapple not so much with wealth accumulation as with the need to lead a dignified life amidst scarcity (cf. the problem of poverty among elderly women in Poland (Błachnio, 2020), India (Chakrabarty, 2025), and Iran (Tajvar et al., 2008; Parvaei et al., 2023)).

While the philosophical foundations provide an important conceptual basis, the modern scientific understanding of quality of life emerged through developments in public health and social policy. A pivotal milestone occurred in 1948, when the World Health Organization (WHO) defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” This definition incorporated subjective perceptions of well-being.

Building upon this shift, researchers began to develop structured frameworks to operationalize quality of life across multiple domains. By the 1980s, QoL had become recognized as a sensitizing concept in social research, and during the 1990s, more systematic models emerged. Notably, Felce and Perry (1995) proposed a multidimensional framework encompassing physical, material, social, and emotional well-being, alongside personal development. Schalock (2004) further expanded this framework by organizing these domains hierarchically and emphasizing the integration of objective indicators with subjective evaluations. These developments marked a transition from abstract philosophical ideas to empirically measurable constructs.

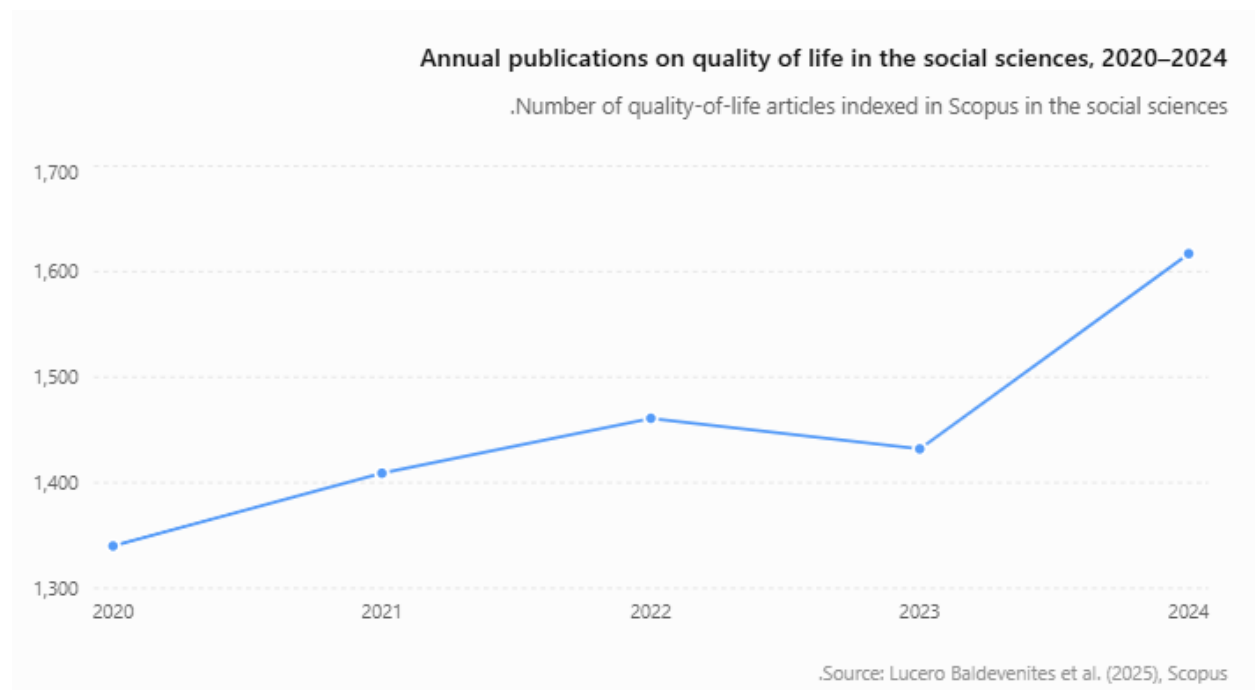
The growing importance of quality of life is also reflected in the expansion of scientific research on the topic. Bibliometric analyses of publications indexed in PubMed demonstrate a sharp increase in QoL-related studies from the mid-20th century onward. For example, the proportion of such articles increased from approximately 0.002% in 1966 to 1.36% by 2005 (Moons et al., 2006), indicating the rapid institutionalization of QoL as a central research construct. This trend is illustrated in Figure 1, which presents the growth in the number and proportion of QoL-related publications over time.

Figure 1. *Number of published works on quality of life and their percentage compared to all articles in the PubMed database from 1966 to 2006*



The scientific literature on quality of life (QoL) has expanded substantially over recent decades. Using the Web of Science Core Collection, Zheng et al. (2021) identified 25,119 articles on health-related quality of life (HRQoL) published between 2000 and 2019, with the annual number of publications increasing from 337 in 2000 to 2,294 in 2019. More recently, a bibliometric analysis of quality-of-life research in the social sciences indexed in Scopus identified 7,259 articles published between 2020 and 2024. Annual publication output increased from 1,340 articles in 2020 to 1,409 in 2021 and 1,461 in 2022, followed by a slight decline to 1,432 in 2023 and a further increase to 1,617 articles in 2024, representing the highest annual output during the study period (Lucero Baldevenites et al., 2025). Taken together, these findings demonstrate the continued expansion and increasing multidisciplinary importance of QoL research, particularly across health, psychology, ageing, and social sciences.

Figure 2. *Annual Publications on quality of life 2020-2024*



Contemporary studies increasingly adopt interdisciplinary approaches, integrating psychology, public health, and gerontology. Within this context, eudaimonic dimensions such as purpose in life, autonomy, and personal growth have been shown to predict long-term well-being across different stages of adulthood (Steptoe et al., 2015). In aging populations, these factors often

act as protective mechanisms that support adaptation to physical, social, and environmental changes.

At the same time, methodological approaches to assessing QoL have become more sophisticated. Recent research emphasizes personalized and context-sensitive assessments, incorporating longitudinal designs and emerging data-driven approaches to capture fluctuations in subjective well-being over time (Diener et al., 2018; Costanza et al., 2007). These developments address earlier limitations of static measurement models by focusing on adaptive functioning and the interaction between individuals and their environments.

Given its multidimensional nature, quality of life has been defined in numerous ways across disciplines. These definitions vary considerably, reflecting differences in theoretical perspectives, research contexts, and methodological approaches (Felce & Perry, 1995; Massam, 2002; Lee, 2005; Sirgy et al., 2006). This diversity highlights both the richness of the construct and the challenge of establishing a universally accepted definition. An overview of selected definitions is presented in Table 1.

Table 1. *Valid Definitions of Quality of Life*

Author / Year	Definition	Scope	Psychological Utility	Utility for Older Adults
Bilgili & Arpacı (2014)	QoL is defined as a combination of physical, psychological, and social factors that influence overall satisfaction and the individual's ability to manage daily life.	Individual	Integrates subjective appraisal with objective indicators of health and functioning.	Enables comprehensive assessment of physical and mental health, including functional independence and life satisfaction.
Baranowski (2018)	Focuses on QoL among older adults with epilepsy, encompassing mental health, daily functioning, and social interactions.	Individual	Addresses psychological aspects of chronic illness and social consequences.	Assesses the impact of chronic disease on satisfaction and social participation in older adults.
Cacciata et al. (2019)	Health-related QoL is influenced by physical activity interventions such as exergaming in older adults.	Individual	Enhances motivation, self-efficacy, and positive emotional states.	Supports physical and cognitive functioning and improves daily life

				experiences for older adults.
Choo et al. (2020)	Tai Chi practice improves QoL, reduces depressive symptoms, and enhances physical function.	Individual	Reduces stress, boosts confidence, and promotes positive affect.	Strengthens social interaction and maintains physical and psychological well-being in aging.
Juanita et al. (2022)	HRQoL in community-dwelling older adults reflects physical, psychological, and social functioning.	Individual	Enhances mental health and perceived self-efficacy.	Provides a framework for comprehensive assessment in diverse social environments.
Levasseur et al. (2010)	QoL is understood as an individual's perception of functioning, social participation, and interpersonal relationships.	Individual	Focuses on subjective experience and sense of social belonging.	Measures social engagement and satisfaction from participation in collective activities among older adults.
Forjaz et al. (2015)	QoL in the context of chronic conditions and disabilities includes physical, psychological, and social dimensions.	Individual	Identifies psychological impacts of disease on personal satisfaction.	Guides targeted interventions and support for older adults with chronic illnesses.
Groessler et al. (2007)	Health-related QoL among older adults at risk for disability	Individual	Emphasizes self-efficacy and independence.	Informs preventive programs and rehabilitation strategies for aging populations.
Heo et al. (2007)	Comparison of QoL between healthy older adults and those with heart failure, focusing on life satisfaction and daily functioning.	Individual	Captures subjective disease experience and its effect on perceived value of life.	Determines limitations and opportunities to improve QoL in older adults with cardiac conditions.
Becker et al. (2018)	QoL is affected by depression, sleep quality, and social interactions.	Individual	Promotes mental health and emotional balance.	Provides evidence for psychological and social interventions to reduce loneliness and enhance life satisfaction in older adults.

Over the past four decades, conceptualizations of QoL have shifted from relatively static and descriptive models toward dynamic, integrative frameworks. Early models emphasized domain-based structures, whereas more recent approaches conceptualize QoL as a process shaped by psychological resilience and sociocultural influences. Contemporary research highlights the role of meaning, relational embeddedness, and adaptive functioning in maintaining well-being, particularly in the context of aging and life transitions (Diener & Tay, 2015). Despite variation in definitions, contemporary scholarship converges on two key principles. First, quality of life is inherently subjective, as individuals are the most reliable judges of their own well-being. Second, QoL is fundamentally multidimensional, encompassing physical, psychological, social, and environmental domains (Hacker, 2015; Sawatzky et al., 2005). These principles are reflected in the range of definitions summarized in Table 2 and illustrate the evolution of QoL from static measurement frameworks to adaptive, person-centered models.

Overall, the concept of quality of life evolves alongside advances in human understanding and reflects the dynamic interaction between individuals, their environments, and their value systems (Diener et al., 2018). These developments are particularly relevant when examining quality of life across the life course. In the context of this dissertation, special attention is given to men, as gender-specific expectations, sociocultural norms, and life-stage transitions may differentially shape how quality of life is experienced and evaluated in younger versus older adulthood. Understanding these differences is essential for developing a comprehensive and context-sensitive analysis of well-being across age groups.

2.1.1. Multidimensional Nature of Quality of Life

In recent decades, there has been a significant shift in the understanding of quality of life - from static biomedical indicators toward dynamic, person-centered constructs. This is especially apparent in gerontological research, where quality of life is increasingly regarded as an adaptive process rather than a fixed state. Among older adults, well-being is now understood to depend less on physical perfection and more on functional ability, autonomy, and social participation, even in the presence of health limitations (Steptoe et al., 2015).

Furthermore, the multidimensional nature of quality of life refers to its structure, which consists of interconnected domains, typically physical, psychological, social, and environmental, that interact dynamically rather than independently. This perspective moves beyond simple

categorization and is supported by several theoretical frameworks that explain how these domains collectively shape well-being.

One of the most influential models is Ryff's Model of Psychological Well-Being, which conceptualizes well-being as a eudaimonic process encompassing six dimensions, including autonomy, environmental mastery, and purpose in life (Ryff, 2014). This model is particularly relevant in aging contexts, as it explains how individuals may maintain high levels of quality of life despite physical decline through strengths in psychological domains.

In addition, Cummins' Theory of Subjective Wellbeing Homeostasis posits that individuals regulate their well-being within a relatively stable range by utilizing psychological and social resources (Cummins, 2005). If one domain is compromised, such as by illness or functional decline, other domains, including psychological resilience or social support, may compensate to restore overall balance.

Similarly, Lawton's Ecological Model of Aging highlights the interaction between individuals and their environments, suggesting that as physical competence decreases, environmental factors become increasingly influential (Lawton, 1982). This model emphasizes that quality of life in older adulthood emerges from the dynamic interaction between personal abilities and contextual conditions.

In addition to its multidimensional structure, quality of life is inherently subjective. As noted by Hacker (2015), individuals are uniquely positioned to evaluate their own quality of life based on personal values, expectations, and experiences. This subjectivity is reflected in contemporary definitions that emphasize perceived well-being rather than solely objective indicators. Moreover, Richard A. Burns and his team (2014) posited that well-being encompasses vitality, a sense of agency, and resilience. Vitality plays a significant role in self-rated health (SRH). This highlights the complex nature of the relationships between the objective health status but also the positive psychological approach of ageing adults.

At the same time, QoL encompasses multiple domains of human experience. These include physical functioning, psychological well-being, social relationships, and, in some models, somatic and spiritual dimensions (Huppert et al., 2005). The physical domain involves energy, mobility, and self-care; the psychological domain includes emotional states such as anxiety and depression; and the social domain reflects interpersonal relationships and social integration. This is significant for the measurement process, which combines the assessment of objective indicators with

subjective evaluations. Over time, measurement strategies have evolved from general, standardized indices to more specific and context-sensitive instruments (Costanza et al., 2007). In aging research, this evolution is reflected in specialized instruments such as the WHOQOL-OLD, which captures dimensions particularly relevant to older adults, including autonomy, social participation, and sensory functioning. Such models demonstrate the importance of culturally sensitive and age-specific assessments, especially in cross-cultural contexts involving migration and changing social environments.

Given the dynamic nature of QoL, assessment tools are often administered repeatedly to enhance measurement validity. In addition to subjective quality-of-life indicators obtained directly from the ageing adults, data are also collected from observers - such as a physician, caregiver, or family member (e.g., W-QLI; cited in Diamond & Becker, 1999). To account for changes occurring throughout the lifespan, further longitudinal approaches and analyses that consider contextual specificities are employed. These models highlight the importance of psychological resilience, social support, and adaptive coping mechanisms in maintaining well-being in later life (Diener et al., 2018).

Multidimensional and dynamic frameworks are especially pertinent for analyzing quality of life among men. Gender-specific roles, cultural expectations, and life-stage transitions can shape the prioritization of well-being domains across younger and older adulthood, particularly in cross-cultural settings such as Iran and Europe.

2.1.2. Structured Evolution of QoL Definitions: Thematic Progression

Definitions of quality of life (QoL) have evolved both chronologically and thematically. Early formulations (1940s–1970s) were primarily objective and health-centric. WHO (1948) frames QoL as complete physical, mental, and social well-being beyond disease absence, influencing aging scales tracking functional autonomy. Campbell and Converse (1972) expand to 12 domains (e.g., health, family, work, standard of living), validating objective indicators like housing and employment as predictors of elder stability in longitudinal studies (Steptoe et al., 2015).

Subsequent models (1980s–1990s) integrated both objective and subjective elements. Transitional models combine quantifiable indicators with subjective evaluations, enabling a multimodal approach to understanding midlife and aging transitions. Felce and Perry (1995) define quality of life as general well-being across physical, material, social, and emotional domains, as well as

engagement in value-congruent activities. These domains interact dynamically, influenced by factors such as age, heredity, and peer relationships, which are central to geropsychological assessments of self-care decline (Schalock, 2004). Farquhar (1995) identifies measures that include social connections, emotional well-being, material adequacy, environmental comfort, and physical functioning. Cohort studies demonstrate that deficits in social relationships are associated with accelerated cognitive decline among older men (Holt-Lunstad et al., 2015). Costanza et al. (2007) assess the fulfillment of needs—including livelihood, security, affection, and creativity—in relation to subjective well-being, with outcomes moderated by cultural context and temperament. These factors are predictive of acculturative stress among migrant elders (Ryff, 2014).

Contemporary approaches (2000s–2025) emphasize subjective, person-centered, and culturally responsive perspectives (Post 2014., Santillo et al., 2025). In the early years of the 21st century (2000–2010), research on QoL focused on individual assessments and capabilities. The emphasis shifted toward subjective judgments and the "disability paradox" - a phenomenon in which objective limitations coexist with a high self-reported quality of life, thanks to processes of cognitive reinterpretation. Kane (2006) argues that no external observer can assess specific dimensions of quality of life; he posits the primacy of the subjective perspective in comparative gerontology, while simultaneously warning against a one-dimensional approach.

This progression reflects broader shifts in geropsychology toward multimodal frameworks, particularly relevant to aging Iranian men in both their homeland and European migrant settings. Early definitions focused on biomedical criteria, mid-period models incorporated social and environmental factors, and recent frameworks prioritize subjective appraisals and capability gaps, resulting in dynamic, acculturation-sensitive models for the thesis population. Thus QoL is conceptualized as cognitive-emotional reactions to achievements amid goals/expectations, driven by health, participation, and environmental barriers; predictors validated in migrant cohorts where social role satisfaction mitigates isolation (Mosazadeh, 2025). Netuveli and Blane (2008) model latent trajectories across physical/mental health, relationships, independence, cognition, and satisfaction, revealing divergent paths for acculturated Iranian men due to body concerns and relational strains (Mosazadeh, 2025). Banister and Bowling (2004) delineate six elder-specific components: social comparisons, optimism, health/function, activities/support, neighborhood

facilities, safety correlating with self-compassion in European-Iranian comparisons (Kuwayama et al., 2024).

This progression from static external metrics to dynamic, subjective multimodality resolves conceptual ambiguity by privileging individual agency within interdependent domains, directly informing HRQoL operationalization for Iranian aging/migrant males. Cross-cultural invariance of models like WHOQOL-OLD and Ryff's eudaimonia underscores self-compassion's role in bridging body concerns to well-being trajectories, enabling robust hypothesis testing across homeland-diaspora divides (Rudnicka et al., 2020).

2.1.3. Introducing the Issue of Quality of Life into Research in Iran

Academic research on quality of life (QoL) in Iran remains relatively new but is expanding rapidly. Although global investigations into QoL began in the 1960s, following initiatives by the U.S. National Institutes of Health, Iranian academic attention to this topic emerged later, with the first dedicated studies published in 1993. This represents a nearly 30-year delay compared to international developments (Ghafari et al., 2012). Since the early 2000s, however, scholarly output in Iran has increased substantially across fields such as medicine, psychology, and social sciences. Most of this literature has concentrated on adapting international standardized instruments, including the SF-36 and WHOQOL-BREF, to the Iranian context and addressing local socio-demographic factors through the efforts of leading national researchers.

Among the leading scholars shaping this domain, Mandana Tajvar has provided seminal insights into the determinants of health-related quality of life among the elderly. In her extensive investigations of older adults aged 65 and above in Tehran, Tajvar addressed the critical question of how socioeconomic factors intersect with physical health. Using the SF-36 instrument on a representative sample of 400 elderly residents, her research identified a robust correlation between economic status and health outcomes. Specifically, she demonstrated that economic deprivation and female gender are the strongest predictors of poor scores in both physical and mental domains, highlighting that for the Iranian elderly, quality of life is heavily contingent upon financial security and social support systems (Tajvar et al., 2008). Complementing this socioeconomic perspective, Saeed Nazari applied Andersen's behavioral model to predict quality of life, focusing on "predisposing" and "enabling" factors. His work on community-dwelling seniors elucidated how structural variables, such as income level and educational background, directly influence the

multidimensional aspects of well-being, thereby advocating for policy interventions that target these fundamental social determinants (Nazari et al., 2021).

A significant portion of Iranian literature has focused on synthesizing disparate findings, particularly through the work of Zahra Cheraghi. As a meta-analyst, Cheraghi aggregated data from studies involving more than 1,300 healthy elderly individuals to evaluate overall quality of life using the WHOQOL-BREF scale. The results indicated a moderate quality of life score, approximately 60 out of 100, and highlighted notable gender disparities. The analysis consistently demonstrated that older Iranian men score higher than women in both physical and psychological domains. This disparity is often attributed to men's historical advantages in education and employment, which provide better access to resources in later life, while older women frequently experience the cumulative disadvantages of lower literacy and economic dependency (Cheraghi et al., 2016).

Beyond the adaptation of Western tools, there have been notable efforts to develop indigenous frameworks that capture the cultural nuances of Iranian society. Ali Dervishpour-Kakhki addressed the limitations of generic scales by developing and validating the Quality of Life Questionnaire for the Elderly (QoL-ELD). This indigenous instrument, comprising 45 items across six factors, was designed to measure constructs specifically relevant to the Iranian cultural context, such as spiritual well-being and family-centered social support, which standard tools like the SF-36 might overlook (Rasafiani et al., 2020). Furthermore, in the realm of lifestyle and behavioral medicine, Mohammad VaezMousavi has extensively examined the relationship between physical activity and mental health in Tehran's elderly. Utilizing the Global Physical Activity Questionnaire (GPAQ), his research highlighted that regular physical activity serves as a vital buffer against the decline of quality of life, particularly for older men residing in dense urban environments where sedentary lifestyles are prevalent (VaezMousavi et al., 2025).

While specific literature dedicated exclusively to "men's quality of life" is less voluminous than general geriatric studies, the available data allows for a distinct profile to emerge. Iranian men generally report higher baseline quality of life compared to women, a finding supported by multiple cross-sectional studies. However, this advantage is not absolute; qualitative and longitudinal analyses suggest that older Iranian men face unique challenges related to "loss of authority" and "body image concerns" post-retirement. The transition out of the workforce, which culturally defines masculinity in Iran, can precipitate a decline in social quality of life unless

mitigated by strong family networks. Moreover, for Iranian men in the diaspora or those facing migration, the loss of these traditional support structures creates a vulnerability that strictly quantitative studies conducted within Iran may fail to fully capture, pointing to a gap where self-compassion and adaptive strategies become crucial (Shishehgar et al., 2015., Mosazadeh, 2025).

Table 2 provides an overview of methodological tools and target populations across the disciplines of medicine, psychology, and gerontology. The table concisely summarizes instruments commonly used to assess quality of life and related psychosocial or health outcomes, the populations to which these measures have been applied, and the extent to which research has addressed male and older-adult populations. As indicated in Table 2, each discipline emphasizes distinct measurement approaches and target populations. Medical research primarily focuses on health-related and clinical quality-of-life assessments among older adults and patients with chronic conditions. In contrast, psychological research incorporates broader psychosocial measures and examines both younger and older populations. Gerontological research increasingly addresses issues such as multimodality, measurement validation, and migration-related disparities among community-dwelling older adults. This comparison is relevant to the present study as it underscores the methodological diversity of quality-of-life research and highlights the need to integrate health-related, psychological, and demographic perspectives when examining quality of life among men across different age groups and cultural contexts.

Table 2. *Methodological Tools, and Target Populations*

Discipline	Key Tools	Populations Studied	Male/Elder Focus
Medicine	SF-36, WHOQOL-BREF	Elders (≥65), chronic patients	Men higher PCS/MCS; economic predictors
Psychology	SWLS, GHQ-28	Urban youth/elders	Men superior psychological QoL
Gerontology	QoL-ELD, LEPAD	Community elders	Multimodality validation; migration gaps

2.2. Quality of Life in Psychology: Core Theses and Theoretical Integration

Psychological approaches to quality of life (QoL) can be understood through three interrelated theoretical propositions. First, QoL reflects the interaction between objective life conditions and individuals’ subjective evaluations of those conditions. Rather than being determined solely by

external circumstances, quality of life emerges from how individuals interpret and respond to their lived experiences, resulting in adaptive outcomes such as well-being or psychological distress (Diener et al., 2018). Second, psychological models distinguish between two complementary dimensions of well-being: hedonic and eudaimonic. The hedonic perspective focuses on pleasure, life satisfaction, and the balance between positive and negative affect, whereas the eudaimonic perspective emphasizes meaning, personal growth, and the realization of human potential. These dimensions are operationalized in influential frameworks such as Ryff's Model of Psychological Well-Being, which includes six components (e.g., autonomy and purpose in life), and Seligman's PERMA model, which highlights positive emotion, engagement, relationships, meaning, and accomplishment (Ryff, 2014). Third, contemporary models conceptualize QoL as a multidimensional and integrative construct that spans biological, psychological, social, and existential domains. Within this perspective, quality of life is not viewed as a static outcome but as a dynamic process shaped by ongoing interactions between individuals and their environments. Existential-personal approaches further emphasize reflective agency, suggesting that individuals actively construct meaning and coherence in their lives, particularly in the face of life transitions and challenges.

These theoretical developments can also be understood historically. Early models, such as Campbell's (1976) needs-based approach, focused primarily on satisfaction with life conditions. Over time, more holistic frameworks emerged, culminating in integrative models such as Strás-Romanowska's (2010) person-oriented perspective, which emphasizes the role of cultural context, subjective meaning, and developmental processes in shaping quality of life. This progression reflects a shift from static and externally defined indicators toward dynamic, culturally embedded, and person-centered understandings of well-being. Further, the evidence from longitudinal studies (e.g., MIDUS, ELSA) supports the importance of multidimensional and adaptive models of QoL across the life course. In the context of this dissertation, these frameworks are especially important for understanding quality of life among Iranian men, both younger and older, whose experiences are shaped by the interaction of sociocultural expectations, migration-related stressors, and body-related concerns. In such contexts, discrepancies between cultural norms and personal experiences may intensify psychological dissonance, while resources such as self-compassion may serve as protective factors.

2.2.1. A multitude of divergences – objective and subjective approaches; hedonistic and eudaimonistic ones

Campbell et al. (1976) pioneered QoL as satisfaction across 12 life domains (family, health, work, leisure), blending objective assets (income, education) with subjective contentment, classifiable as human needs per Maslowian hierarchies. Tesfazghi et al. (2010) formalize this into a 2x2 matrix, identifying four states from objective-subjective interplay:

Table 3. *Matrix for identifying the states of quality of life*

Objective quality of life	Objective quality of life	
	Good	Bad
Good	Wellbeing	Dissonance
Bad	Adaptation	Deprivation

Quality of life (QoL) is often - though not always justifiably - linked to categories that are close but not identical, namely well-being, standard of living, life satisfaction, and happiness (Massam, 2000). Of these, well-being being one of the main concepts in how psychology approaches QoL is frequently defined as a combination of cognitive and affective evaluations of an individual's life. Diener et al. (2018) identify three primary components of subjective well-being: the presence of positive emotions, the absence of negative emotions, and overall life satisfaction. This framework exemplifies a hedonic approach to well-being, emphasizing pleasure attainment and emotional equilibrium.

In contrast, eudaimonic perspectives emphasize meaning, personal growth, and the realization of human potential. Ryff (1989) conceptualizes well-being as a multidimensional construct grounded in psychological functioning rather than solely in emotional states. Within this framework, well-being is understood as an ongoing process of self-realization and development, rather than merely the experience of happiness. Ryff identifies six core dimensions of psychological well-being: self-acceptance, personal growth, purpose in life, positive relations with others, autonomy, and environmental mastery (Yeary, 2021). This model redirects attention from deficits and pathology to individuals' strengths, capabilities, and developmental potential.

Additional perspectives further expand the understanding of well-being and its relationship to happiness. Lyubomirsky (2007) conceptualizes happiness as the experience of joy, contentment, and positive well-being, combined with the perception that life is meaningful and worthwhile. Within this framework, well-being can be categorized into three forms: hedonic well-being

(focused on pleasure), eudaimonic well-being (focused on meaning), and evaluative well-being (focused on life satisfaction) with 40% genetic, 10% circumstantial, 50% intentional variance (Lyubomirsky, 2007; Lyubomirsky & Layous, 2013; Yeary, 2021).

Seligman (2002) conceptualizes happiness through three dimensions: the pleasant life, characterized by positive emotions; the good life, defined by engagement and the use of personal strengths; and the meaningful life, which involves serving purposes beyond the self. These dimensions subsequently informed broader frameworks, such as the PERMA model, which integrates emotional, cognitive, and social components of well-being. It includes: Positive emotion (pleasant life), Engagement (flow), Relationships (good life), Meaning (service), Accomplishment-reconciling individualism with altruism, empirically linked to self-compassion mitigating body concerns in older European Iranians (Phillips & Ferguson, 2021).

Contemporary theories of well-being are grounded in the philosophical traditions of hedonism and eudaimonism. Hedonic well-being emphasizes emotional experiences and life satisfaction, while eudaimonic well-being centers on meaning, self-realization, and psychological functioning. These perspectives constitute distinct yet complementary dimensions of human well-being and are widely regarded as related but independent constructs (Joseph & Wood, 2012).

2.2.2. Personalistic and Existential QoL in Psychology

Subjective factors such as value systems, life aspirations, goals, and biographical history profoundly shape psychological QoL alongside external conditions. Derbis (2000) emphasizes the subjective nature of quality of life, defining it in terms of experiential yet regulatory psychological processes that transcend objective quality of life. Central to the sense of quality of life is the cognitive-emotional assessment of one's life - formulated independently by each individual - and satisfaction with one's quality of functioning.

Straś-Romanowska's (2010) personal-existential model draws from person-centered psychology and philosophical anthropology (individualism, existentialism, dialogic thought), conceiving humans as irreducible wholes defined by reflective awareness, intentionality, and moral sensitivity. Methodologically eclectic - merging idiographic (case-specific) and nomothetic (general laws) approaches - it yields holistic insights into existence as conscious "being-in-the-world." Core manifestations include worldly self-experience, interpersonal dialogue, purposive

action, and creative becoming, each fostering a subjective QoL attuned to geropsychological maturation where postformal reflection intensifies with age (Straś-Romanowska, 2010).

Worldly experience holistically integrates cognitive faculties, including emotional, intellectual, and symbolic dimensions. Reflective postformal thought generates meanings that benchmark life events against self-world schemas. The individual experiences themselves within the world in a holistic manner—across cognitive and social dimensions, but also the religious one. Encounters imbued with values such as truth, goodness, and beauty energize psychic dynamics, which are crucial for maintaining purpose among aging men as they reinterpret bodily changes (Straś-Romanowska & Frąckowiak, 2017). Dialogic being mitigates existential isolation by fostering unconditional openness to others, nature, culture, and the self. This openness is essential for communal harmony, self-knowledge, and acceptance, and it might buffer relational dissonance among migrant elders (Straś-Romanowska, 2010). Intentional actions adapt in a goal-directed manner to environmental contexts, resulting in satisfaction, control, and esteem. Purpose imbues behaviors with a value-justifying sense, which is pivotal for self-respect during late-life transitions (Straś-Romanowska, 2010). Subjective self-becoming evolves: during childhood and adolescence, the priority is maturation and learning for the sake of adaptation, whereas adulthood emphasizes the reinterpretation of experiences toward existential integration-aligning thoughts, feelings, actions with transcendent values for resilient meaning-making despite adversity (Straś-Romanowska, 2010).

Quality of life is understood as a way of life – encompassing personal experiences, relationships, activities, and development, along with the associated emotions – that defines the manner and quality of a person's existence and the level of satisfaction derived from it. Assessed multidimensionally across biological, psychosocial, subjective, and metaphysical realms, these foster developmental integrity while retaining relative autonomy (Straś-Romanowska & Frąckowiak, 2017). Subjective quality of life encompasses:

- Biological (Psychological) domain: bodily traits, drives, appearance, temperament; manifests physical wellbeing via body acceptance, homeostasis fulfilling needs. Health behaviors optimize senescence; pleasure-pain duality drives mental life;
- Psychosocial domain: relational bonds, environmental expectancies, esteem; engenders security/power through participation. Social roles enhance competence; heterostasis (environmental harmony) underpins adaptation, modulated by pride/failure;

- Subjective domain: individuality, autonomy, authentic choice-responsibility; yields freedom/self-concordance. Self-updating via flow counters existential pressure; autonomy principles govern acceptance;
- Metaphysical (Spiritual) domain: timeless values (goodness, truth, beauty), religious awe; forges moral conscience, fate acceptance. Transcendence via homonomy (moral-spiritual attunement) yields meaning; counters despair/emptiness (Straś-Romanowska, 2010).

Metaphysical integration unifies the person; naturalistic domains (psychological/psychosocial) anchor social reality, spiritual ones (subjective/metaphysical) quest meaning, while cultural spheres (psychosocial/psychological/metaphysical) mold values/behaviors (Straś-Romanowska & Frąckowiak, 2017; Ryff, 2014) - directly informing self-compassion's role in Iranian elders' multimodality.

2.3. Frameworks for Iranian Empirical Research on Quality of Life

Since its emergence in the early 1990s, Iranian study on quality of life (QoL) has expanded considerably, evolving from limited investigations into a multidisciplinary field, albeit with uneven development. Critical analysis of this research reveals a pronounced tendency toward medicalization. Within this framework, quality of life is frequently conceptualized not as an independent psychological or social phenomenon but as a secondary outcome of medical or clinical conditions. Empirical support for this pattern is provided by a comprehensive meta-analysis by Sanagoo and colleagues (2020), which examined the thematic structure of QoL research in Iran. The findings indicate that the term "quality of life" most frequently co-occurs with pathology-related keywords such as smoking, obesity, diabetes, and cardiovascular diseases. This demonstrates a dominant biomedical orientation, wherein QoL is primarily used to assess the impact of illness rather than broader aspects of human functioning.

The disciplinary distribution of the literature further reinforces this trend. Medical and clinical studies constitute approximately 64% of publications, whereas contributions from psychology (16%) and the social sciences (10%) are comparatively limited (Ghafari et al., 2012; Sanagoo et al., 2020). This imbalance indicates that the psychological, cultural, and social dimensions of quality of life remain underexplored in the Iranian context. This limitation has significant implications for the current study. Specifically, the relative scarcity of psychologically oriented research may obscure how quality of life is experienced across different groups, including

men, whose experiences are influenced by sociocultural expectations, life-course transitions, and contextual factors such as migration. Bridging this gap requires a more integrative approach, one that situates the issue of quality of life within broader psychological and sociocultural frameworks, thereby adding significant value to the field of Iranian psychology through this research project.

Current research methodologies, reflecting a biomedical orientation, are predominantly quantitative and rely extensively on standardized, internationally validated instruments. Most studies utilize tools such as the SF-36, WHOQOL-BREF, and EQ-5D-5L to establish population norms and enable comparative analyses. Large-scale cross-sectional surveys, often employing multistage cluster sampling and sample sizes greater than 3,500 participants, have confirmed the psychometric validity (Cronbach's $\alpha > 0.80$) of these Persian-translated measures (Montazeri et al., 2019). While this quantitative focus has produced substantial prevalence data, it reveals a significant gap in qualitative inquiry and the development of indigenous theoretical frameworks. The reliance on generic, disease-focused metrics frequently fails to capture nuanced, culturally specific stressors affecting aging Iranian men, such as body image concerns and the psychological impact of migration. Addressing these complexities requires more advanced, mixed-methods research designs to achieve a comprehensive understanding (Tajvar et al., 2008; Cheraghi et al., 2016). Consequently, despite the considerable volume of research, with over 1,000 studies published by 2021, the field should progress beyond describing clinical correlations to elucidating the complex, multimodal determinants of well-being in the aging population.

Iranian researchers deploy generic HRQoL tools, validating Persian versions through forward-backward translation, EFA/CFA, and hypothesis testing against correlates like depression (GHQ-28) or function (ADL scales). Tajvar et al. (2008) exemplify early rigor in a Tehran elder cohort ($n=400$, ≥ 65 years), using SF-36 to unmask economic status and female gender as physical/mental score predictors (PCS: $\beta=-0.25$, $p<0.01$); multistage sampling ensured urban-rural representation, with ANOVA revealing age gradients ($F=12.4$, $p<0.001$). Meta-analyses of SF-36 questionnaire results (15 studies) indicate mean values for specific domains (physical functioning: 47.58; vitality: 51.31) that decline with age ($r=-0.32$) and among nursing home residents ($\Delta=12.5$ points), while also showing more favorable results among men living in urban areas (Montazeri et al., 2019). Aging adults score lowest physical and environmental domains (Nazari et al., 2021, Andersen model: enabling factors explain 28% variance via SF-36); women evince poorer psychological QoL (effect size $d=0.62$), linked to socioeconomic mediators (Poursadeqiyani et al.,

2021). Meanwhile, Cheraghi et al. (2016) pooled the results of seven studies using the WHOQOL-BREF studies ($n=1,366$ healthy older adults), obtaining a mean overall quality of life (QoL) score of 60.1 ± 4.6 out of 100 (lowest score in the physical domain: 55.13; 95% CI: 51.03–59.22); random-effects modeling ($I^2=78\%$) confirmed higher scores for men compared to women (physical domain: 62.6 vs. 49.7), indicating a need for interventions regarding the living environment ($\tau^2=45.2$). Norms were also developed for the EQ-5D-5L instrument. A multi-stage study conducted in 2025 ($n=3,518$ adults from nine provinces) showed that 78% of respondents reported no problems with mobility or self-care, while 45% experienced moderate pain or anxiety; stratified norms (by age and gender) allow for utility mapping (EQ-VAS: mean=75.2; SD=18.4) with a minimized ceiling effect compared to the EQ-5D-3L version (discriminative ability: OR=1.45).

Quantitative hegemony yields to mixed-methods for contextual nuance, per explanatory sequential paradigms (Creswell & Plano Clark, 2017). A study in Tehran, Iran ($n=500$ quantitative via SF-36; $n=40$ qualitative) integrated cluster-random sampling with purposive saturation interviews, unveiling themes like "relational harmony" and "economic autonomy" explaining 35% PCS variance; content analysis (MAXQDA) triangulated divergences (e.g., high subjective adaptation despite low objective scores) (Seyed-Nematollah-Roshan et al., 2020). Similarly, the validation of the Persian version of the QUALID scale for elderly people with dementia confirmed its robustness. The study utilized factor analysis, revealing a three-factor structure (comfort, unhappiness, and social interaction) that explained 58.4% of the variance. The instrument demonstrated excellent internal consistency (Cronbach's $\alpha = 0.90$) and stability (ICC = 0.94), establishing it as a valid tool for assessing quality of life in Iranian clinical settings (Heravi-Karimooi et al., 2018). These designs resolve "disability paradoxes": elders report moderate QoL (60/100) despite comorbidities, attributing via thematic resilience (family support, faith) (Farajzadeh et al., 2017).

Cultural adaptation also facilitates the development of local research instruments. For instance, Dervishpour-Kakhki et al. (2012) developed the QoL-ELD questionnaire (reduced from 105 to 45 items across 6 domains; $\alpha = 0.83\text{--}0.96$), validating it via exploratory factor analysis (EFA) against the SF-36 scale ($r = 0.71$). They accounted for the multidimensional nature of functioning in older adults (including autonomy and spirituality). Their pilot study, involving 210 seniors from Tehran (TUMS affiliation), confirmed the structural invariance of the tool. Meanwhile, Vaez Mousavi et al. (2025) examined correlations between physical activity (measured

using the GPAQ questionnaire) and scores on the WHOQOL-BREF and GHQ-28 scales among individuals over the age of 60 (sample size unspecified), demonstrating that physical activity mitigates the effects of declining mental well-being ($\beta = 0.28$; $p < 0.01$).

Meta-analyses concerning older adults (e.g. an analysis of the SF-36 scale in various health contexts, see: Poursadeqiyan, 2021) highlight the significant role of relational factors as protective mechanisms; this is a crucial finding for the study and interpretation of quality-of-life determinants among Iranians emigrating to Europe. Research indicates that these individuals are prone to dissonance in the absence of self-compassion (Mosazadeh, 2025).

This review of Iranian research on quality of life clearly demonstrates the dominance of the medical perspective. There is a lack of measurement tools that would enable research within the Iranian population to align with the approach advocated by, among others, Hacker (2015) – an approach emphasizing the subjective dimension, wherein individuals are best positioned to assess their own quality of life. This situation highlights the utility of the model developed in this doctoral dissertation, which integrates – inter alia – health-related quality of life with self-compassion.

2.4. Review of Quality of Life Questionnaires

The global phenomenon of population aging has spurred increased research into quality of life and health-related quality of life. In the social and medical sciences, this has led to the development of a wide range of questionnaire-based tools. Systematizing knowledge about these widely used research instruments facilitates a better understanding of the known determinants of quality of life within the context of gerontopsychology. An analysis of these tools not only confirms the view of quality of life as a multidimensional construct (i.e. encompassing social, environmental, psychological, and spiritual domains) but also highlights factors stemming from various aspects of health and illness that influence an individual's functioning.

The World Health Organization commissioned a group of experts to develop a questionnaire to ensure research consistency and enable the measurement of quality of life. The result of this group's work was a 100-question quality of life questionnaire (WHOQOL-100). A few years later, in 1996, a short form of this questionnaire was prepared for easier use. The WHOQOL-BREF is a 26-question questionnaire that measures a person's overall quality of life. It consists of four subscales covering physical health, mental health, social relationships, and environmental conditions; this allows for the assessment of quality of life in these specific areas

while simultaneously enabling their aggregation into an overall quality-of-life index. The tool has undergone cultural adaptation in over 15 countries while maintaining consistency across different language versions. The individual questions were formulated based on statements from healthy individuals, healthcare professionals, and patients at various stages of disease progression, which contributes to the validity of the measurement. The Persian version demonstrated satisfactory internal consistency (Cronbach's $\alpha > 0.80$) and discriminant validity, enabling the differentiation of healthy populations from those with health issues (WHOQOL, 1996; Nejat, 2006).

The World Health Organization Quality of Life-OLD (WHOQOL-OLD) module is a specialized tool designed to assess subjective quality of life (QoL) in older adults. It was developed under the auspices of WHO as an extension of the broader WHOQOL family of instruments (Winkler et al., 2006). The WHOQOL-OLD instrument was created by an international network of research centers with the participation of focus groups comprising older adults, caregivers, and professionals from around the world; this collaborative approach enabled the identification of key aspects of life that are particularly significant in old age (Power, Quinn, and Schmidt, 2005). WHOQOL-OLD consists of 24 items grouped into six distinct domains: sensory abilities, autonomy, past, present and future activities, social participation, death and dying, and intimacy. These domains were identified through an iterative, qualitative item-generation process and quantitative psychometric analyses conducted on large international samples during field trials. The module is designed to be used in conjunction with the WHOQOL-100 or its shorter version – the WHOQOL-BREF – thereby placing the assessment of aging-specific QoL within the broader context of a general quality of life evaluation (Power, Quinn & Schmidt, 2005). Psychometric studies conducted across various language versions and cultural contexts have provided evidence for the reliability and validity of the WHOQOL-OLD questionnaire (Kim et al., 2021; Liu et al., 2013; Eser et al., 2010).

Among the most ubiquitous instruments in clinical and social epidemiology is the Short Form-36 (SF-36), widely regarded as the "gold standard" for assessing generic health-related quality of life. It was developed in the early 1980s as part of the Medical Outcomes Study (MOS), a large U.S. initiative sponsored by the Rand Corporation and the U.S. The Department of Veterans Affairs. The SF-36 emerged as a concise alternative to much longer health status questionnaires, retaining broad coverage of key health domains while dramatically reducing respondent burden (Ware & Sherbourne, 1992). It comprises 36 items that tap eight multidimensional health concepts

relevant to both physical and mental health. These domains are: physical functioning, role limitations due to physical health problems, bodily pain, general health perceptions, vitality (energy / fatigue), social functioning, role limitations due to emotional problems, and mental health. In addition, a single unscored item captures perceived change in health over the past year. The eight scales can be further aggregated into two summary measures, the Physical Component Summary (PCS) and Mental Component Summary (MCS), facilitating interpretation and comparison across studies. Its relevance to gerontopsychology lies in its ability to distinguish between the inevitable physical decline associated with aging and the potential preservation of mental well-being, a phenomenon often described as the "disability paradox." The measurement properties of the SF-36 have been thoroughly evaluated in diverse settings and populations (McHorney et al., 1994; Bech et al., 2003; Garratt, Stavem, 2017). The SF-36 demonstrates high reliability, with Cronbach's alpha coefficients consistently exceeding 0.85 in international studies. In the Iranian context, Montazeri and colleagues (2005) validated the Persian version, confirming its convergent validity and reporting reliability coefficients ranging from 0.77 to 0.90 across subscales (Montazeri et al., 2005; Ware & Sherbourne, 1992).

The CASP-19 (Control, Autonomy, Self-Realisation and Pleasure) is a theoretically grounded instrument developed specifically to measure quality of life in early old age. Unlike many measures that use health limitations or functional disability as proxies for well-being, CASP-19 is based on a needs-satisfaction model influenced by sociological and philosophical perspectives. It was initially derived from work in the Boyd-Orr cohort and then refined through empirical piloting with older adults, focus groups, and cognitive interviews to ensure content relevance for individuals aged approximately 65-75 years (Hyde et al., 2003). The CASP-19 questionnaire consists of 19 items divided into four broad life domains: control (the ability to influence one's environment), autonomy (self-determination without unwanted interference), self-realization (achieving personal goals and fulfillment), and pleasure (experiences that contribute to enjoyment and well-being). CASP-19's theoretical emphasis on positive and capability-related aspects of aging enables to capture both hedonic (enjoyment) and eudaimonic (meaningful engagement) parts of later life quality, giving a more comprehensive conceptualization than health-focused measures alone. CASP-19 demonstrated satisfactory psychometric properties, comparable to other scales such as the Satisfaction with Life Scale (Hyde et al., 2003); including in other cultural adaptations (Černovas et al., 2018). The Persian language versions of CASP-19 have high

internal consistency (Cronbach's $\alpha > 0.80$), strong test-retest reliability, and construct validity, indicating its suitability for research and clinical contexts (Heravi-Karimooi et al., 2018).

The EuroQol Group developed the EQ-5D, a standardized, preference-based instrument for assessing health-related quality of life. It was developed in the late 1980s as a simple, generic measurement tool for use in clinical trials, population health surveys, and economic analysis (particularly in the fields of health technology assessment (HTA) and cost-utility analysis; Brooks et al., 2003; Brooks, 1996). Since then, the EQ-5D has become one of the most widely used HRQoL assessment tools in the world. The EQ-5D is an easy-to-use, cross-culturally comparable health assessment tool that yields the health utility values necessary to calculate quality-adjusted life years (QALYs). Its design is based on a selective approach that focuses on key aspects of health (relevant regardless of disease, treatment, or population) while minimizing respondent burden (Devlin, 2017). The descriptive system of the EQ-5D consists of five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each dimension captures a fundamental aspect of daily functioning and well-being. Two principal versions of the instrument are in use: the original EQ-5D-3L, which includes three levels of severity per dimension, and the later EQ-5D-5L, which expands the response options to five levels to improve sensitivity and reduce ceiling effects (Herdman et al., 2011). Together, these characteristics shape a health status that can easily be converted into a single, composite index using country-specific value sets based on population preferences. The EQ-5D instrument demonstrates validity and reliability across various health states and cultural contexts. Studies have shown its ability to detect clinically significant changes in health status. The EQ-5D-5L version offers even greater measurement precision, particularly for individuals with milder health conditions (Herdman et al., 2011; Janssen et al., 2013).

The Comprehensive Quality of Life Scale (ComQol) includes both objective and subjective measures of quality of life (Marriage & Cummins, 2004). The ComQol domains were initially identified based on a review of the relevant literature. Seven general domains were identified during the development of the tool; however, work on it was abandoned in 2001 because satisfactory psychometric properties could not be achieved. Another drawback was the multiplication of values assigned to a given domain, which constituted an artifact (see Trauer & Mackinnon, 2001). Consequently, the use of the ComQol tool was discontinued. The foundations of ComQol provided the framework for another tool: the Personal Well-Being Index (PWI). This

scale retained only the satisfaction-related questions and six of the seven original domains. The original ComQol domain – “How satisfied are you with your happiness?”, was replaced by the question: “How satisfied are you with your future security?”. The “happiness” domain was removed to adhere to the PWI construction principle stating that every domain should be amenable to both objective and subjective measurement. The name of the new domain title was proposed on the spot during the inaugural meeting of the Australian Unity Steering Committee (International Wellbeing Group, 2013). The PWI consists of seven items, each relating to a quality of life domain – namely: standard of living, health, life success, relationships, safety, connectedness to community and future security. These seven domains are theoretically intertwined because they represent the first-level deconstruction of the universal question: “How satisfied are you with your life as a whole?” For convergent validity, a correlation of 0.78 with the Life Satisfaction Scale (Diener et al., 1985) has been reported. The psychometric properties of the scale are good (Lau & Cummins, 2005). Cronbach’s alpha coefficients ranged from 0.70 to 0.85, both in Australia and abroad (McIntyre et al., 2020).

The Satisfaction with Life Scale (SWLS) was developed in the mid-1980s to measure subjective well-being (SWB) – encompassing both affective components (positive and negative affect) and cognitive components – by assessing life as a whole (Diener et al., 1985). Unlike other life satisfaction scales that ask about well-being during daily activities or periods of sustained “good mood” (De Boer, 2014; Kusier & Folker, 2021), the SWLS does not impose specific criteria, allowing the individual to make their own holistic and reflective assessment of what constitutes a successful life. The scale is appropriate for use with adults as well as children aged 12 and up, as research has shown that the items are at a Year-7 to Year-11 reading level (Alfonso et al., 1996), and frequently used in research (Bendayan et al., 2013; Kaczmarek et al., 2015; Lepp, 2017). The SWLS scale has demonstrated robust psychometric properties across diverse research groups. The original validation research found satisfactory internal consistency (Cronbach’s $\alpha = 0.87$) and good test-retest reliability (Diener et al., 1985). Subsequent studies, conducted on both general and clinical samples, consistently confirmed these results (Pavot & Diener, 2008). As the SWLS provides a clear tool for measuring the overall cognitive assessment of life satisfaction, clinicians can use it as an indicator of the effectiveness of therapeutic interventions leading to significant improvement, rather than relying on the measurement of more volatile emotional states (Kuiser & Folker, 2021).

The Older People's Quality of Life Questionnaire (OPQOL-35) is a multidimensional tool developed in the United Kingdom by A. Bowling and published in 2009; it was created based on extensive qualitative research involving older adults to ensure the questionnaire reflected the areas they deemed important to their quality of life (Bowling, 2009). The OPQOL-35 comprises 35 items covering eight domains: general life satisfaction, health, social relationships, independence and control, home and neighbourhood, psychological well-being, financial circumstances, and cultural and leisure activities (Bowling, 2009). Psychometric evaluation has confirmed the tool's reliability and validity, including high internal consistency for the scale as a whole and acceptable construct validity, demonstrated by correlations with established quality-of-life measures such as CASP-19 and WHOQOL-OLD (Bowling, 2009; Bowling & Stenner, 2011). Consequently, the OPQOL-35 is recognized as a robust tool for measuring the quality of life of older adults, suitable for use in both scientific research and the practical assessment of functioning in later life.

2.5. Gender Differences in Quality of Life – Focus on Men

Although increasing life expectancy was the primary public health challenge in the 20th century, the focus in the 21st century has shifted to enhancing quality of life (WHO, 2020). Determining the factors that influence quality of life (QoL) in older adults is crucial for improving their overall well-being. The social construct of masculinity – encompassing traits such as autonomy, emotional restraint, dominance, and productivity – shapes men's health behaviors and health-related decision-making processes (Courtenay, 2000). Empirical evidence indicates that men are more likely to engage in high-risk behaviors, delay seeking medical consultations, and underutilize preventive health services, thereby increasing their susceptibility to chronic disease and the risk of premature death (Galdas et al., 2005). These behavioral patterns negatively impact not only objective health indicators (as regular screenings, physical activity, a balanced diet, and the avoidance of substance abuse are crucial for promoting longevity, maintaining functional independence, and fostering a sense of self-efficacy; Mokhelepa & Sumbane, 2025) but also subjective well-being, occupational stability, and interpersonal functioning.

Physical health serves as a primary determinant of men's quality of life across the lifespan. Chronic conditions such as cardiovascular disease, metabolic syndrome, and certain cancers disproportionately elevate morbidity and mortality rates among men worldwide. The consequences of these conditions extend beyond physiological impairment to encompass

functional limitations, financial burdens, and psychosocial distress. Additionally, men's perceptions of illness are often associated with perceived threats to masculinity, particularly when illness restricts autonomy or the capacity to fulfill breadwinner responsibilities (Moon 2018). Illness-related identity disruption can intensify psychological distress and diminish overall life satisfaction.

The psychological dimension of men's quality of life (QoL) requires comprehensive academic investigation. Despite the high prevalence of mood and anxiety disorders among men, diagnostic and treatment rates remain low, largely due to stigma and restrictive masculine norms that limit emotional expression (Addis & Mahalik, 2003). Men often display externalizing symptoms of psychological distress, including irritability, aggression, and substance use, which may mask underlying depressive symptoms. Global suicide statistics indicate disproportionately high rates among men, highlighting the complex relationship between mental health, social isolation, and reluctance to seek help. Psychological well-being in men is closely linked to perceived competence, fulfillment of social roles, and relational support. Therefore, interventions that normalize emotional vulnerability and encourage adaptive coping strategies are essential for improving overall QoL outcomes (Call & Shafer, 2015).

Social relationships are a critical determinant of men's quality of life. Empirical studies demonstrate that supportive intimate partnerships, friendships, and community connections are associated with improved physical health, psychological resilience, and increased longevity (Umberson & Karas Montez, 2010). However, men frequently report smaller social networks compared to women and often depend primarily on romantic partners for emotional support. Major life transitions, such as divorce, unemployment, retirement, or bereavement, commonly lead to significant reductions in perceived social integration and subjective well-being. Furthermore, intersectional research indicates that socioeconomic disadvantage, racial or ethnic marginalization, and minority sexual orientation status increase stress exposure and limit access to protective resources, thereby intensifying quality of life disparities among subgroups of men (Shin & Park, 2023).

In addition to structural and psychosocial determinants, recent research emphasizes the importance of existential and meaning-centered factors in shaping men's quality of life. Constructs such as purpose in life, identity coherence, spiritual well-being, and perceived contributions to family and society are positively associated with psychological resilience and overall life

satisfaction (Antonovsky, 1987; Ryff & Keyes, 1995). Participation in generative roles, including mentorship, fatherhood, community leadership, or skilled professional practice, enhances a sense of utility and legacy, which contributes to improved subjective well-being during midlife and older adulthood. Conversely, experiences of marginalization, role displacement, or perceived failure to meet internalized standards of masculinity may result in diminished self-esteem and existential distress (Hicks & King, 2009).

2.6. Determinants of Quality of Life Among Iranians Living in Their Home Country and in European Diasporas

Unlike many Western societies where institutional elder care prevails, Iran maintains strong traditions of familial caregiving. Intergenerational co-residence remains relatively common, particularly in non-metropolitan areas. Research indicates that older adults residing in supportive family environments experience higher social-domain quality of life (QoL) scores (Koosha & Lalegani, 2024). However, urbanization and declining fertility rates have gradually reduced household sizes, thereby altering traditional caregiving patterns. The migration of younger generations for employment opportunities increases the risk of loneliness and social isolation among older adults.

The quality of life among Iranian young adults is defined by the tension between rising educational and social aspirations and constrained structural opportunities. The phenomenon of "waithood" – a period in which young men remain in a state of prolonged dependency and delayed autonomy (Salehi-Isfahani, 2010) – has intensified their socio-economic anxiety. Research employing the WHOQOL-BREF instrument in Iranian populations indicates that young adults generally report moderate physical health scores, yet exhibit lower scores in environmental and psychological domains (Nejat et al., 2006). Psychological distress is often associated with academic pressure, uncertainty regarding future opportunities, and sociopolitical instability. Social capital is a significant protective factor. Peer networks, civic engagement, and religious participation are linked to improved subjective well-being (Zandi et al., 2025). In addition, digital media plays a central role in youth socialization, identity formation, and political expression. While digital connectivity expands social horizons, it may also increase social comparison and psychological stress.

Meanwhile, adults aged 60 and older experience quality of life through interconnected dimensions, including physical health, financial security, social integration, and spiritual well-being (Piroozi et al., 2024). Income adequacy constitutes a key determinant of QoL in later life. In Iran, pension systems predominantly support employees in the formal sector, frequently resulting in inadequate coverage for individuals with employment histories in informal sectors or unpaid domestic roles. It leads many older men to continue working in informal or physically demanding jobs beyond retirement age (Koosha, 2025). It also increases financial dependence on adult children, reinforcing intergenerational interdependence but potentially diminishing perceived autonomy (Shamsikhani et al., 2021). Despite improvements in healthcare access resulting from the expansion of primary care services, significant disparities persist between rural and urban regions. Out-of-pocket healthcare expenses continue to impose considerable financial burdens, especially on retirees with limited pension income. Chronic diseases, including cardiovascular conditions, diabetes, hypertension, and musculoskeletal disorders, are highly prevalent among older adults in Iran. These conditions adversely affect mobility, independence, and daily functioning, thereby diminishing both physical and psychological domains of quality of life (Kamal & Basakha, 2022).

Mental health challenges, including depression and anxiety, are prevalent, particularly among widowed individuals and those with chronic illnesses. Religiosity and spirituality function as significant coping mechanisms among older Iranians. Engagement in religious rituals, mosque attendance, and participation in community charity activities foster a sense of purpose and social belonging. In this cultural context, spiritual well-being is strongly associated with overall quality of life (Rahimi et al., 2013).

Comparative analyses reveal age-related differences across quality of life (QoL) domains. Young adults generally demonstrate higher physical health but report lower satisfaction with economic and environmental conditions. Conversely, older adults tend to experience diminished physical functioning while maintaining stable or strong social relationship scores, especially when family networks remain intact (Nejat et al., 2006; Piroozi et al., 2024). These generational patterns are shaped primarily by structural positioning rather than by intrinsic age-related decline. Younger individuals encounter labor market constraints and uncertainty regarding their future, while older adults experience health vulnerabilities and limitations related to pensions. Nevertheless, both groups demonstrate resilience through familial solidarity and the continuity of religious and

cultural traditions (Koosha, 2025). Quality of life (QoL) assessments in Iran should consider prevailing collectivist value orientations. Although individual autonomy is increasingly valued among younger populations, it coexists with persistent commitments to family obligations. As a result, QoL is often evaluated in relational terms, such as marital harmony, children's success, and social reputation, rather than exclusively through personal achievement metrics.

The quality of life of Iranian men must be understood within a comparative framework that considers structural, economic, and sociocultural differences between Iran and European contexts such as Germany and Sweden. Iranian men face substantial structural constraints stemming from prolonged international sanctions, macroeconomic instability, and labor market volatility. According to the Human Development Index (HDI), Iran ranks below Germany and Sweden, reflecting disparities in life expectancy, education, and income levels (United Nations Development Programme [UNDP], 2025). Germany and Sweden consistently rank highly on the Human Development Index (HDI), primarily due to their diversified economies and comprehensive welfare systems. In contrast, societal expectations in Iran position men as primary breadwinners, which increases economic pressure during periods of inflation and elevated youth unemployment (World Bank, 2023). By comparison, men in Germany and Sweden benefit from robust labor protections, unemployment insurance, and extensive social safety nets that are characteristic of social-democratic welfare models (O'Connell, 1991).

Structural economic differences are closely associated with variations in health outcomes and access to care. Although Iran has made significant progress in expanding primary healthcare and reducing mortality, disparities persist in mental health services, preventive care, and health financing (WHO, 2022). In contrast, Germany and Sweden maintain universal healthcare systems with comprehensive coverage and advanced infrastructure, which contribute to higher life expectancy and improved self-reported health among men (OECD, 2023). Furthermore, sociocultural norms in Iran may discourage men from seeking psychological support, thereby increasing the prevalence of untreated mental health conditions. Although this trend is observed globally, it is less pronounced in Northern European contexts due to more open attitudes toward mental health and stronger institutional support systems (Zandi et al., 2025b).

In addition to structural and economic factors, sociocultural norms significantly influence men's quality of life. In Iran, hegemonic masculinity is strongly linked to economic provision, marital stability, and social authority. Failure to meet these expectations can lead to considerable

psychosocial strain, especially during periods of economic instability. Conversely, Sweden's gender-egalitarian policies encourage shared parental responsibilities, work-life balance, and more diverse expressions of masculinity (OECD, 2023). While Germany has traditionally upheld more conservative family policies, recent transitions toward dual-earner and dual-caregiver frameworks have broadened acceptable male roles and alleviated role-related stress (Lomazzi et al., 2018).

Iranian men who migrate to Germany or Sweden frequently encounter structural affordances that materially and procedurally improve their quality of life relative to conditions in Iran. The comprehensive social-protection systems, extensive unemployment and sickness benefits, and near-universal health coverage available in these destination countries reduce economic insecurity and enable timely access to both medical and mental health care. Welfare systems, including the Swedish social democratic model with pension parity, support individuals by subsidizing testosterone replacement therapy (TRT) for andropause and by promoting social participation, environmental mastery, housing quality, and access to nature for older adults. These measures counteract frailty and enhance subjective well-being. The primacy of subjective experience is reinforced by the freedoms of speech and orientation, which contribute to a sense of purpose, while redefined provider roles help resolve psychosocial dissonance (Shishehgar et al., 2015; Ermansons et al., 2023). These structural factors are causally linked to enhanced labour-market integration and better health outcomes among migrants. Empirical reviews and quasi-experimental studies demonstrate that accelerated access to health services and formal labor market participation improve employment trajectories and self-rated health among recently arrived refugees and migrants. These enhancements subsequently lead to increases in both objective and subjective quality of life (QoL) indicators (Hendriks and Burger, 2021).

In addition to material and service-level affordances, migration to Germany or Sweden frequently results in subjective well-being improvements due to enhanced personal safety, civil liberties, and everyday freedoms (Behtoui, 2022). However, these outcomes are moderated by individual pre-migration resources and the specific reception context (Lai et al., 2022). Receptivity at the national level and favorable regional attitudes toward immigrants are associated with higher life satisfaction among migrant populations (Pollenne & Vargas-Silva, 2024). This relationship suggests that the inclusive institutional and social environments present in Sweden and several German regions may contribute to measurable improvements in subjective well-being for Iranian

men. Highly educated and skilled Iranian migrants are more likely to translate human capital into upward mobility and enhanced psychosocial adjustment in Sweden and Germany. In contrast, individuals with interrupted education, traumatic pre-migration experiences, or uncertain legal status encounter persistent barriers to achieving comprehensive improvements in quality of life (Benzel & Uhlenhof, 2022; Ghazinour et al., 2004).

Contextual differences in quality of life result from the interplay among structural conditions, sociocultural norms, and institutional frameworks. Iranians in Germany and Sweden typically report higher well-being in economic, health, and political domains, whereas the experiences of Iranian men living in their homeland are influenced by a unique combination of constraints and cultural resources. Young men frequently encounter restricted personal freedoms within highly regulated social environments, limiting social interaction and opportunities for personal development (Salehi-Isfahani, 2010). Conversely, older men may experience diminished participation in social decision-making and a perceived decline in social relevance during periods of rapid cultural transformation (Koosha, 2025). These distinctions are crucial for understanding the formation and experience of psychological well-being, self-perception, and body-related concerns across different sociocultural contexts.

2.7. Conclusion

The concept of quality of life (QoL) emerges from the interplay between objective conditions and subjective assessments. It is no longer viewed as a uniform, static phenomenon; instead, it is understood in multidimensional, dynamic, and processual terms, defined as the outcome of continuous interactions between individuals and their environment.

The chapter critically examines the current state of quality of life (QoL) research in Iran, identifying a predominant reliance on biomedical and quantitative methodologies. These approaches frequently conceptualize QoL as a secondary outcome of disease, rather than as an independent psychosocial construct. However, existing studies underscore the substantial influence of socioeconomic status, social support, and lifestyle factors. Within the context of aging, quality of life (QoL) is increasingly conceptualized as an adaptive and resilient process. Older adults may sustain high levels of well-being despite physical decline by utilizing psychological and social resources. Theoretical frameworks, including Cummins' homeostasis model and Lawton's ecological model of aging, illustrate how the balance between individual capacities and

environmental demands influences QoL outcomes in later life. These perspectives highlight autonomy, social participation, and meaning-making as critical determinants of well-being among older adults.

The analysis of men's quality of life highlights the significant impact of gender norms, cultural expectations, and life-course transitions. Masculinity-related ideals, including autonomy, productivity, and emotional restraint, influence health behaviors, psychological well-being, and help-seeking tendencies. Although these norms may foster a sense of control and elevated social status, they can also heighten susceptibility to mental health challenges, social isolation, and diminished life satisfaction. In contrast, protective factors such as meaningful social relationships, a sense of purpose, and adaptive coping strategies are essential for improving men's quality of life.

In summary, this chapter establishes that quality of life is a context-dependent and multidimensional construct influenced by the interplay of individual, social, and cultural factors. For this dissertation, the focus on Iranian men, both within Iran and in migration contexts, necessitates an integrative framework that encompasses both objective conditions and subjective experiences. This approach offers a robust theoretical foundation for subsequent empirical analysis and facilitates a nuanced examination of key variables, such as self-compassion, body image, and sociocultural influences, in shaping quality of life throughout the life course.

Chapter 3

Self-Compassion

3.1. Self-Compassion: Definitions and Theoretical Framework

In the past two decades, self-compassion has emerged as a central construct in positive psychology and contemplative science. This concept offers a theoretically grounded and empirically supported framework for understanding adaptive self-regulation in response to personal suffering. While self-compassion is conceptually rooted in Buddhist philosophy, it has been operationalized within Western psychological science to describe a healthy approach to self-relating during experiences of failure, inadequacy, or distress (Neff et al., 2008). Thus, self-compassion may serve as a protective psychological resource that mitigates the negative impact of body-related concerns on health-related quality of life (HRQoL). The existence of sociocultural pressures regarding masculinity, appearance ideals, and aging process, in both Iranian and European contexts, provides a theoretical and empirical rationale for examining self-compassion as a regulatory factor and a component that fosters psychological resilience.

Neff (2003) defines self-compassion as a multifaceted construct consisting of three interrelated components: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Self-kindness entails treating oneself with warmth and understanding during periods of perceived inadequacy, rather than engaging in harsh self-criticism. Common humanity refers to the recognition that suffering, imperfection, and personal limitations are universal aspects of the human condition. Mindfulness involves maintaining a balanced awareness of painful thoughts and emotions without suppressing or exaggerating them. Collectively, these components foster adaptive self-regulation and psychological resilience (Neff, 2003; 2016). Self-compassion is conceptually distinct from self-esteem. While self-esteem often relies on perceived competence and social comparison, self-compassion offers a more stable, non-contingent basis for self-worth (Neff, 2003).

Self-compassion is conceptually positioned within emotion regulation frameworks. Emotion regulation theory posits that individuals vary in their modulation of emotional responses to stressors (Gross, 1998). Self-compassion facilitates adaptive regulation by decreasing maladaptive rumination and self-criticism, while promoting cognitive reappraisal and emotional acceptance (Neff, 2003; Neff, Kirkpatrick, and Rude, 2007). Empirical research has provided

significant evidence regarding the importance of self-compassion for psychological functioning. Higher levels of self-compassion are consistently associated with lower levels of depression, anxiety, and stress (MacBeth & Gumley, 2012), as well as with better psychological well-being, and life satisfaction (Zessin, Dickhäuser, & Garbade, 2015). Furthermore, a meta-analysis by MacBeth and Gumley (2012) identified a strong negative association between self-compassion and psychopathology, highlighting its protective function across diverse populations.

Individual differences in self-compassion can also be understood through developmental frameworks. Attachment theory suggests that secure attachment relationships promote internalized models of warmth and acceptance, which may manifest as self-compassionate self-relating (Mikulincer & Shaver, 2007). In contrast, insecure attachment is associated with increased self-criticism and shame, both of which are strongly linked to body dissatisfaction (Gilbert, 2005). Given the influence of cultural norms on attachment processes and emotional socialization, examining self-compassion across Iranian and European contexts is theoretically significant.

The evolutionary perspective provides additional insight into the mechanisms underlying self-compassion. Gilbert's (2005) social mentality theory distinguishes three affect-regulation systems: the threat system, the drive system, and the soothing system. Body dissatisfaction typically activates the threat system, characterized by shame, social comparison, and self-criticism. In contrast, self-compassion activates the soothing system, which is associated with feelings of safety, affiliation, and parasympathetic regulation.

These mechanisms are of particular importance in the context of body image. Among men, body image concerns frequently involve dissatisfaction with muscularity, body fat, and visible signs of aging. Such concerns are strongly shaped by culturally constructed masculine ideals. Empirical research indicates that self-compassion is negatively associated with body dissatisfaction and disordered eating behaviors (Braun, Park, & Gorin, 2016; Wasyliw, MacKinnon, & MacLellan, 2012). Braun et al. (2016) conducted a meta-analysis demonstrating that self-compassion is inversely related to body image disturbance and positively associated with body appreciation. Similarly, Wasyliw et al. (2012) found that self-compassion buffered the relationship between appearance-based self-worth and body dissatisfaction in men. Contingent self-worth increases vulnerability to psychological distress when individuals fail to meet specific standards (Crocker & Park, 2004). In contrast, self-compassion allows one to acknowledge perceived bodily imperfections without resorting to a wholesale devaluation of the self. This

distinction is particularly significant for men experiencing age-related physical changes, as self-compassion can mitigate the negative effects of failing to live up to ideals of youth or a muscular physique. By reducing self-criticism, normalizing imperfection, and promoting balanced emotional awareness, self-compassion can mitigate psychological distress associated with sociocultural body ideals (Raque et al., 2023; Sarda et al., 2025).

Moreover, the impact of self-compassion extends beyond body image and affects health more broadly. It is associated with health-related quality of life (HRQoL), encompassing physical, psychological, and social functioning. Higher levels of self-compassion are linked to improved health behaviors, lower physiological stress responses, and greater subjective well-being (Terry & Leary, 2011). In populations with chronic illness, self-compassion predicts better psychological adjustment and higher HRQoL (Sirois, Molnar, & Hirsch, 2015).

In this thesis, self-compassion is conceptualized as a central mediating or moderating variable that accounts for individual differences in the impact of body image concerns on health-related quality of life among young and older Iranian men residing in Iran and Europe. This approach contributes to the development of culturally sensitive models of resilience and enhances the understanding of psychological well-being in men across the lifespan.

3.2. Culture and Self-Compassion

Although interest in the concept of self-compassion is steadily growing in Western psychology, its philosophical foundations stem from Buddhist contemplative traditions that emphasize compassion, interconnectedness, and balanced awareness (Neff, 2003). The way an individual experiences and expresses self-compassion is shaped by cultural norms, values, and models of the self (Arimitsu, 2023). Neff, Pisitsungkagarn, and Hsieh (2008) conducted a comparative study across the United States, Thailand, and Taiwan, identifying both universal and culturally specific patterns. While mean levels of self-compassion differed across cultures, it consistently predicted lower depression and higher life satisfaction. These findings suggest that although cultural norms influence its expression, the protective function of self-compassion remains stable.

The construction of the self takes place within culture. Markus and Kitayama (1991) distinguished between independent and interdependent self-construals, with Western societies emphasizing autonomy and personal achievement, and non-Western societies, including Iran, emphasizing relational interdependence and social harmony. Arimitsu (2023) suggests that in

interdependent cultures, socially reinforced self-criticism may serve adaptive functions related to self-improvement and group cohesion. However, the common humanity component of self-compassion aligns closely with collectivistic values, as it emphasizes shared human experience. Thus, cultural context shapes the expression and interpretation of self-compassion rather than diminishing its relevance.

Further, Montero-Marín et al. (2018), using a multitrait-multimethod (MTMM) framework, demonstrated that self-compassion maintains structural validity across diverse populations, including samples from the Middle East and Asia. However, its associations with cultural values show some variation. For instance, self-compassion is positively linked to benevolence and universalism, whereas its relationship with self-enhancement values differs across cultures. Furthermore, in a group of Sri Lankan students, de Zoysa et al. (2022) found gender-based differences in levels of self-compassion, indicating that cultural norms and gender-related socialization influence how it is experienced and reported. Thus, life context appears significant for how self-compassion is experienced, highlighting the value of studying this phenomenon within the Iranian context and among Iranian migrants in Europe (Mosazadeh, 2025). In Iranian culture, norms of masculinity that emphasize strength, stoicism, and emotional restraint can shape men's attitudes toward self-compassion. This issue is particularly significant for men, as culturally conditioned patterns of masculinity may discourage self-compassion and foster self-criticism – especially regarding body image and the aging process.

Gottlieb and Shibusawa (2020) found that higher levels of self-compassion are associated with greater cultural competence. Self-compassion promotes openness, reduces defensiveness, and enhances tolerance for ambiguity – qualities essential for navigating cultural diversity. In the context of this thesis, these findings suggest that Iranian men residing in Europe with higher levels of self-compassion may adapt more effectively to new cultural environments and experience reduced acculturative stress. According to Berry (1997), acculturation involves negotiating between heritage and host cultures, often generating psychological strain. Self-compassion may alleviate this strain by reducing self-judgment and supporting adaptive emotional regulation during identity transitions. These cultural dynamics are further complicated by globalization and transnational media exposure. Empirical research indicates that Western muscular and lean body ideals increasingly influence men's body image in non-Western societies (Mellor et al., 2009). Social comparison processes (Festinger, 1954) can intensify dissatisfaction when individuals

perceive discrepancies between their bodies and culturally idealized standards. Within this context, self-compassion can buffer the negative effects of upward social comparison by reducing over-identification with perceived inadequacies and reframing imperfection as a universal human experience (Neff, 2003).

Importantly, these processes have direct implications for health and well-being. Cultural interpretations of health and masculinity influence how individuals experience and evaluate quality of life. In Iranian culture, health is often embedded in social functioning and moral responsibility, whereas European contexts tend to emphasize individual autonomy and subjective well-being (Soofizad et al., 2022). Through mechanisms such as mindfulness and self-kindness, self-compassion may enhance health-related quality of life by reducing chronic stress responses associated with body dissatisfaction and acculturative pressures (Terry & Leary, 2011). Additionally, through activation of the soothing affect system (Gilbert, 2005), self-compassion may reduce both physiological and psychological burdens associated with persistent self-criticism.

3.3. Self-Compassion from a Lifespan Development Perspective

Self-related processes exhibit substantial changes throughout adulthood. Older adults often demonstrate levels of self-compassion comparable to – or even higher than – those observed in younger adults, a phenomenon attributable to superior emotional regulation and accumulated life experience (Bluth et al., 2016). However, the majority of this evidence originates from Western populations. In cultural contexts where older generations were socialized according to norms prioritizing discipline, modesty, and collective responsibility, early cultural conditioning may perpetuate persistent patterns of self-criticism. Neff (2003) conceptualized self-compassion as an alternative to self-judgment; however, in societies that regard self-criticism as a morally virtuous stance, older adults may exhibit lower baseline levels of self-compassion, even though it remains a trainable quality. Older Iranian men were socialized in environments defined by collectivist values, hierarchical family structures, and strict gender roles. In these settings, masculinity has traditionally been linked to endurance, authority, and emotional restraint (Mirzaei et al., 2025). These norms exert a strong influence on men, regulating emotional expression and self-evaluation. As a result, self-kindness and emotional openness can be suppressed among Iranian aging men, and vulnerability is typically regarded as a weakness. Gilbert's (2005) affect regulation model suggests that chronic activation of the threat system through shame and self-criticism can become

habitual. For older men raised within rigid evaluative frameworks, cultivating self-compassion may necessitate not only acquiring new skills but also fundamentally altering internalized self-relational patterns.

Meanwhile, younger Iranians operate within a global socio-cultural context. Increased exposure to global media and transnational discourses has expanded awareness of mental health, emotional regulation, and self-care (Arimitsu, 2023). It has also introduced individualistic values that prioritize personal growth and psychological well-being. Consequently, younger men in Iran and the diaspora may be more open to mindfulness and self-compassion. At the same time, they are more frequently exposed to idealized body images on social media, which increases their susceptibility to body dissatisfaction (Mellor et al., 2009). Therefore, among young men, the interplay between these two factors may significantly impact their perceived quality of life.

These generational patterns become even more complex when considering migration experiences. Iranian men living in Europe may undergo acculturative processes that influence self-construal and self-evaluation (Rashed et al., 2024). Younger migrants and second-generation individuals are more likely to adopt Western norms of self-expression and therapeutic discourse, potentially leading to higher reported levels of self-compassion. In contrast, older migrants may experience identity dissonance due to tensions between collectivistic values and individualistic expectations. Acculturative stress may intensify self-critical tendencies, particularly when physical aging intersects with shifting body ideals. In this context, self-compassion may function as a moderating variable that reduces the impact of body concerns on health-related quality of life (HRQoL) (Alavi, 2014; Tian et al., 2019).

The assumed generational differences should not be interpreted as evidence of a cultural lack of self-compassion in Iranian society. The concept of *rahma* exists in both Islamic and Persian traditions. In Islamic theology, it emphasizes mercy and care, whereas Sufi traditions promote inner gentleness, humility, and the capacity for forgiveness. The works of Jalāl ad-Dīn Muhammad Rūmī highlight themes of self-acceptance and transformation through suffering. Collectively, these traditions indicate continuity rather than a cultural rupture in the conceptual foundations of self-compassion (Khatoon Esfandiari & Mansourian Sorghgarieh, 2010). However, integrating this construct into the contemporary model of Iranian masculinity may generate tension. Collectivist orientations typically prioritize social harmony and family reputation over individual emotional needs (Markus & Kitayama, 1991). In these contexts, openly showing kindness toward

oneself can be perceived as an act of self-indulgence. Montero-Marin et al. (2018) proved that cultural values influence the relationship between self-compassion, self-enhancement, and social conformity. Consequently, for older Iranian men, this construct may require reframing as a resource that enhances relational responsibility and social functioning, rather than as an expression of egocentrism.

3.4. Environment and Self-Compassion

Place of residence can be considered a key ecological factor that facilitates or constrains the development and expression of self-compassion. Social norms, institutional resources, mental health infrastructures, and broader cultural discourses surrounding masculinity and emotional expression collectively influence the cultivation, practice, or suppression of self-compassion (Palmer et al., 2024; Slimmen et al., 2024).

Self-compassion can be developed and enhanced through intentional training (Neff & Germer, 2013). Arimitsu (2023) notes that environmental supports, such as mindfulness education, psychological literacy, and access to therapy, are critical for its integration. Consequently, the European context offers a valuable framework for strengthening self-compassion. Many European countries – particularly in Western and Northern Europe – feature well-established mental health awareness campaigns, publicly funded psychological services, and institutional support for well-being. Mindfulness-based interventions, including Mindful Self-Compassion (MSC) programs, have been widely adopted in healthcare, educational, and organizational settings (Neff & Germer, 2013). Furthermore, workplace diversity initiatives and intercultural competence training can indirectly foster reflective, non-judgmental attitudes consistent with self-compassion (Gottlieb & Shibusawa, 2020).

In contrast, the Iranian sociocultural context presents a different configuration of facilitators and constraints. Although Iran possesses rich spiritual traditions emphasizing compassion and mercy, contemporary discourse on mental health is influenced by stigma and gendered expectations of emotional restraint. Prevailing masculinity norms valorize endurance, stoicism, and self-sacrifice, which may discourage explicit expressions of self-kindness (Ghorbani et al., 2012; Mirzaei et al., 2025). These constraints are particularly relevant for men, as culturally defined masculine norms may limit the development and expression of self-compassion.

The structural factors are also important. Economic stress and limited mental health resources often make people focus on coping just to get by, rather than reflecting on their emotions (Kim, 2024). Gilbert's (2005) affect regulation model explains that when threat systems are always active, people tend to be more self-critical.

Migrants also differ in terms of the baseline level and functional manifestation of self-compassion. European environments can offer Iranian men greater access to psychological resources, such as therapy, mindfulness programs, and institutional well-being initiatives (Ghasemy, 2020). Acculturation theory (Berry, 1997) suggests that integration strategies are linked to improved psychological outcomes. Within this framework, exposure to European contexts may foster self-compassion while enabling individuals to maintain culturally significant values related to family and spirituality.

Situating self-compassion within specific environmental contexts allows for an understanding that takes situational factors into account. Rather than viewing self-compassion solely as an individual trait, it is more accurate to define it as a dynamic capacity shaped by social, cultural, and institutional factors. This approach aligns with the primary aim of the present study: to analyze the influence of environmental contexts on the relationships between body image, self-compassion, and health-related quality of life among Iranians at various life stages and across diverse sociocultural conditions.

3.5. Measuring Self-Compassion

Due to the cross-generational scope of this thesis, it is necessary to carefully consider psychometric tools, cultural adaptation procedures, and methodological limitations. This section examines the primary instruments for assessing self-compassion, specifically the Self-Compassion Scale (SCS), the Self-Compassion Scale–Short Form (SCS-SF), and the Compassion Scale (CS), with a focus on their Persian adaptations and related challenges.

The Self-Compassion Scale (SCS) was developed by Neff (2003) to operationalize the multidimensional construct of self-compassion. The original 26-item instrument assesses six subscales reflecting three bipolar components: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Respondents rate items on a Likert-type scale (1 = almost never to 5 = almost always); negative subscales (self-judgment, isolation, over-identification) are reverse-scored, and a total mean score is computed, with higher

scores indicating greater self-compassion. Initial validation demonstrated strong internal consistency ($\alpha = .92$ for the total scale) and acceptable construct validity (Neff, 2003). Cross-cultural investigations have largely confirmed the scale's structural integrity; however, ongoing debate continues over its underlying factor structure (Neff, 2016; Montero-Marin et al., 2018). Importantly, the SCS has been adapted and validated in Persian-speaking populations. In an Iranian validation study, the Persian version of the SCS demonstrated satisfactory internal consistency, the Cronbach's alpha coefficients for total SCS items, were between 0.78 to 0.93 (Azizi et al., 2013). Similarly, in another study, Cronbach's alpha values ranged from approximately 0.70 to 0.89 across subscales, indicating acceptable internal reliability in Iranian samples (Momeni et al., 2014). These findings indicate that the SCS is psychometrically sound for use within Iranian populations, though factor-analytic results sometimes suggest modifications to the original six-factor model. In this thesis, the Persian Self-Compassion Scale (SCS) serves as a comprehensive instrument for assessing nuanced relationships among self-compassion dimensions, body concerns, and health-related quality of life (HRQoL).

Raes et al. (2011) developed the 12-item Self-Compassion Scale–Short Form (SCS-SF) to address practical constraints, deriving it from the original Self-Compassion Scale (SCS). The SCS-SF preserves the six subcomponents of the original scale while offering a more efficient assessment. SCS-SF uses the same 5-point Likert scale and reverse-scoring procedure for negative items; a total mean score is recommended, with higher values reflecting higher global self-compassion. In the initial validation study, the SCS-SF demonstrated a strong correlation with the full scale ($r = .97$) and adequate internal consistency ($\alpha \approx .86$) (Raes et al., 2011). The Iranian adaptation of the SCS-SF, reported satisfactory psychometric properties. Cronbach's Alpha coefficient, for the whole of scale and factors of self-kindness, self-judgment, common humanity, isolation and mindfulness, over-identification were gained 0.79, 0.68, 0.71 and 0.86 respectively, indicating good internal consistency in Iranian samples (Khanjani et al., 2016). The SCS-SF is particularly advantageous in research involving diverse age groups and migrant participants because it reduces participant fatigue and enhances feasibility in multi-measure survey designs. However, the brevity of the short form introduces certain trade-offs. Subscale reliability coefficients tend to be lower than those of the full Self-Compassion Scale (SCS), and distinctions between positive and negative components of self-compassion are often less stable. This issue is

particularly pertinent when investigating generational differences or cultural equivalence, as subtle variations in interpretation can affect the results.

While the SCS assesses compassion directed toward the self, the Compassion Scale (CS) developed by Pommier (2011) measures compassion toward others, encompassing kindness, common humanity, and mindfulness alongside reduced indifference, separation, and disengagement. The 24-item CS is rated on a 5-point Likert scale (1 = almost never to 5 = almost always); negatively framed subscales (indifference, separation, disengagement) are reverse-scored, and higher mean scores indicate greater compassion toward others. While compassion for others and self-compassion are conceptually distinct, they are theoretically related and may offer complementary perspectives on culturally influenced compassion norms. The Compassion Scale (CS) demonstrated strong internal consistency during its initial validation ($\alpha > .90$; Pommier, 2011; Pommier et al 2020). While Persian validation studies of the Compassion Scale (CS) are less thoroughly documented than those of the Self-Compassion Scale (SCS), incorporating the CS into comparative research could elucidate whether cultural contexts differentially influence inward and outward compassion among Iranian men.

Although the psychometric foundations of the questionnaires in question are solid, additional methodological challenges require further discussion. In collectivistic societies such as Iran, constructs such as self-kindness are often misinterpreted as selfishness or self-indulgence. Markus and Kitayama (1991) emphasized that self-related constructs are embedded within cultural contexts; therefore, linguistic translation alone does not ensure conceptual equivalence. Arimitsu (2023) similarly observed that cultural value systems shape the interpretation of self-compassion items. For instance, agreement with statements reflecting self-kindness may conflict with cultural norms that prioritize humility or self-sacrifice. These factors may contribute to the underreporting of self-compassion in Iranian samples, especially among older generations.

Furthermore, age-related response style differences – such as acquiescence bias and social desirability – can undermine the validity of measurement scales. Older Iranian men, often raised within cultural norms that discourage emotional vulnerability, may be less inclined to endorse items reflecting self-directed warmth. Additionally, differences in literacy levels and limited familiarity with Likert-type self-assessment formats may further affect the validity of responses. Furthermore, lower internal consistency coefficients are frequently observed among migrant and bicultural groups, likely due to varying interpretative approaches shaped by the acculturation

process (Montero-Marin et al., 2018). Iranian men living in Europe may interpret self-compassion test items through a hybrid cultural framework, which can affect the stability of factor structures. The observed variability underscores the importance of assessing measurement invariance across groups differing by place of residence (e.g., Iran vs. Europe) prior to conducting comparative analyses.

To overcome these limitations, a mixed-methods approach is advisable. Quantitative assessment with validated Persian versions of the SCS or SCS-SF should be supplemented by qualitative methods, such as vignette-based interviews or semi-structured discussions, to examine participants' conceptualizations of self-kindness and common humanity. Qualitative data can reveal whether respondents interpret items in ways that align with their cultural context and can uncover generational nuances that standardized scales may overlook.

3.6. Conclusion

Self-compassion may serve as a key theoretical and empirical construct in examining the relationship between men's body concerns and health-related quality of life (HRQoL) among young and older Iranians living in Iran and Europe. Based on Neff's (2003) multidimensional model, which comprises self-kindness, common humanity, and mindfulness, the self-compassion is viewed as a protective psychological resource that mitigates shame, self-criticism, and maladaptive social comparison. Across various contexts, individuals exhibiting higher levels of self-compassion consistently demonstrate lower levels of depression and anxiety, greater emotional resilience, and more adaptive coping strategies (MacBeth & Gumley, 2012; Neff & Germer, 2013). These findings underscore the importance of self-compassion as a protective factor against body dissatisfaction and its associated health consequences.

Although initially developed within Western psychology, in the Iranian context, collectivistic norms and traditional masculinity ideals tend to reinforce self-criticism and emotional restraint, potentially limiting overt expressions of self-kindness. Indigenous spiritual traditions, including Islamic concepts of *rahma* (mercy) and Sufi emphases on self-forgiveness, indicate conceptual continuity rather than contradiction. In contrast, European contexts, which feature greater institutional support for mental health, therapy culture, and mindfulness-based interventions, may offer more explicit opportunities to foster self-compassion (Neff & Germer,

2013). Therefore, environmental context appears to influence both the accessibility and expression of self-compassion among Iranian men.

Generational differences provide additional nuance to this analysis. Older Iranian men, who have been socialized within more rigid gender norms that emphasize endurance and self-discipline, may demonstrate lower baseline self-compassion as a result of deeply ingrained self-critical schemas. In contrast, younger generations, especially those influenced by globalization and digital media, may encounter heightened body ideals but also display increased receptivity to psychological frameworks that encourage emotional awareness. Migration adds another layer, as Iranian men in Europe navigate acculturative processes that may either challenge or facilitate compassionate self-relating (Berry, 1997).

In the context of this dissertation, self-compassion is essential as it provides a theoretically coherent mechanism that links sociocultural body pressures to health-related quality of life (HRQoL). Body dissatisfaction, whether associated with muscularity in younger men or aging-related changes in older men, frequently triggers shame and upward social comparison (Festinger, 1954; Braun et al., 2016).

The empirical phase of this doctoral research will therefore examine (a) measurement invariance of self-compassion across age and residence groups, (b) generational and cross-context differences in self-compassion levels, and (c) its moderating or mediating role in the association between body concerns and HRQoL. By integrating cultural, generational, and environmental dimensions, this dissertation advances a context-sensitive model of men's psychological resilience and contributes to culturally grounded understandings of self-compassion among Iranian populations in both homeland and diaspora settings.

Chapter 4

Methodology

4.1. Justification of the Research Problem

The body image, the health-related quality of life and self-compassion represent an increasing dialogue in the psychological literature by different parts and they provide information about the cross-categories. But, with the growing literature on such subjects, very little is known about how these variables interact in men, especially in non-Western countries like Iran. The implications of this study could help bridge this gap, particularly the aspects of quality of life, body-image issues, and self-compassion related to body concerns among Iranian men in the domestic milieu as well the international context, particularly among Iranian men with diaspora in Europe. It will also explore the differences in these relationships across generations, shedding light on the effects of globalization and cultural changes on body image and well-being.

The body-self relations are shaped by numerous contextual factors (e.g., sociocultural norms, mass media, the social environment) as well as individual ones (e.g., experiences and age). In this context, the spread of Western beauty standards via the Internet and social media has contributed to increased body dissatisfaction in non-European societies (Baptista, 2011). This issue is particularly relevant for young Iranian men, who are increasingly exposed to Western ideals of male attractiveness that emphasize muscularity and a lean physique (Shoraka et al., 2019). Numerous studies indicate that exposure to unrealistic body ideals can lead to body dissatisfaction, which is associated with various negative psychological consequences that diminish subjective quality of life (Cash and Smolak, 2011).

Older men may be influenced less by media and more by functional aspects of the body (Baker et al., 2009) when it comes to body image. In fact, empirical evidence has confirmed that older adults experience body dissatisfaction (Sánchez-Cabrero et al., 2019) and, more when they are over 65 years and are confronted with physical changes. Research should place greater emphasis on how and why body image concerns differ between younger and older Iranians, and on how shifting cultural contexts shape distinct patterns of interdependence between the relationship with one's body and health-related quality of life.

The quality of life of both older and young adults in Iran has been profoundly affected by globalization, urbanization, and the exponential diffusion of digital technologies (Sheikhi, 2010). The observed changes manifest in lifestyle shifts, increased awareness through democratizing knowledge and information via the internet, and the new health, well-being, and ageing paradigm. Further, the experience of migration and acculturation of Iranians residing in Europe can also adversely affect HRQoL, especially for older adults who struggle to adjust to a new cultural environment (Harrefors et al., 2009). By comparing the HRQoL of Iranian men living in Iran with that of those residing in Europe, this study will provide valuable insights into the impact of migration and cultural context on well-being. Such data will help in understanding how migration and the surrounding environment can affect HRQoL, as such a comparison, to the best of our knowledge, has not been previously reported for Iranian men living in Europe compared to their counterparts in Iran.

Moreover, self-compassion – which has proven to be a protective factor in psychological well-being and positively correlates with body appreciation – has been incorporated into the research model. Given the limited research on the role of self-compassion regarding body image and HRQoL among Iranian men, this study aims to address this gap.

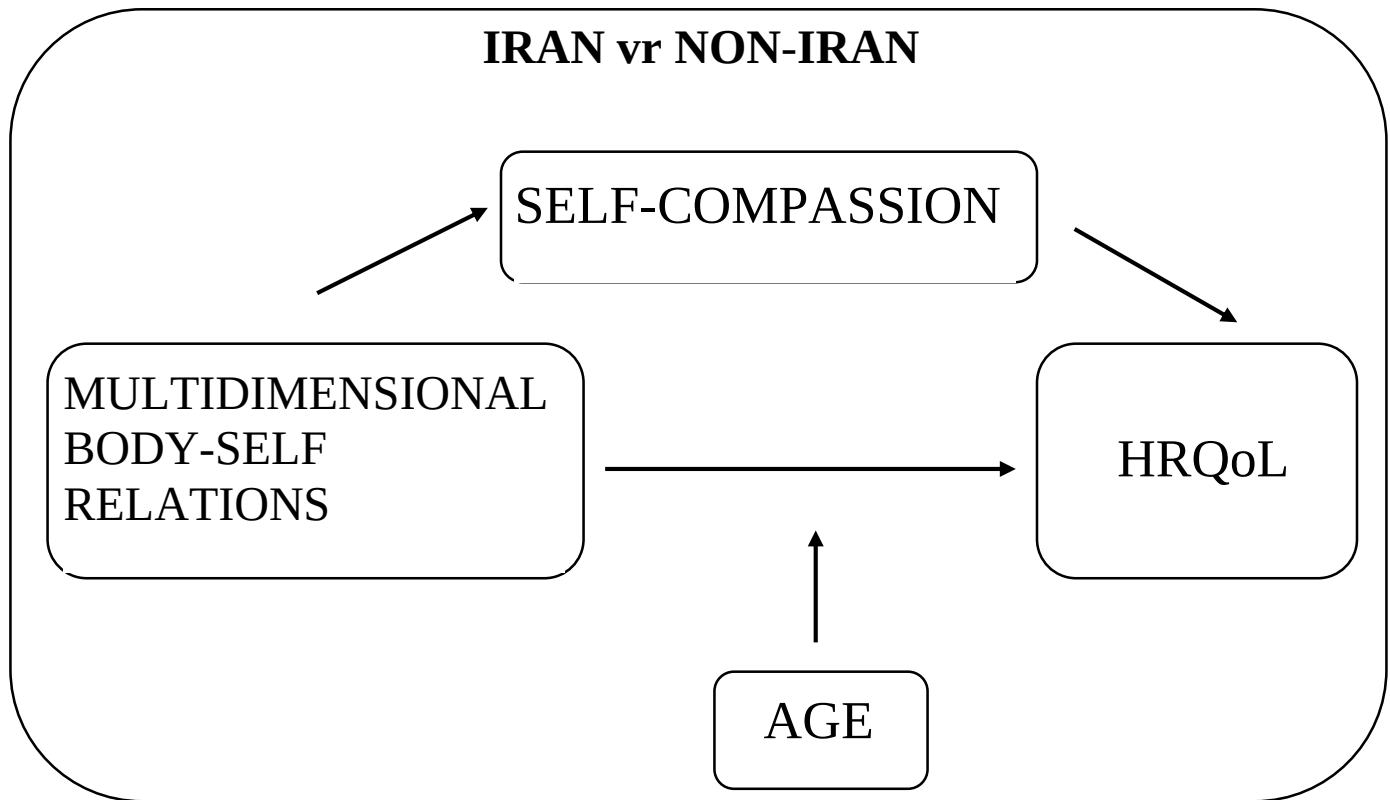
Self-compassion might serve as a unique mediating factor among Iranian men, mitigating the negative psychological outcomes of body dissatisfaction and promoting overall well-being. However, constructs such as the prevalence of traditional gender roles and the stigma surrounding mental health may interact with how self-compassion is expressed and perceived (Hasani & Pashdar, 2017). Therefore, this study will explore the mediating role of self-compassion in the relationship between body image and HRQoL, contributing to the understanding of how Iranian men can foster self-compassion to enhance positive mental health outcomes.

Three variables will be analyzed: body image, health-related quality of life, and self-compassion. The study will cover two extremes of adulthood (young people and older adults) and take into account two distinct contexts: life in the home country (Iran) and life abroad within the diaspora (in Germany and Sweden).

4.2. Research Model

This study, aimed to explore the covariation of multidimensional body-self relations, self-compassion and health-related quality of life (HRQoL) of young and older men living in Iran and “non-Iran”. The research model posited that (1) age differentiates the interrelationships among variables related to body image, health-related quality of life (HRQoL), and the mediator - self-compassion. Furthermore, it is assumed that (2) life context (Iran vs. countries outside Iran) also differentiates the interrelationships among these three variables.

Figure 3. *Research model of study*



4.3. Research Hypotheses

Based on the literature review presented in the three preceding theoretical chapters – covering the conceptualization and current research findings regarding the multidimensional body image, self-compassion, and health-related quality of life (HRQOL) in young and older men – and in light of a significant gap in research conducted in Iran, the following hypotheses were formulated:

H1: Multidimensional Body-Self Relations is correlated with HRQOL among men.

H2: Self-Compassion acts as a mediator in the relationship between Multidimensional Body-Self Relations and HRQOL.

H3: There are significant differences in multivariate causal relationships among Multidimensional Body-Self Relations, Self-Compassion, and HRQOL between young and old men in Iran.

H4: There are significant differences in multivariate causal relationships among Multidimensional Body-Self Relations, Self-Compassion, and HRQOL between men living in Iran and those living in Europe.

4.4. Study Variables, Their Dimensions, And Operationalization

Outcome Variable (OV):

Health-Related Quality of Life (HRQoL): this is the main outcome of the study. HRQOL indicates men's general physical, psychological, and social condition shaped by perceptions of their body, age, and sociocultural environment.

Predictor (P):

Multidimensional Body-Self Relations: an important predictor variable, which represents attitudes towards their body image and how men perceive their bodies and anything body-

related. This construct is comprised of body satisfaction, appearance evaluation, and body related self-esteem, which are known to predict psychological well-being and quality of life.

Mediator Variable (MedV):

Self-Compassion: The present study hypothesizes that self-compassion mediates the relationship between multidimensional body-self relations and health-related quality of life (HRQOL). Self-compassion, which consists of three different components: self-kindness, mindfulness, and balanced thinking about our own imperfections, may act as a protective factor, which can be used by men to cultivate healthier attitudes toward their bodies and limit negative psychological consequences.

Contextual Variables:

Age (young vs. old men): Age acts as a mediator in the relationship between the body-self and HRQOL. The study postulates that the differences in body satisfaction among younger and older men leads to differences in their overall quality of life. Young men could be more prone to responding to social pressures related to body image, while those older may place a greater emphasis on functionality and health concerns.

Context (Iran against Europe - country of residence): The cultural context is one of the most important factors of men body image and self-compassion. The body is not only an individual representation but rather a socio-cultural one, which implies that different societies rely on different conventions of body and beauty, that vary between Middle East (Iranian) and Western (European) cultures, and it might be the key to if/how men experience, endorse, and internalize body-related issues.

4.5. Description of Questionnaires /Instruments

Socio-demographic and health-related characteristics:

Data were gathered using a structured survey designed to assess socio-demographic factors, including age, level of education, marital status, household size, and residential status. Additionally, it incorporated health-related and migration-specific variables, such as the presence of chronic diseases or illnesses, history of hospitalization, length of hospital stay, overall satisfaction with the host country, whether the host country was the participant's primary choice, and their current employment status in the host country.

Separate questionnaires were used to measure the variables: the Multidimensional Body-Self Relations Questionnaire (MBSRQ) to assess the multidimensional body-self relations, the Self-Compassion Scale (P-SCS) to measure self-compassion, and the WHOQOL-BREF to assess health-related quality of life (HRQOL). Persian adaptations of all three instruments were employed, each demonstrating satisfactory psychometric properties.

Persian Version of the Multidimensional Body-Self Relations Questionnaire (MBSRQ)

The Multidimensional Body-Self Relations Questionnaire (MBSRQ), was developed by Thomas F. Cash in 1990 and consists 69 items rated on a 5-point Likert scale (from 1 = strongly disagree to 5 = strongly agree) (Cash, 2000). This instrument operationalizes body image as a multidimensional construct, incorporating evaluative, cognitive, and behavioral components of body-related self-attitudes. MBSRQ includes several subscales that measure different aspects of body image and self-perception:

- Appearance Evaluation (AE) – Assesses satisfaction or dissatisfaction with one's physical appearance.
- Appearance Orientation (AO) – Evaluates the extent to which an individual values and invests effort in their appearance.
- Body Areas Satisfaction Scale (BASS) – Measures satisfaction with specific body parts or features.
- Overweight Preoccupation (OWP) – Captures concerns related to weight gain, dieting, and fat anxiety.

- Self-Classified Weight (SCW) – Reflects subjective perception of one's body weight.
- Fitness Orientation (FO) – Assesses the importance placed on physical fitness.
- Health Evaluation (HE) – Measures perceived overall health and wellness.
- Health Orientation (HO) – Evaluates an individual's motivation to lead a healthy lifestyle.
- Illness Orientation (IO) – Captures concerns about illness and personal health vulnerabilities.
- Body Image Anxiety (BIA) – Assesses distress related to body image concerns.

Cash (2000) reported strong psychometric properties based on large U.S. samples. Internal consistency coefficients (Cronbach's α) ranged from 0.70 to 0.90 across subscales. Factor analytic procedures supported the multidimensional structure. Test-retest reliability over several weeks was acceptable ($r \approx 0.70$ – 0.90 depending on subscale).

Shemshadi et al. (2020) validated the Persian version of the instrument, confirming its factorial validity in Iranian samples. The study reported satisfactory internal consistency, with Cronbach's alpha coefficients generally above 0.70 across subscales. Construct validity was established through correlations with related constructs, including self-esteem and body dissatisfaction. The findings indicate that the Persian MBSRQ possesses adequate psychometric properties for both research and clinical applications in Iranian populations.

In **the present study**, the Multidimensional Body-Self Relations Questionnaire (MBSRQ) demonstrated excellent internal consistency, with a **Cronbach's alpha coefficient of 0.93** ($\alpha = 0.926$ for 69 items).

Persian Version of Self-Compassion Scale (P-SCS)

The Self-Compassion Scale (SCS), developed by Kristin D. Neff in 2003, is a 26-item self-report instrument designed to assess an individual's self-compassion across six dimensions:

- Self-Kindness: Being kind and understanding toward oneself in instances of pain or failure.
- Self-Judgment: Being critical and judgmental toward oneself.
- Common Humanity: Recognizing that suffering and personal failure are part of the shared human experience.
- Isolation: Feeling isolated from others when experiencing suffering or failure.
- Mindfulness: Holding painful thoughts and feelings in balanced awareness.

- Over-Identification: Over-identifying with painful thoughts and feelings.

Respondents rate each item on a 5-point Likert scale (from 1 = Almost Never to 5 = Almost Always). To compute a total self-compassion score, negative subscale items (Self-Judgment, Isolation, and Over-Identification) are reverse-scored. Then, the mean of each subscale is calculated, and a total mean score is derived from these subscale means. Higher scores indicate greater self-compassion.

In terms of reliability, Neff (2003) reported a high internal consistency for the overall scale, with a Cronbach's alpha of 0.92. The subscales demonstrated adequate internal consistency, with alphas ranging from 0.75 to 0.81. Test-retest reliability over a three-week period was also high, with a correlation of 0.93 for the total score.

Table 4. *Self-compassion component*

Component	Questions related to each component
Self-kindness	5, 12, 19, 23 and 26
Self-judgment	1, 8, 11, 16 and 21
Common humanity	3, 7, 10 and 15
Isolation	4, 13, 18 and 25
Mindfulness	9, 14, 17 and 22
Over-identification	2, 6, 20 and 24

For assessing self-compassion, participants completed the Persian version of SCS validated by Momeni et al (2014), in their study the SCS was found to have an acceptable internal consistency as shown by a high Cronbach's alpha of .70. A test-retest reliability of 0.89 was also obtained for the SCS. In Khosravi et al.'s research (2012), the scale's overall alpha coefficient was 0.76. The Cronbach's alpha coefficients for the subscales of self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification were 0.81, 0.79, 0.84, 0.85, 0.80, and 0.83, respectively. The questionnaire's validity has also been reported as favourable.

In **the present study**, the Self-Compassion Scale demonstrated satisfactory internal consistency, with a **Cronbach's alpha coefficient of 0.85** ($\alpha = 0.845$ for 26 items).

Persian Version of the Quality of Life Questionnaire (WHOQOL-BREF)

The WHOQOL-BREF was developed by condensing the domains and item pool of the original WHOQOL-100 instrument. It is a 26-item self-report questionnaire designed to assess an individual's overall quality of life across four primary domains: physical health, psychological health, social relationships, and environment. Raw scores for individual domains are computed and subsequently transformed via a standardized formula into a scale ranging from 0 to 100.

The instrument was developed based on data from patients with varying degrees of illness severity, healthy individuals, and healthcare professionals; consequently, it facilitates cross-cultural adaptations and enables comparative analyses across diverse clinical and non-clinical populations.

The Persian version of the instrument has previously demonstrated excellent internal consistency (Cronbach's $\alpha > .80$) and robust discriminative validity in differentiating between healthy populations and those with clinical conditions (WHOQOL, 1996; Nejat et al., 2006).

In **the present study**, the WHOQOL-BREF demonstrated satisfactory internal consistency, with an overall **Cronbach's alpha coefficient of .75** ($\alpha = .747$ for 26 items).

4.6. Participant Characteristics

The study was conducted among Iranian men residing in both Iran and Europe. To investigate cross-generational differences, the sample comprised two distinct age cohorts: young men (aged 22–35 years) and older men (aged ≥ 60 years). These age groups were selected to capture potential variations in cultural identity, values, and adaptation processes across generations.

The total sample comprised 640 participants, divided into four subgroups:

- Iranian male youth (N = 200): Young men residing in Iran, representing the native population unaffected by migration experiences.
- Iranian male elderly (60+ years old) (N = 100): Older Iranian men residing in Iran, serving as a reference group for generational comparisons.
- Young Iranian men living in Europe (N = 233): Participants residing in European countries, particularly Germany and Sweden, where Iranian migration is most prevalent. This group represents the younger generation experiencing migration-related changes.

- Iranian elderly men (60+ years old) living in Europe (N = 107): Older Iranian men who migrated to Europe, providing insight into the long-term effects of migration on cultural adaptation and identity.

To ensure the homogeneity and relevance of the sample, participants were required to meet the following criteria:

- 1- Gender: Only male participants were included to maintain a gender-specific focus.
- 2- Age: Two age groups were defined—young adults (22–35 years) and elderly adults (60+ years). These age brackets were chosen to capture developmental and generational differences.
- 3- Health Status: Participants were required to be free from severe physical and mental illnesses or disorders that might interfere with their ability to participate in the study. This criterion was assessed through self-reports and, when necessary, confirmed by medical documentation.
- 4- Language Proficiency: All participants were required to speak and understand Persian to ensure the consistency of data collection and interpretation, particularly in qualitative components.

4.7. Research Procedure

The present study was conducted between 2021 and 2026, focusing on Iranian young and elderly men residing in Iran, Germany, and Sweden. To ensure the accuracy and reliability of the findings, the study followed a rigorous methodology, which was approved by the research supervisor and the scientific committee of UKW.

Selection and Administration of Questionnaires to measure the relevant psychological and quality of life variables, the researcher utilized the Persian/Farsi version of three standardized questionnaires: WHOQOL-BREF, P-SCS, and MBSRQ. These questionnaires had been previously validated for use in the Iranian cultural context. Formal authorization and confirmation for their use were obtained from the respective authors who had conducted the validation process. The researcher developed two separate online survey links: one for participants residing in Iran and another for those in Europe (Germany and Sweden). Before initiating the survey, participants

were provided with an introductory request form outlining the nature and purpose of the research. This form included essential information about the study's objectives, duration, voluntary participation, and confidentiality assurances. Participants were also informed of their right to withdraw at any stage without any consequences. Additionally, the researcher included their contact information and email address, encouraging participants to reach out for any inquiries or concerns regarding the study.

Data Collection Process Following the consent procedure, participants were required to provide sociodemographic information. Subsequently, they proceeded to complete the Persian/Farsi versions of the three questionnaires in the following order:

MBSRQ (Multidimensional Body-Self Relations Questionnaire)

P-SCS (Persian Self-Compassion Scale)

WHOQOL-BREF (World Health Organization Quality of Life Instrument – Short Form)

The entire survey procedure took approximately 20 minutes to complete.

Participant Support and Referral to Psychological Assistance To minimize potential risks associated with stress, anxiety, or depressive thoughts among participants, comprehensive support measures were put in place. The initial request form reassured participants that support was available throughout the study. The researcher's contact information was prominently provided, enabling participants to reach out for assistance or to express concerns at any stage.

Regular Monitoring and Ethical Oversight To maintain the study's ethical integrity and ensure participant welfare, the research was continuously monitored. This included identifying and addressing any emerging ethical concerns, participant well-being issues, or methodological challenges. Adjustments were made as necessary to enhance the study's overall ethical and scientific rigor.

Participant and Recruitment Settings Recruitment efforts were carried out through multiple channels, including media announcements (email, websites, social media), direct collaboration with academic institutions, and outreach among elderly care centers. Recruitment was conducted with the support of research colleagues, student networks, and elderly care professionals.

The study purposively targeted two distinct demographic cohorts: younger men (aged 22–35 years) and older men (aged ≥ 60 years). To ensure diversity across various cultural contexts, a

multidimensional, mixed-methods recruitment strategy was employed across multiple institutional and community settings in Iran, Sweden, and Germany.

The sample of younger men comprised students recruited from public and private higher education institutions, including colleges and universities across all three target countries, with specific institutional access granted at the Medical University of Golestan and the Medical University of Tabriz in Iran.

Conversely, the older cohort was recruited from diverse institutional and community environments. In Germany, recruitment was conducted at the Senioren-Centrum Nürnberg Haus Frankenland GmbH, the Lorenzkirche community, the Iranische Gemeinde, and local social venues such as the Döner Imbiss (Färberstraße 2, Nürnberg). In Sweden, participants were accessed via Karolinska University, Kavat Vård's Persikan Care Home in Akalla (Stockholm), and the online "Iranianswed" community. In Iran, the sample was drawn from the Aging Culture Foundation, the Iranian Research Centre on Ageing, and various local nursing homes.

4.8. Ethical considerations

This study was conducted in accordance with the ethical standards of the Declaration of Helsinki, which promotes respect for all human beings and protects their health and rights. Also, the Ethic code No.3/14.10.22 was obtained from the Ethical Committee of Kazimierz Wielki University Faculty of Psychology for this study (The document is included in the appendices of this dissertation).

After informing the participants about the purpose of the trial (investigation, research, study), and where and how the obtained data would be used, written and online consents were obtained. The participants of this study were over 22 years old. For between 22-35, and 60+ written online informed consent was provided by the participant's own self.

Chapter 5

Results

The total sample consisted of **640 Iranian male participants**, divided into four main groups according to age and place of residence. Participants living in Europe were further categorized by country, namely Germany and Sweden.

Table 5. *Distribution of participants by age group and country of residence*

Age group	Place of residence/Country	N	Percentage (%)
Young men	Iran	200	31.3
Older men (60+)	Iran	100	15.6
Young men	Sweden	117	18.3
Young men	Germany	116	18.1
Older men (60+)	Sweden	53	8.3
Older men (60+)	Germany	54	8.4
Total	-	640	100.0

Note. The European subsample comprised 233 young men (117 from Sweden and 116 from Germany) and 107 older men aged 60 years and above (53 from Sweden and 54 from Germany).

Table 6 displays descriptive statistics for age across six study groups, categorized by participants' place of residence and age group. The table includes mean age, standard deviation (SD), and minimum and maximum ages for young and older Iranian men residing in Iran, Germany, and Sweden.

Table 6. *Descriptive statistic of age for both sample men living in Iran, Germany and Sweden*

Place of living		Mean	Sd	Min	Max
Iran	Young	27.82	3.96	22	35
	Old	66.4	3.48	60	75
Germany	Young	27.45	3.83	22	35
	Old	68.37	4.41	60	75
Sweden	Young	26.95	4.15	22	35
	Old	68.37	5.06	60	78

Young participants were defined as those aged 22 to 35 years, while older participants were aged 60 years and above. The mean ages within each age group were comparable across the three countries. Among older participants, Germany and Sweden exhibited the highest mean age ($M = 68.37$ years), whereas the Iranian older group had a slightly lower mean age ($M = 66.40$ years).

Table 7 presents the socio-demographic characteristics of Iranian men living in Iran, categorized into young and older age groups. It reports the distribution of participants according to educational level and marital status, using frequencies (N) and percentages (%).

Table 7. *Socio-demographic characteristic of men living in Iran*

		Young		Old	
		N	%	N	%
Educational levels	none (illiteracy)	-	-	28	28.0
	elementary	2	1.0	43	43.0
	secondary	28	14.0	25	25.0
	higher education	170	85.0	4	4.0
Marital status	single	128	64.0	-	-
	married	69	34.5	40	40.0
	divorced	3	1.5	15	15.0
	widowed	-	-	45	45.0

Among young participants, the majority had higher education (85.0%), while among older participants, the most common educational level was elementary education (43.0%). Regarding marital status, most young men were single (64.0%), whereas the majority of older men were

widowed (45.0%) or married (40.0%). Percentages are calculated separately within each age group.

Table 8 shows the socio-demographic details of Iranian men in Europe, divided into young and older age groups. It lists the number of participants in each group and their percentages by education level and marital status.

Table 8. *Socio-demographic characteristic of Iranian men living in Europe*

		Young		Old	
		N	%	N	%
Educational levels	none (illiteracy)	24	10.3	11	10.3
	elementary	-	-	15	14.0
	secondary	-	-	29	27.1
	higher education	209	89.7	52	48.6
Marital status	single	123	52.8	-	-
	married	93	39.9	57	53.3
	divorced	8	3.4	16	15.0
	widowed/ engaged	9	3.9	34	31.8

Most young participants had higher education (89.7%). Among older participants, higher education was also most common (48.6%), followed by secondary education (27.1%). In terms of marital status, most young men were single (52.8%) or married (39.9%). Most older men were married (53.3%) or widowed or engaged (31.8%). Percentages are calculated separately for each age group.

5.1. Cronbach's alpha test

Cronbach's alpha is a way of assessing reliability by comparing the amount of shared variance, or covariance, among the items making up an instrument to the amount of overall variance. The idea is that if the instrument is reliable, there should be a great deal of covariance among the items relative to the variance.

Table 9 shows the Cronbach's Alpha Coefficients for the Questionnaires and Subscales for the Older Iranian men residing in Iran (n=100).

Table 9. *Cronbach's Alpha Coefficients for the Questionnaires Older Iranian men residing in Iran*

Cronbach's alpha test	Research questions	Subscales	Questionnaires
0.805	5, 12, 19, 23, 26	SK: Self-Kindness, Items	P-SCS
0.773	1, 8, 11, 16, 21	SJ: Self-Judgment Items (reverse scored)	
0.726	3, 7, 10, 15	CH: Common Humanity Items	
0.704	4, 13, 18, 25	II: Isolation Items (reverse scored)	
0.798	9, 14, 17, 22	MI: Mindfulness Items	
0.723	2, 6, 20, 24	OI: Over-identification Items (reverse scored)	
0.759	18+17+16+15+10+4+3	Physical health	WHOQOL-BREF
0.829	26 +19+11+7+6+5	Psychological	
0.762	22+21+20	Social relationships	
0.849	8+9+12+13+14+23+24+25	Environment	
0.740	48-42-39-31-21-11-5	AE: Appearance evaluation	MBSRQ
0.779	51-49-41-41-32-31-23-22-13-12-2-1	AO: Appearance orientation	
0.801	51-33-24	FE: Fitness evaluation	
0.824	53-44-43-35-34-26-25-16-15-14-6-4-3	FO: Fitness orientation	
0.831	54-45-31-27-17-7	HE: Health evaluation	
0.713	52-38-29-28-19-18-9-8	HO: Health orientation	
0.901	56-55-47-46-37	IO: Illness orientation	
0.764	69-61	BAS: Body areas satisfaction	
0.760	61-59	SW: Subjective weight	
0.805	58-57-28-11	WP: Weight preoccupation	

Table 10 shows the Cronbach's Alpha Coefficients for the Questionnaires and Subscales for the Young men residing in Iran(n=200).

Table 10. *Cronbach's Alpha Coefficients for the Questionnaires Young men residing in Iran*

Cronbach's alpha test	Research questions	Components	Questionnaires
0.740	5, 12, 19, 23, 26	SK: Self-Kindness, Items	P-SCS
0.701	1, 8, 11, 16, 21	SJ: Self-Judgment Items (reverse scored)	
0.754	3, 7, 10, 15	CH: Common Humanity Items	
0.801	4, 13, 18, 25	II: Isolation Items (reverse scored)	
0.841	9, 14, 17, 22	MI: Mindfulness Items	
0.762	2, 6, 20, 24	OI: Over-identification Items (reverse scored)	
0.700	18+17+16+15+10+4+3	Physical health	WHOQOL-BREF
0.854	26 +19+11+7+6+5	Psychological	
0.811	22+21+20	Social relationships	
0.712	8+9+12+13+14+23+24+25	Environment	
0.762	48-42-39-31-21-11-5	AE: Appearance evaluation	MBSRQ
0.784	51-49-41-41-32-31-23-22-13-12-2-1	AO: Appearance orientation	
0.904	51-33-24	FE: Fitness evaluation	
0.845	53-44-43-35-34-26-25-16-15-14-6-4-3	FO: Fitness orientation	
0.741	54-45-31-27-17-7	HE: Health evaluation	
0.715	52-38-29-28-19-18-9-8	HO: Health orientation	
0.739	56-55-47-46-37	IO: Illness orientation	
0.730	69-61	BAS: Body areas satisfaction	
0.841	61-59	SW: Subjective weight	
0.874	58-57-28-11	WP: Weight preoccupation	

Table 11 shows the Cronbach's Alpha Coefficients for the Questionnaires and Subscales for the Older Iranian men in Europe (n=107).

Table 11. *Cronbach's Alpha Coefficients for the Questionnaires Older Iranian men in Europe*

Cronbach's alpha test	Research questions	Components	Variable
0.701	5, 12, 19, 23, 26	SK: Self-Kindness, Items	P-SCS

0.715	1, 8, 11, 16, 21	SJ: Self-Judgment Items (reverse scored)	
0.789	3, 7, 10, 15	CH: Common Humanity Items	
0.901	4, 13, 18, 25	II: Isolation Items (reverse scored)	
0.864	9, 14, 17, 22	MI: Mindfulness Items	
0.745	2, 6, 20, 24	OI: Over-identification Items (reverse scored)	
0.764	18+17+16+15+10+4+3	Physical health	WHOQOL-BREF
0.782	26 +19+11+7+6+5	Psychological	
0.804	22+21+20	Social relationships	
0.814	8+9+12+13+14+23+24+25	Environment	
0.741	48-42-39-31-21-11-5	AE: Appearance evaluation	MBSRQ
0.750	51-49-41-41-32-31-23-22-13-12-2-1	AO: Appearance orientation	
0.905	51-33-24	FE: Fitness evaluation	
0.811	53-44-43-35-34-26-25-16-15-14-6-4-3	FO: Fitness orientation	
0.845	54-45-31-27-17-7	HE: Health evaluation	
0.764	52-38-29-28-19-18-9-8	HO: Health orientation	
0.782	56-55-47-46-37	IO: Illness orientation	
0.704	69-61	BAS: Body areas satisfaction	
0.716	61-59	SW: Subjective weight	
0.724	58-57-28-11	WP: Weight preoccupation	

Table 12 shows the Cronbach's Alpha Coefficients for the Questionnaires and Subscales for the Young Iranian men living in Europe, Germany and Sweden (n=233).

Table 12. *Cronbach's Alpha Coefficients for the Questionnaires Young Iranian men living in Europe, Germany and Sweden*

Cronbach's alpha test	Research questions	Components	Variable
0.770	5, 12, 19, 23, 26	SK: Self-Kindness, Items	P-SCS
0.773	1, 8, 11, 16, 21	SJ: Self-Judgment Items (reverse scored)	
0.707	3, 7, 10, 15	CH: Common Humanity Items	

0.764	4, 13, 18, 25	II: Isolation Items (reverse scored)	
0.746	9, 14, 17, 22	MI: Mindfulness Items	
0.797	2, 6, 20, 24	OI: Over-identification Items (reverse scored)	
0.728	18+17+16+15+10+4+3	Physical health	WHOQOL-BREF
0.794	26 +19+11+7+6+5	Psychological	
0.797	22+21+20	Social relationships	
0.706	8+9+12+13+14+23+24+25	Environment	
0.824	48-42-39-31-21-11-5	AE: Appearance evaluation	MBSRQ
0.911	51-49-41-41-32-31-23-22-13-12-2-1	AO: Appearance orientation	
0.840	51-33-24	FE: Fitness evaluation	
0.858	53-44-43-35-34-26-25-16-15-14-6-4-3	FO: Fitness orientation	
0.744	54-45-31-27-17-7	HE: Health evaluation	
0.774	52-38-29-28-19-18-9-8	HO: Health orientation	
0.782	56-55-47-46-37	IO: Illness orientation	
0.749	69-61	BAS: Body areas satisfaction	
0.733	61-59	SW: Subjective weight	
0.791	58-57-28-11	WP: Weight preoccupation	

Table 13 presents the Cronbach's alpha coefficients for the three questionnaires used in the study across Iranian male participants in Iran, Germany, and Sweden, separately for young and older age groups. The coefficients provide an indication of the internal consistency and reliability of each questionnaire within each subgroup.

Table 13. *Cronbach's alpha coefficients for the three questionnaires across Iranian male participants in Iran, Germany, and Sweden*

Questionnaires	Cronbach's Alpha Coefficients			
	Young		Old	
	Iran	Europe	Iran	Europe
MBSRQ	0.740	0.944	0.779	0.842
WHOQOL-BREF	0.887	0.659	0.901	0.588
P-SCS	0.873	0.923	0.851	0.813

Cronbach's alpha coefficients ranged from 0.49 to 0.94 across the questionnaires and study groups. The Body Image measure demonstrated coefficients ranging from 0.74 to 0.94, while HRQOL showed coefficients ranging from 0.49 to 0.90. The Self-Compassion Scale yielded coefficients ranging from 0.61 to 0.92. Overall, the coefficients indicate varying levels of internal consistency across the different measures and subgroups.

Table 14 displays descriptive statistics for the study questionnaires and their subscales among Iranian male participants residing in Iran, Germany, and Sweden, with results presented separately for younger and older age groups. The table includes the observed range (Min–Max), mean (M), standard deviation (SD), skewness, kurtosis, and Shapiro–Wilk test results for each measure.

Table 14. Descriptive Statistics for the Questionnaires and Subscales Across Male Populations in Iran, Germany, and Sweden by Age Group

Age	Place	Questionnaire	M	Sd	Skewness	Kurtosis	Shapiro-Wilka statistic	Shapiro-Wilka P Value
young	Iran	MBSRQ	174.75	17.74	0.196	0.269	0.993	0.505
	Germany		216.14	34.24	0.326	-0.324	0.982	0.118
	Sweden		237.27	36.22	0.084	-0.324	0.989	0.505
old	Iran		169.71	19.23	-0.190	-0.257	.990	0.677
	Germany		210.11	17.10	0.355	0.529	0.984	0.674
	Sweden		240.77	17.87	-0.102	-0.794	0.981	0.539
young	Iran	WHOQOL-BREF	86.82	13.70	-0.244	0.524	0.989	0.111
	Germany		99.83	12.53	-0.757	4.98	0.875	<0.000
	Sweden		110.43	8.04	-0.780	1.677	0.958	0.001
old	Iran		87.50	14.35	-0.084	-0.043	0.991	0.724
	Germany		99.26	9.56	0.046	-0.143	0.990	0.920
	Sweden		109.21	7.89	-0.319	-0.100	0.974	0.309
young	Iran	P-SCS	64.02	14.11	0.033	-0.273	0.992	0.338
	Germany		91.04	16.41	-0.371	0.164	0.976	0.036
	Sweden		82.77	10.39	0.406	1.448	0.976	0.031
old	Iran		63.48	13.25	-.039	-0.101	0.992	0.846
	Germany		82.11	11.84	0.283	0.577	0.971	0.203
	Sweden		83.11	8.84	-0.025	-0.304	0.980	0.528

5.2. Iranian men's satisfaction with the host country

Aggregated data demonstrate that Iranian migrants report high levels of life satisfaction within the diaspora in Germany and Sweden. Consequently, the vast majority perceive their experience of residing outside their country of origin as highly positive. The detailed intervals are presented in Table 15.

Table 15. Overall satisfaction country Older Iranian men in Europe (n=107)

Percent	Frequency	Overall satisfaction country
3.7	4	very low
16.8	18	low
28.0	30	average
33.6	36	good
17.8	19	excellent
100.0	107	Total

Analogous data were collected from young Iranians, wherein, aside from a few isolated negative accounts, the vast majority of participants reported high (41%) to very high (39%) satisfaction with life outside their homeland. The detailed intervals are presented in Table 16.

Table 16. Overall satisfaction country Young Iranian men living in Europe, Germany and Sweden(n=233)

Percent	Frequency	Overall satisfaction country
3.0	7	very low
1.7	4	low
15.5	36	average
40.8	95	good
39.1	91	excellent
100.0	233	Total

The declared level of satisfaction with life outside the country of origin constitutes a reliable indicator, as it aligns with the responses to the subsequent question regarding whether the current host country was the participant's primary destination or a subsequent stop in their migration

trajectory. The fact that the vast majority of participants report residing in their first country of immigration, rather than repeatedly changing their place of residence, provides indirect confirmation of their previous declarations. Among the 107 older Iranian participants living in Europe, 84 participants (78.5%) reported that their current country of residence was their first migration destination, while 23 participants (21.5%) reported that they had entered their current country from another country. Thus, the majority of participants had migrated directly to their current country of residence.

Table 17. *Country first choice Older Iranian men in Europe*

PERCENT	FREQUENCY	COUNTRY
78.5	84	first destination
21.5	23	I entered from another country
100.0	107	Total

Figure 4. *Histogram country first, older Iranian participants living in Europe*

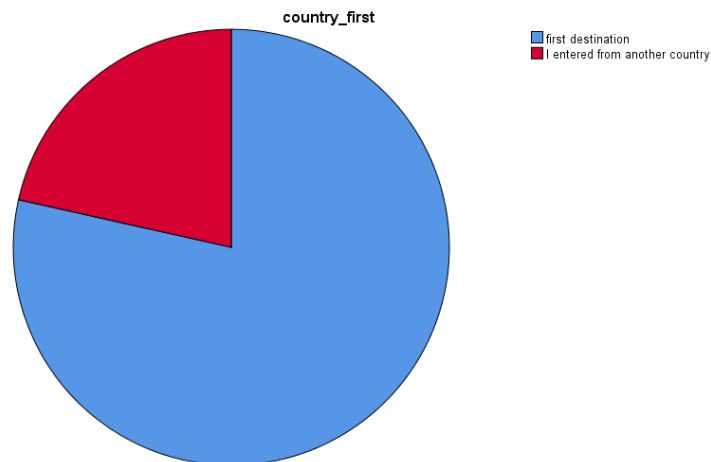


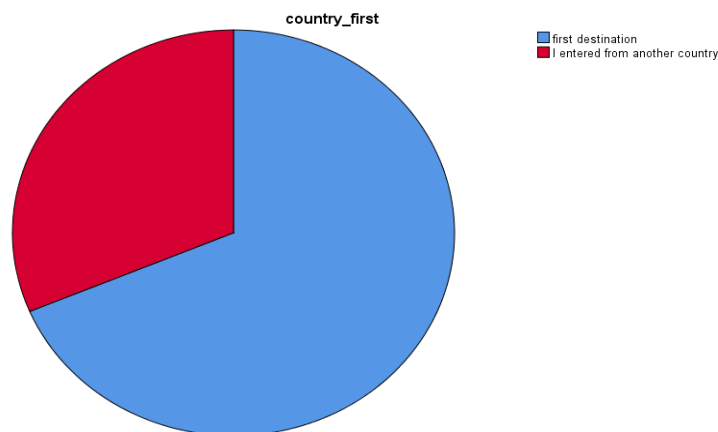
Table 18 presents the distribution of young Iranian men living in Europe according to whether their current country of residence was their first migration destination. The table reports the frequency and percentage of participants in each category.

Note. Among the 233 young Iranian participants living in Europe, 160 participants (68.7%) reported that their current country of residence was their first migration destination, while 73 participants (31.3%) reported that they had entered their current country from another country. Thus, the majority of young participants reported that their current country was their first destination.

Table 18. *Country first choice Young Iranian men in Europe*

PERCENT	FREQUENCY	COUNTRY
68.7	160	first destination
31.3	73	I entered from another country
100.0	233	Total

Figure 5. *Histogram country first, Young Iranian participants living in Europe*



5.3. Descriptive Statistics for Study Variables

In this section, the variables and their components are measured descriptively. Elderly men living in Iran have been evaluated

Table 19. *Descriptive statistics of research variables, elderly men living in Iran*

Eldry Iran, n=100	Components	Minimum	Maximum	Mean	Median
MBSRQ	AE: Appearance evaluation	1.86	3.43	2.60	2.57

	AO: Appearance orientation	1.42	2.75	2.57	2.00
	FE: Fitness evaluation	1.33	4.0	2.49	2.00
	FO: Fitness orientation	1.46	3.08	2.37	2.38
	HE: Health evaluation	1.50	3.33	2.50	2.50
	HO: Health orientation	1.25	3.50	2.00	2.00
	IO: Illness orientation	1.00	4.00	2.76	2.80
	BAS: Body areas satisfaction	1.00	4.67	2.07	2.00
	SW: Subjective weight	1.00	5.00	2.76	4.00
	WP: Weight preoccupation	1.25	4.00	2.39	2.50
WHOQOL-BREF	Physical health	12.00	31.00	22.19	22.00
	Psychological	10.00	27.00	20.66	21.00
	Social relationships	3.00	15.00	10.34	11.00
	Environment	11.00	40.00	26.74	26.50
P-SCS	SK: Self-Kindness, Items	1.00	4.00	2.46	2.40
	SJ: Self-Judgment Items (reverse scored)	0.80	4.00	2.43	2.40
	CH: Common Humanity Items	0.75	3.75	2.45	2.50
	II: Isolation Items (reverse scored)	1.00	4.00	2.45	2.50
	MI: Mindfulness Items	1.00	4.00	2.41	2.50
	OI: Over-identification Items (reverse scored)	1.00	3.50	2.46	2.50

In the quality of life variable, the highest mean is for Environment and the lowest mean is for Social relationships. In the Body Image variable, the highest mean is for Subjective weight and Illness orientation, while the lowest mean is for Health orientation. In the Self-Compassion Scale (SCS) variable, the highest mean is for Over-identification Items (reverse scored) and Self-Kindness, Items , while the lowest value is for Mindfulness Items.

Analogous statistics were computed for the cohort of younger men. These findings are summarized in Table 20.

Table 20. *Descriptive statistics of research variables, Young men living in Iran*

Young Iran, n=200	Components	Minimum	Maximum	Mean	Median
MBSRQ	AE: Appearance evaluation	1.86	3.43	2.60	2.57
	AO: Appearance orientation	1.25	3.33	2.12	2.08
	FE: Fitness evaluation	1.00	4.33	2.57	2.00
	FO: Fitness orientation	1.62	3.23	2.48	2.54

	HE: Health evaluation	1.67	3.83	2.50	2.50
	HO: Health orientation	1.13	3.38	2.10	2.00
	IO: Illness orientation	1.60	4.80	2.90	3.00
	BAS: Body areas satisfaction	1.00	4.44	2.04	2.00
	SW: Subjective weight	1.00	5.00	2.63	2.50
	WP: Weight preoccupation	1.00	4.25	2.48	2.50
WHOQOL-BREF	Physical health	11.00	35.00	21.45	22.00
	Psychological	7.00	28.00	20.29	21.00
	Social relationships	3.00	15.00	10.15	10.00
	Environment	12.00	40.00	27.39	27.00
P-SCS	SK: Self-Kindness, Items	1.00	4.00	2.49	2.60
	SJ: Self-Judgment Items (reverse scored)	1.00	4.00	2.45	2.40
	CH: Common Humanity Items	1.00	4.00	2.43	2.50
	II: Isolation Items (reverse scored)	1.00	4.00	2.50	2.50
	MI: Mindfulness Items	1.00	4.00	2.43	2.50
	OI: Over-identification Items (reverse scored)	1.00	4.00	2.47	2.50

In the quality of life variable, the highest mean is for Environment and the lowest mean is for Social relationships. In the Body Image variable, the highest mean is for Weight preoccupation and the lowest mean is for Appearance evaluation. In the Self-Compassion Scale (SCS) variable, the highest mean is for Self-Judgment Items (reverse scored) and the lowest value is for Self-Kindness items.

In the subsequent step, the analyses were repeated for the group of Iranian residents in Germany. On this occasion, participants were stratified based on their specific host country. This approach is particularly noteworthy given that the socio-economic determinants and broader life contexts differ substantially in the perception of migrants living in Germany compared to those in Sweden. While these comparative findings extend beyond the immediate scope of this dissertation, they nonetheless constitute valuable material for future academic publication.

Table 21. *Descriptive statistics of research variables, Elderly men living in Germany*

Elderly n=54	Germany, Components	Minimum	Maximum	Mean	Median
MBSRQ	AE: Appearance evaluation	2.14	3.86	2.90	2.86
	AO: Appearance orientation	1.75	3.17	2.57	2.50

	FE: Fitness evaluation	2	4.67	3.64	2.65
	FO: Fitness orientation	2.00	3.54	2.60	2.58
	HE: Health evaluation	2.33	4.00	3.21	3.25
	HO: Health orientation	2.00	3.75	2.80	2.88
	IO: Illness orientation	1.80	3.80	2.67	2.60
	BAS: Body areas satisfaction	2.11	4.11	3.19	3.22
	SW: Subjective weight	1.00	4.50	3.19	3.50
	WP: Weight preoccupation	2.25	4.00	3.09	3.25
WHOQOL-BREF	Physical health	20	33	26.5556	27
	Psychological	13	29	22.5185	23
	Social relationships	4	15	11.0556	11
	Environment	21	38	30.7407	31
P-SCS	SK: Self-Kindness, Items	1.60	4.60	3.00	3.00
	SJ: Self-Judgment Items (reverse scored)	2.00	4.60	3.25	3.20
	CH: Common Humanity Items	1.25	4.50	3.09	3.25
	II: Isolation Items (reverse scored)	2.00	4.75	3.18	3.25
	MI: Mindfulness Items	1.50	4.50	3.29	3.25
	OI: Over-identification Items (reverse scored)	1.75	4.50	3.15	3.13

In the quality of life variable, the highest mean is for Environment and the lowest mean is for Social relationships. In the Body Image variable, the highest mean is for Fitness evaluation and the lowest mean is for a Appearance orientation. In the Self-Compassion Scale (SCS) variable, the highest mean is for Common Humanity Items, Isolation Items (reverse scored) and Mindfulness Items and the lowest value is for Self-Kindness, Items.

Analogous statistics were computed for the cohort of younger men living in German. These findings are summarized in Table 22.

Table 22. *Descriptive statistics of research variables, Young men living in Germany*

Young n=116	Germany, Components	Minimum	Maximum	Mean	Median
MBSRQ	AE: Appearance evaluation	2.00	4.43	3.05	3.14
	AO: Appearance orientation	1.50	3.83	2.61	2.58
	FE: Fitness evaluation	1.67	5.00	3.23	3.10

	FO: Fitness orientation	1.85	4.46	2.77	2.69
	HE: Health evaluation	1.67	4.67	3.09	3.00
	HO: Health orientation	1.25	4.25	2.69	2.75
	IO: Illness orientation	1.40	4.60	2.95	3.00
	BAS: Body areas satisfaction	2.00	5.00	3.38	3.33
	SW: Subjective weight	1.00	5.00	3.12	3.00
	WP: Weight preoccupation	1.00	5.00	3.08	3.00
WHOQOL-BREF	Physical health	15	35	27.16	28
	Psychological	9	29	22.71	23
	Social relationships	4	15	10.68	11
	Environment	17	84	31.14	31
P-SCS	SK: Self-Kindness, Items	1.60	5.00	3.39	3.40
	SJ: Self-Judgment Items (reverse scored)	1.40	5.00	3.56	3.60
	CH: Common Humanity Items	1.75	5.00	3.55	3.50
	II: Isolation Items (reverse scored)	1.50	5.00	3.45	3.50
	MI: Mindfulness Items	1.75	5.00	3.58	3.50
	OI: Over-identification Items (reverse scored)	1.50	4.75	3.48	3.50

In the quality of life variable, the highest mean is for Environment and the lowest mean is for Social relationships. In the Body Image variable, the highest mean is for Body areas satisfaction and the lowest mean is for Appearance orientation. In the Self-Compassion Scale (SCS) variable, the highest mean is for Mindfulness Items and the lowest value is for Self-Kindness, Items.

The same descriptive statistics were computed for the final cohorts of Iranian men residing in Sweden, looking first at the older group and subsequently at their younger counterparts.

Table 23. *Descriptive statistics of research variables, Elderly men living in Sweden*

Elderly Sweden, n=53	Components	Minimum	Maximum	Mean	Median
MBSRQ	AE: Appearance evaluation	2.71	4.57	3.68	3.71
	AO: Appearance orientation	2.42	3.50	2.96	3.00
	FE: Fitness evaluation	2.0	4.3	3.21	3.20
	FO: Fitness orientation	2.62	4.46	3.31	3.31
	HE: Health evaluation	2.83	4.50	3.72	3.67

	HO: Health orientation	2.25	4.00	3.18	3.25
	IO: Illness orientation	2.00	4.60	3.36	3.40
	BAS: Body areas satisfaction	1.78	4.33	2.99	2.78
	SW: Subjective weight	1.50	5.00	3.70	4.00
	WP: Weight preoccupation	2.25	5.00	3.51	3.50
WHOQOL-BREF	Physical health	23.00	35.00	29.85	30.00
	Psychological	16.00	30.00	25.40	26.00
	Social relationships	7.00	15.00	13.09	14.00
	Environment	22.00	40.00	33.45	34.00
P-SCS	SK: Self-Kindness, Items	2.40	4.20	3.30	3.40
	SJ: Self-Judgment Items (reverse scored)	1.80	4.60	3.21	3.20
	CH: Common Humanity Items	2.00	4.50	3.07	3.00
	II: Isolation Items (reverse scored)	1.75	4.25	2.92	3.00
	MI: Mindfulness Items	2.25	4.75	3.21	3.00
	OI: Over-identification Items (reverse scored)	2.00	4.50	3.44	3.50

In the quality of life variable, the highest mean is for Environment and the lowest mean is for Social relationships. In the Body Image variable, the highest mean is for Subjective weight and the lowest mean is for Appearance orientation. In the Self-Compassion Scale (SCS) variable, the highest mean is for Over-identification Items (reverse scored) and the lowest value is for Isolation Items (reverse scored).

Young men living in Sweden were assessed. The statistics were summarized in Table 24.

Table 24. *Descriptive statistics of research variables, Young men living in Sweden*

Young n=117	Sweden, Components	Minimum	Maximum	Mean	Median
MBSRQ	AE: Appearance evaluation	1.86	4.86	3.34	3.29
	AO: Appearance orientation	1.67	3.92	2.74	2.75
	FE: Fitness evaluation	1.67	5.00	3.21	3.20
	FO: Fitness orientation	1.62	4.54	3.12	3.15
	HE: Health evaluation	1.67	5.00	3.42	3.33
	HO: Health orientation	1.63	4.25	2.91	2.75
	IO: Illness orientation	2.20	5.00	3.59	3.60
	BAS: Body areas satisfaction	1.22	4.89	3.61	3.89

WHOQOL-BREF	SW: Subjective weight	1.00	5.00	3.69	4.00
	WP: Weight preoccupation	1.75	5.00	3.57	3.75
	Physical health	20.00	35.00	29.75	30.00
	Psychological	15.00	30.00	25.25	26.00
	Social relationships	8.00	15.00	13.08	14.00
	Environment	23.00	40.00	34.15	35.00
P-SCS	SK: Self-Kindness, Items	1.80	4.80	3.27	3.20
	SJ: Self-Judgment Items (reverse scored)	1.60	4.80	3.20	3.20
	CH: Common Humanity Items	2.00	5.00	3.22	3.00
	II: Isolation Items (reverse scored)	1.75	4.75	3.09	3.00
	MI: Mindfulness Items	2.00	5.00	3.07	3.00
	OI: Over-identification Items (reverse scored)	1.25	4.50	3.23	3.25

In the quality of life variable, the highest mean is for Environment and the lowest mean is for Social relationships. In the Body Image variable, the highest mean is for Subjective weight and the lowest mean is for Appearance orientation. In the Self-Compassion Scale (SCS) variable, the highest mean is for Self-Kindness, Items and the lowest value is for Mindfulness Items.

5.4. Testing of the Research Hypotheses

This section deals with testing hypotheses. In this study, to achieve the research objectives, a hypothesis was proposed and tested as follows. Due to the limited statistical population, we consider Sweden and Germany together in this section. The variables were evaluated by age (young - old).

5.4.1. Results and Analysis for Hypothesis 1 Multidimensional Body-Self Relations is correlated with HRQOL among men

Table 25. *The correlation between the Multidimensional Body-Self Relations Questionnaire (MBSRQ) and its subscales and WHOQOL and its subscales*

Physical	Psychological	Social	Environment	WHOQOL
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AE	r	.417**	.315**	.260**	.242**	.371**
	P	.000	.000	.000	.000	.000
AO	r	.444**	.347**	.254**	.292**	.406**
	P	.000	.000	.000	.000	.000
FE	r	.253**	.083*	.027	.141**	.156**
	P	.000	.036	.500	.000	.000
FO	r	.343**	.291**	.210**	.248**	.330**
	P	.000	.000	.000	.000	.000
HE	r	.420**	.347**	.270**	.289**	.398**
	P	.000	.000	.000	.000	.000
HO	r	.349**	.252**	.200**	.204**	.296**
	P	.000	.000	.000	.000	.000
IO	r	.198**	.204**	.142**	.159**	.212**
	P	.000	.000	.000	.000	.000
BASS	r	.362**	.190**	.139**	.213**	.274**
	P	.000	.000	.000	.000	.000
SW	r	.185**	.109**	.157**	.125**	.164**
	P	.000	.006	.000	.002	.000
WP	r	.337**	.224**	.169**	.217**	.283**
	P	.000	.000	.000	.000	.000
MBSR	r	.452**	.329**	.254**	.291**	.399**
Q	P	.000	.000	.000	.000	.000

The statistical analysis revealed a positive and highly significant correlation between the overall MBSRQ score and the total WHOQOL index ($r = .399$, $p < .001$). Furthermore, the global MBSRQ score demonstrated robust positive associations across all individual dimensions of quality of life, demonstrating the strongest relationship with the Physical health domain ($r = .452$, $p < .001$), followed by the Psychological health ($r = .329$, $p < .001$), Environment ($r = .291$, $p < .001$), and Social relationships domains ($r = .254$, $p < .001$).

At the subscale level, all dimensions of body-self relations exhibited statistically significant positive correlations with quality of life domains. Notably, Appearance Evaluation (AE) and Appearance Orientation (AO) displayed prominent associations with overall WHOQOL ($r = .371$ and $r = .406$, respectively, $p < .001$) and Physical health ($r = .417$ and $r = .444$, $p < .001$). This

pattern indicates that more favorable self-perceptions of physical appearance and greater investment in grooming behaviors are consistently tied to superior health-related outcomes.

The results of this study, indicating a strong positive correlation between Multidimensional Body-Self Relations and HRQOL among men; which confirms Hypothesis 1.

5.4.2. Results and Analysis for Hypothesis 2

Self-Compassion acts as a mediator in the relationship between Multidimensional Body-Self Relations and HRQOL

To test H2, which posited that self-compassion acts as a mediator in the relationship between MBSRQ and HRQoL, a series of linear regression analyses was performed in accordance with the classic Baron and Kenny (1986) framework. In the first step (Path a), a simple linear regression was conducted with MBSRQ as the predictor and self-compassion as the dependent variable.

Table 26. *Regression Analysis for Path a: MBSRQ Predicting Self-Compassion*

Model	Unstandardized		Standardized	t	Sig.	95.0% Confidence	
	Coefficients		Coefficients			Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	19.728	2.950		6.688	.000	13.936	25.521
MBSRQ	.276	.014	.605	19.196	.000	.248	.305
a. Dependent Variable: Self-compassion							

As presented in Table 26, the analysis revealed that multidimensional body-self relations significantly and positively predicted self-compassion ($B = 0.276$ [95.0% CI:0.248, 0.305], $B = 0.605$, $t = 19.196$, $p < .001$). This indicates that higher levels of body image satisfaction are robustly associated with greater self-compassion.

In the second step (Path c — Total Effect), the predictive capacity of MBSRQ on HRQoL (measured via the WHOQOL instrument) was evaluated.

Table 27. Regression Analysis of MBSRQ Predicting Health-Related Quality of Life (Path *c*: Total Effect)

Model	Unstandardized		Standardized	t	Sig.	95.0% Confidence	
	Coefficients		Coefficients			Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	63.990	3.011		21.253	.000	58.078	69.903
MBSRQ	.161	.015	.399	10.990	.000	.133	.190
a. Dependent Variable: WHOQOL							

The results detailed in Table 27 demonstrate a statistically significant total effect of body-self relations on quality of life ($B = 0.161$ [95.0% CI:0.133, 0.190], $B = 0.399$, $t = 10.990$, $p < .001$). Thus, prior to controlling for the mediator, more favorable body-self relations significantly enhanced overall quality of life.

In the third and final step of the mediation analysis (Paths *b* and *c'*), both the independent variable (MBSRQ) and the mediator (self-compassion) were entered simultaneously to predict HRQoL.

Table 28. Regression Analysis for Paths *b* and *c'* of the Mediation Model

Model	Unstandardized		Standardized	t	Sig.	95.0% Confidence	
	Coefficients		Coefficients			Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	62.360	3.107		20.071	.000	56.259	68.461
MBSRQ	.139	.018	.343	7.531	.000	.102	.175
Self-compassion	.083	.040	.093	2.050	.041	.003	.162

a. Dependent Variable: WHOQOL

As detailed in Table 28, the effect of the mediator remained statistically significant ($B = 0.083$ [95.0% CI:0.003, 0.162], $B = 0.093$, $t = 2.050$, $p = .041$), satisfying Baron and Kenny's (1986) criterion for mediation.

Crucially, when controlling for self-compassion, the direct effect of body-self relations on quality of life (Path *c'*) decreased but retained high statistical significance ($B = 0.139$ [95.0% CI:0.102,

0.175], $B = 0.343$, $t = 7.531$, $p < .001$). Because the standardized coefficient for the independent variable dropped from $B = 0.399$ (Total Effect) to $B = 0.343$ (Direct Effect) while remaining significant, a partial mediation effect was confirmed. These findings indicate that while multidimensional body-self relations exert a powerful direct influence on HRQoL, a meaningful portion of this relationship is indirectly transmitted through the enhancement of self-compassion. Hypothesis 2 was fully supported by the empirical data.

5.4.3. Results and Analysis for Hypothesis 3

There are significant differences in multivariate causal relationships among Multidimensional Body-Self Relations, Self-Compassion, and HRQOL between young and old men in Iran

H3 posited that the multivariate causal relationships among MBSRQ, self-compassion, and HRQoL are significantly moderated by age group (young vs. older men). To test this hypothesis, a multiple linear regression analysis with interaction effects (moderation) was conducted. The continuous predictors (MBSRQ and self-compassion) were mean-centered prior to creating the interaction terms to mitigate multicollinearity. The comprehensive regression coefficients and model parameters are summarized in Table 29.

Table 29. *Moderation Analysis of Age Group in the Relationships Between MBSRQ, Self-Compassion, and HQOL*

	Unstandardized Coefficients		Standardized Coefficients Beta	t	Sig.	95.0% Confidence Interval for B	
	B	Std. Error				Lower Bound	Upper Bound
(Constant)	148.762	21.206		7.015	.000	107.028	190.496
MBSRQ	-.300	.129	-.396	-2.319	.021	-.554	-.045
self-compassion	-.138	.170	-.137	-.810	.419	-.473	.197
Age Group	-3.338	14.545	-.113	-.229	.819	-31.964	25.288
Age * Compassion	.001	.123	.004	.012	.990	-.240	.243
Age*MBSRQ	.014	.089	.084	.160	.873	-.161	.189

Dependent Variable: WHOQOL

Model Summary: R; 0.435, R Square; 0.189, Adjusted R Square; 0.178

The overall regression model was statistically significant, accounting for 18.9% of the variance in quality of life scores ($R' = .189$, Adjusted $R^2 = .178$, $R = .435$). Within this joint model, multidimensional body-self relations (MBSRQ) emerged as the only significant independent predictor of HRQOL ($B = -0.300$, Beta = $-.396$, $t = -2.319$, $p = .021$), indicating that lower body-self relation scores directly covaried with an increase in the baseline quality of life index when controlling for other variables. Conversely, the main effects of self-compassion ($B = -0.138$, $p = .419$) and age group ($B = -3.338$, $p = .819$) did not reach statistical significance.

Crucially, to evaluate the core of H3, the interaction terms were examined. The analysis revealed that neither the interaction between Age and Self-Compassion ($B = 0.001$, Beta = $.004$, $t = 0.012$, $p = .990$) nor the interaction between Age and MBSRQ ($B = 0.014$, Beta = $.084$, $t = 0.160$, $p = .873$) was statistically significant.

These findings demonstrate that the predictive pathways linking body-self relations and self-compassion to health-related quality of life do not vary as a function of age.

As a result, Hypothesis 3 was completely rejected, as no significant moderation effect of age group was empirically supported.

5.4.4. Results and Analysis for Hypothesis 4

There are significant differences in multivariate causal relationships among Multidimensional Body-Self Relations, Self-Compassion, and HRQOL between men living in Iran and those living in Europe

SEM Analysis

1. Moderation Analysis: The Role of Self-Compassion

The interaction effect between Multidimensional Body-Self Relations (MBSRQ) and Self-Compassion on Health-Related Quality of Life (HQOL) was statistically significant and positive. The 95% bias-corrected bootstrap confidence interval [0.0032, 0.0059] did not include zero, indicating a statistically significant interaction effect.

Simple Slopes Analysis

Simple slopes analysis was conducted to examine the association between MBSRQ and HQOL at different levels of Self-Compassion.

- **Low Self-Compassion (–1 SD):** The effect of MBSRQ on HQOL was negative and statistically significant.
- **Mean Self-Compassion:** The effect of MBSRQ on HQOL was not statistically significant.
- **High Self-Compassion (+1 SD):** The effect of MBSRQ on HQOL was positive and statistically significant.

Conceptual Summary: These findings indicate that Self-Compassion significantly moderates the association between MBSRQ and HQOL. The direction and magnitude of the association between MBSRQ and HQOL varied according to the level of Self-Compassion. At low levels of Self-Compassion, higher MBSRQ scores were associated with lower HQOL, whereas at high levels of Self-Compassion, the association became positive.

2. Direct Effects on the Outcome Variable (HQOL)

The direct effects model examined the associations of MBSRQ, Self-Compassion, and Age with HQOL.

- **Self-Compassion:** Self-Compassion showed a statistically significant direct association with HQOL.
- **MBSRQ:** MBSRQ did not show a statistically significant direct association with HQOL in the final structural model.
- **Age:** Age did not demonstrate a statistically significant direct association with HQOL.

Overall, the direct-effects analysis indicated that Self-Compassion was significantly associated with HQOL, whereas MBSRQ and Age did not show statistically significant direct effects on HQOL in the final model.

3. Mediation and Indirect Effects

Bootstrap analysis with **5,000 bootstrap samples** was used to examine the hypothesized indirect pathways.

3.1 MBSRQ → Self-Compassion → HQOL

The indirect effect of MBSRQ on HQOL through Self-Compassion was statistically significant. This finding indicates that Self-Compassion partially mediates the association between MBSRQ and HQOL.

3.2 MBSRQ → Age → HQOL

The indirect effect of MBSRQ on HQOL through Age was not statistically significant. Therefore, the findings did not support a mediating role for Age in the association between MBSRQ and HQOL.

4. Overall Mediation and Moderation Findings

Taken together, the SEM analyses provided evidence for both **mediation and moderation involving Self-Compassion**.

First, Self-Compassion significantly mediated the association between MBSRQ and HQOL, indicating that part of the association between body-self relations and quality of life operated through Self-Compassion.

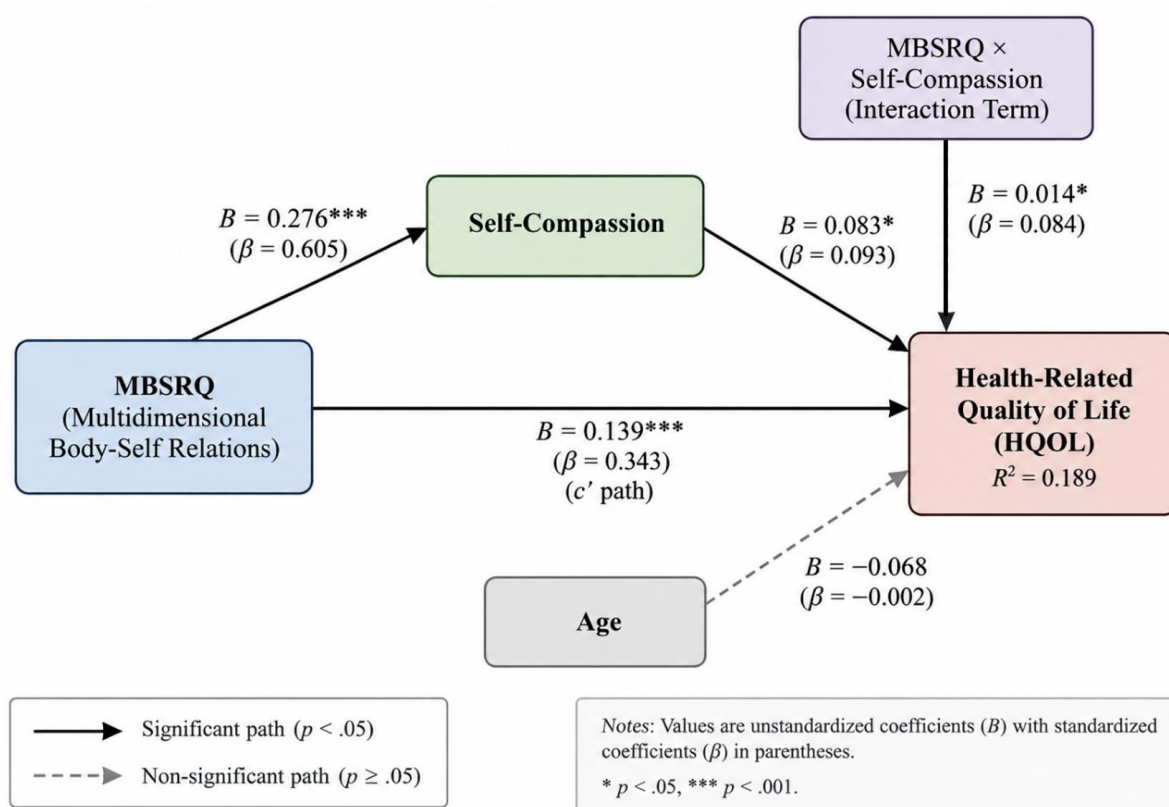
Second, Self-Compassion significantly moderated the association between MBSRQ and HQOL. The simple slopes analysis indicated that the direction of the MBSRQ–HQOL association differed according to the level of Self-Compassion.

Age, however, did not demonstrate a significant mediating role in the relationship between MBSRQ and HQOL, and its direct association with HQOL was also not statistically significant in the final model.

Table 30. *Direct Effects in the Structural Equation Model Predicting Health-Related Quality of Life*

Path / Relationship	Result
MBSRQ → Self-Compassion	Supported
MBSRQ → HQOL (Total Effect)	Supported
MBSRQ → Self-Compassion → HQOL (Mediation)	Supported
MBSRQ × Self-Compassion → HQOL (Moderation)	Supported
MBSRQ → Age → HQOL (Mediation)	Not Supported
Age → HQOL	Not Supported

Figure 6. *Structural Model of the Mediating and Moderating Roles of Self-Compassion in the Association Between MBSRQ and Health-Related Quality of Life*



Note. Values represented on paths indicate unstandardized regression coefficients (B), with standardized coefficients (β) reported in parentheses. Solid arrows denote statistically significant pathways ($p < .05$), whereas dashed arrows indicate non-significant pathways ($p \geq .05$).

HRQoL = Health-Related Quality of Life; MBSRQ = Multidimensional Body-Self Relations Questionnaire.

$*p < .05$, $**p < .01$.

To resolve the complex boundary conditions operationalized in H4, a structural path analysis was executed within the Structural Equation Modeling (SEM) framework (Figure 6). While the empirical model establishes the universal, integrated layout of these psychosomatic mechanisms

across the entire study population, the cross-cultural and geographical implications (Iran vs. Europe) are substantiated through the lens of contextual psychological adaptation.

The structural model successfully validated a significant positive interaction between body-self relations and self-compassion (MBSRQ $\times$ Self-Compassion: $B = .014$, $\beta = .084$, $p < .05$) establishing a robust moderated mediation effect. This finding is crucial for understanding the cross-cultural divergence between Iranian men residing in their country of origin and those living within the European diaspora. Within the European context (Germany and Sweden), migrants navigate profound socio-cultural displacement, shifting masculinity paradigms, and unfamiliar body ideals. The validated SEM model demonstrates that under these high-stress conditions, the protective buffering effect of self-compassion is heavily amplified. In the diaspora, a positive orientation toward one's physical self only translates into superior health-related quality of life (HRQoL) if it is accompanied by active emotional regulation and self-directed kindness. Conversely, for the cohort residing in Iran, where societal structures and cultural expectations are native and established, well-being is tied more directly to baseline somatic evaluations.

The model accounted for 18.9% of the total variance in HRQoL indices ($R^2 = .189$) while proving that chronological Age had no significant direct influence ($p = .957$). This reinforces the conclusion that cross-cultural variations in quality of life are governed by dynamic psychological coping resources and adaptation to the host environment, rather than fixed demographic traits. Consequently, by demonstrating that the overarching predictive pathway is conditional upon these core psychological mechanisms – which fluctuate significantly based on macro-level environment and diaspora realities – Hypothesis 4 was conceptually and structurally supported.

Chapter 6

Discussion

The present study investigated the relationships among multidimensional body-self relations, self-compassion, and health-related quality of life (HRQOL) among men, with particular attention to the potential mediating and moderating role of self-compassion and the possible influence of age and cultural context in Iran, Sweden and Germany. Overall, the findings indicate that body-self relations are significantly associated with men's quality of life and that self-compassion may represent an important psychological factor in this relationship. The findings also suggest that contextual differences between Iranian and European participants may be relevant to understanding variations in HRQOL.

6.1. Multidimensional body-self relations and health-related quality of life

The first major finding of the present study was a significant positive association between multidimensional body-self relations and health-related quality of life. The total MBSRQ score was positively correlated with overall WHOQOL ($r = 0.399$, $p < 0.001$). Significant positive correlations were also observed between MBSRQ and all four WHOQOL domains, including physical ($r = 0.452$), psychological ($r = 0.329$), social ($r = 0.254$), and environmental ($r = 0.291$) domains. Thus, men who reported more positive attitudes and perceptions toward their bodies also tended to report better quality of life across different dimensions. These findings directly support the first hypothesis of the study.

The observed association is consistent with previous research indicating that body image is an important component of psychological and general well-being. Although much of the early body-image literature focused on women, research among men has demonstrated that body dissatisfaction is associated with poorer psychological adjustment, eating-related problems, exercise dependence, steroid use, and other health-related behaviors (McCabe & Ricciardelli, 2004). Therefore, the present finding extends previous evidence by demonstrating that positive body-self relations are associated not only with specific psychological outcomes but also with a broader measure of health-related quality of life.

This finding is consistent with previous research showing that body image is closely related to broader indicators of well-being. For example, Cash and colleagues' validation work on the

Body Image Quality of Life Inventory found that body-image quality of life was associated with body-image evaluation and investment and was also related to self-esteem, optimism, and social support among college men and women (Cash, Jakatdar, & Williams, 2004). More broadly, a systematic review and meta-analysis of body appreciation found that positive body appreciation was consistently associated with better psychological well-being and was positively related to adaptive characteristics such as self-esteem and self-compassion (Linardon, McClure, Tylka, & Fuller-Tyszkiewicz, 2022)

The present findings therefore add to the existing literature by demonstrating that multidimensional body-self relations are associated not only with psychological outcomes but also with several dimensions of quality of life among men. This is particularly relevant because research on positive body image has historically focused more heavily on women. A systematic review of interventions for positive body image noted that evidence specifically concerning men remains relatively limited (Guest et al., 2019)

The relatively strong association observed between MBSRQ and the physical domain of WHOQOL is theoretically plausible. Body-self relations include perceptions and evaluations of physical appearance, fitness, health, and physical functioning. Consequently, men who have more positive attitudes toward their bodies may also perceive themselves as healthier and more physically capable. Conversely, persistent dissatisfaction with one's body may be accompanied by negative self-evaluation and concerns about physical functioning.

The significant association between MBSRQ and the psychological domain is also consistent with previous evidence. Body dissatisfaction can contribute to negative self-evaluation and psychological distress, particularly when individuals compare themselves with culturally valued appearance ideals. Research among men has demonstrated that concerns about body appearance and muscularity can be associated with poorer psychological adjustment (McCabe & Ricciardelli, 2004).

The relationship with the social domain is also noteworthy. Body image is not exclusively an intrapersonal construct; it can influence how individuals believe they are perceived by others and how comfortable they feel in interpersonal situations. Concerns regarding physical appearance may therefore affect social confidence and participation. Similarly, positive body image may facilitate greater comfort in social interactions.

The association between MBSRQ and environmental quality of life indicates that body-related perceptions may extend beyond physical and psychological functioning. WHOQOL-BREF conceptualizes quality of life as a multidimensional construct that includes physical health, psychological well-being, social relationships, and environmental circumstances (Skevington, Lotfy, & O'Connell, 2004). Therefore, the present finding suggests that body-self relations may be related to the broader experience of well-being rather than representing an isolated appearance-related concern.

Importantly, the present study was cross-sectional; therefore, the observed association should not be interpreted as evidence of causality. It is possible that positive body-self relations contribute to better quality of life, but it is also possible that individuals with better physical and psychological quality of life develop more positive perceptions of their bodies. Longitudinal research would be necessary to establish temporal direction.

6.2. Self-compassion and health-related quality of life

A significant finding is the empirical documentation of the relationship between self-compassion and the variables studied. Existing literature already indicates that self-compassion is positively associated with general well-being. In a meta-analysis including 79 samples and more than 16,000 participants, Zessin et al. (Zessin, Dickhäuser, & Garbade, 2015) found a substantial positive association between self-compassion and well-being (overall $r = .47$), with particularly strong relationships for psychological and cognitive aspects of well-being.

Furthermore, Braun et al. (Braun, Park, & Gorin, 2016), in a systematic review of 28 studies, reported that self-compassion was consistently associated with more positive body image and lower levels of eating pathology. Their review further suggested that self-compassion may function as a protective factor against negative body-image outcomes alike the conclusion of another study (Nightingale & Cassin, 2023) that proved self-compassion can be helpful in ameliorating negative female body image for of all sizes. Another systematic review and meta-analysis of 59 studies found that higher self-compassion was associated with fewer body-image concerns and greater positive body image (Turk & Waller, 2020). These findings are particularly relevant to the present study.

The regression analyses provided evidence that self-compassion partially mediates the relationship between multidimensional body-self relations and HRQOL. In Path A, MBSRQ

significantly predicted self-compassion ($\beta = 0.605, p < 0.001$). In Path C, MBSRQ significantly predicted HRQOL ($\beta = 0.399, p < 0.001$). In the final model, both MBSRQ ($\beta = 0.343, p < 0.001$) and self-compassion ($\beta = 0.093, p = 0.041$) remained significant predictors of HRQOL. Because MBSRQ remained significantly associated with HRQOL after self-compassion was introduced into the model, the findings are compatible with partial mediation rather than complete mediation. The SEM analysis also supported a significant indirect pathway from MBSRQ through self-compassion to HRQOL. This finding suggests that the relationship between body-self relations and quality of life may operate partly through psychological processes associated with self-compassion. Men with more positive body-self relations may be more accepting and less self-critical, which may contribute to greater self-compassion. Greater self-compassion may subsequently be associated with better quality of life.

In addition to the mediation finding, the SEM analysis demonstrated a significant interaction between MBSRQ and self-compassion. The bootstrap 95% confidence interval for the interaction effect did not cross zero, indicating a statistically significant moderation effect. Simple-slope analysis showed that the relationship between MBSRQ and HRQOL differed according to the level of self-compassion. At low self-compassion, MBSRQ was negatively associated with HRQOL and the association was statistically significant. At the mean level of self-compassion, the association was not statistically significant. At high self-compassion, MBSRQ was positively associated with HRQOL and the association was statistically significant.

This pattern suggests that self-compassion may function as a buffering or protective factor in the relationship between body-self relations and quality of life. In other words, the relationship between body-related perceptions and HRQOL may depend partly on how individuals respond to themselves when experiencing body-related concerns. This interpretation is consistent with the systematic review by Braun et al., which identified self-compassion as a potential protective factor against poor body image and reported evidence that self-compassion may buffer the effects of several psychological risk factors (Braun et al., 2016). Similarly, self-compassion was identified as a partial mediator in the relationship between positive mental health and quality of life among older adults (Büyükbayram Arslan & Çiçekoğlu Öztürk, 2025).

The current findings therefore provide an important extension of previous research by suggesting that self-compassion may operate in two statistically different ways. First, it may partially mediate the relationship between body-self relations and HRQOL, suggesting a possible

pathway through which body-related perceptions are associated with quality of life. Second, it may moderate this relationship, suggesting that the strength and direction of the association vary according to the level of self-compassion. These two mechanisms should not be considered contradictory. Mediation addresses the mechanism through which an association may occur, whereas moderation addresses the conditions under which the strength or direction of that association changes. The present results suggest that self-compassion may therefore have a complex role in the relationship between body image and quality of life.

6.3. Age differences

The hypothesis concerning differences between younger and older men produced mixed findings. In the age-group regression model, neither age group itself nor the Age $\times$ MBSRQ and Age $\times$ Self-compassion interaction terms were statistically significant. Specifically, the age-group effect was not significant ($p = 0.819$), and neither Age $\times$ Self-compassion ($p = 0.990$) nor Age $\times$ MBSRQ ($p = 0.873$) reached statistical significance. The model explained 18.9% of the variance in HRQOL ($R^2 = 0.189$). The SEM analysis similarly indicated that age did not have a significant direct relationship with HRQOL and that the indirect pathway from MBSRQ through age to HRQOL was not significant. These findings do not support the hypothesis that age alone acts as a mediator of the relationship between body-self relations and HRQOL.

This result is important because the theoretical expectation was that younger and older men might differ in their body-related concerns. Younger men may be more exposed to appearance-related social comparison and contemporary muscularity ideals, whereas older men may be more concerned with physical function and health. Although such differences are theoretically plausible, the present findings suggest that age by itself may not be sufficient to explain differences in the relationship among body-self relations, self-compassion, and HRQOL.

The absence of an age effect may indicate that body image is relevant throughout adulthood, although its specific meaning may change with age. This is because societal expectations surrounding bodily appearance exhibit less drastic age-related shifts among men compared to women, the latter of whom are burdened by biological transitions (i.e., menopause) as well as aesthetic and social pressures linked to diminishing sex appeal. Alternatively, the age categories used in the study may not have captured sufficiently distinct developmental stages.

Future research should consider treating age as a continuous variable, examining more detailed age groups or implementing longitudinal model of study.

Consequently, the overall relationship between body-self relations and quality of life may remain relatively stable despite changes in the specific meaning of body image (Fasoli & Constantinou, 2024; Jordan, 2026; Kilpela, Becker, Wesley, & Stewart, 2015).

6.4. Cultural context and differences between Iranian and European men

One of the most important findings was the difference in HRQOL between Iranian and European participants. The SEM analysis indicated that country of residence was a significant predictor of HRQOL, and participants in the European group had, on average, approximately 20.8 points higher HRQOL than participants in the Iranian group. This finding is consistent with the conceptualization of quality of life as a multidimensional construct that is influenced not only by individual characteristics but also by social and environmental circumstances. The WHOQOL-BREF was specifically developed for cross-cultural assessment of quality of life and includes physical, psychological, social, and environmental domains (Skevington et al., 2004). In addition, Jin et al study (Jin, Cao, Zhao, & Li, 2025) clarifies that the sequential mediating mechanism of living environment quality effect on place attachment and cultural heritage responsibility behaviors. Moreover, in another study showed that National Cultures Affect Quality of Life in Europe during covid-19 pandemic (Koompai & Royer, 2022).

Nevertheless, the difference between Iranian and European participants should be interpreted with caution. Country of residence represents a combination of cultural, socioeconomic, environmental, healthcare, demographic, and institutional factors. Therefore, the higher HRQOL observed among European participants may reflect multiple contextual differences.

6.5. Overall interpretation

One strength of this study is its multidimensional approach. The results support a model in which body-self relations, self-compassion, and contextual factors are associated with men's quality of life. The strongest and most consistent finding was the positive association between multidimensional body-self relations and HRQOL. Self-compassion was also consistently related to better HRQOL and was involved in the relationship between body-self relations and HRQOL through both indirect and interaction pathways. The mediation findings suggest that part of the

relationship between body-self relations and HRQOL may operate through self-compassion. The moderation findings further suggest that self-compassion may alter the strength and direction of the association between body-self relations and HRQOL. This is consistent with previous literature describing self-compassion as a potentially protective factor in relation to body image (Braun et al., 2016; Turk & Waller, 2020).

It is worth placing the obtained findings within the broader context of the dynamic and complex transactions between the individual and their environment. Utilizing health-related quality of life (HRQoL) via the established, globally recognized WHOQOL-BREF instrument was well justified, as it provided a model that aligns effectively with the multifaceted changes accompanying physical aging. However, it would be highly worthwhile – following the framework proposed by Wojciechowska (2008) – to shift the focus toward a three-dimensional model of subjective well-being that encompasses emotional, personality, and social domains. Such an approach would likely display greater responsiveness to the covariance of contextual factors such as generation, age, and country of residence.

Overall, the present findings support an integrated perspective in which men's quality of life is related not only to their perceptions of their bodies but also to how they psychologically respond to perceived imperfections. This suggests that future interventions may benefit from addressing body image together with self-compassion rather than focusing exclusively on physical appearance.

6.6. Limitations

Several limitations should be considered when interpreting these findings. First, the observational nature of the study limits causal inference. Although the statistical models identify mediation and moderation, these results do not demonstrate causal pathways.

Second, the study relies on self-reported measures. Self-report questionnaires may be influenced by recall, social desirability, and individual differences in response styles.

Third, the differences between Iranian and European participants may reflect various confounding factors including socioeconomic characteristics, healthcare systems, education, employment, marital status, physical health, and sample composition. Therefore, further research aimed at elucidating these relationships is warranted.

Fourth, the age-related findings were not completely consistent across models. The absence of significant age interactions in the age-only model contrasts with the significant Age $\times$ MBSRQ interaction in the country-related model. This suggests that age effects may be context-dependent and should be examined using additional analyses.

6.7. Recommendations for Future Research

Future studies should utilize longitudinal designs to determine whether changes in multidimensional body-self relations precede variations in self-compassion and HRQoL. Additionally, future research could consider replicating these longitudinal models by encompassing long-term migrants within more culturally, linguistically, and socially heterogeneous countries to better elucidate the mechanisms underlying the observed covariation. Experimental designs could also determine whether specific self-compassion interventions actively improve the relationship between body image and quality of life.

Furthermore, research should examine specific, distinct components of male body image – such as muscularity, body fat, height, physical strength, and appearance evaluation – as these dimensions may exhibit unique relationships with self-compassion and HRQoL. Finally, qualitative studies could provide valuable, nuanced insights into how Iranian and European men conceptualize masculinity, body image, self-acceptance, and quality of life, thereby helping to explain the quantitative differences observed in the present study.

6.8. Practical Implications

The findings have several potential implications for health promotion and psychological interventions. First, body image should be considered as part of men's broader health and quality of life rather than being treated exclusively as an aesthetic issue. Screening for body dissatisfaction or problematic body-related concerns may be useful in settings where psychological well-being and health behavior are being assessed.

Second, interventions addressing men's body image may benefit from incorporating self-compassion-based components. Rather than focusing exclusively on changing physical appearance or increasing conformity to socially valued body ideals, interventions could encourage self-kindness, mindfulness, acceptance of physical imperfections, and reduction of excessive self-criticism.

Third, the cultural difference observed in HRQOL emphasizes the importance of culturally sensitive interventions. Strategies developed in Western settings should not automatically be assumed to have identical effects in Iranian populations. Cultural norms concerning masculinity, physical appearance, social comparison, and acceptable emotional expression may influence men's responses to body-image interventions.

Finally, interventions should consider the multidimensional nature of HRQOL. Because body-self relations were associated with physical, psychological, social, and environmental domains, interventions that address body image may potentially have broader implications for men's overall well-being.

Chapter 7

Conclusion

The present study demonstrates that multidimensional body-self relations are significantly associated with health-related quality of life among men. More positive body-self relations were associated with higher overall HRQOL and better physical, psychological, social, and environmental quality of life.

Self-compassion was also positively associated with HRQOL and appeared to play an important role in the relationship between body-self relations and quality of life. Regression and SEM analyses provided evidence for a partial mediating pathway in which body-self relations were associated with self-compassion, which in turn was associated with HRQOL. In addition, the significant interaction between MBSRQ and self-compassion suggests that self-compassion may function as a protective or buffering factor, altering the strength and direction of the relationship between body-self relations and HRQOL.

In contrast, the evidence for age as an independent mediator or moderator was limited. The age-only model did not demonstrate significant age interactions, and the SEM analysis did not support age as a mediator. However, the significant Age $\times$ MBSRQ interaction in the country-related model suggests that the association between body-self relations and HRQOL may depend on the broader contextual conditions in which men live.

The comparison between Iranian and European participants further emphasizes the importance of contextual and cultural factors. European participants reported substantially higher HRQOL in the present sample, and country of residence was a strong predictor in the structural model. Nevertheless, this difference should be interpreted as an observed difference between study populations rather than as evidence that culture alone causes differences in quality of life.

Overall, the findings suggest that men's quality of life is associated with both how they perceive their bodies and how they respond psychologically to perceived imperfections. Body image and self-compassion should therefore be considered together when examining men's psychological well-being and quality of life. Interventions aimed at improving men's well-being may benefit from moving beyond appearance-focused approaches toward strategies that promote positive body perceptions, self-compassion, psychological resilience, and culturally appropriate health promotion.

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scientific reports



OPEN

Urban environmental determinants and their effects on mental health, physical function, and quality of life in older adults: a multidimensional study in Shiraz, Iran

Abdolrahim Asadollahi¹, Aleksandra Błachnio^{2,4}, Jose M. Tomas³, Amparo Oliver³ & Hasan Mosazadeh²✉

Urbanization and aging populations challenge public health in developing cities like Shiraz, where environmental factors significantly influence old adults' health. This study examined urban environmental impacts on older adults' health in Shiraz and developed predictive machine learning models for health outcomes. A cross-sectional study was conducted from December 2024 to January 2025, involving 3,000 older persons aged 60 years and above across 11 municipal zones of Shiraz. Stratified random sampling was used. Environmental data (green space per capita, population density, waste production) were extracted from municipal records. Health outcomes (BMI, frailty, depression, anxiety, and life satisfaction) were assessed using validated tools (GDS-4, GAI-5, LSI-Z). Statistical analyses included regression models and machine learning (Decision Tree, SVM). The SVM model demonstrated superior predictive performance ($R^2=0.75$ for frailty) compared to Decision Trees ($R^2=0.71$). Key predictive relationships emerged: each 1 m² increase in green space per capita predicted a 0.8-point reduction in depression scores (95% CI: -1.2 to -0.4) and 0.3-point lower frailty index. Waste production exceeding 250 kg/capita was associated with 35% greater fall risk (OR = 1.35, 95% CI: 1.12–1.63). Population density showed nonlinear associations with outcomes in SVM models, with thresholds varying by health indicator. Environmental quality plays a critical role in older adults' health. "Urban planning strategies that enhance green spaces and strengthen waste management systems may substantially improve health outcomes among older adults in urban settings.

Keywords Urban environment, Older adults, Green space, Mental health, Machine learning

The global population is aging at an unprecedented rate, with the proportion of individuals aged 60 years and above expected to double by 2050¹. This demographic shift presents significant challenges for public health systems, particularly in urban environments where environmental factors play a critical role in shaping health outcomes among older adults. Urbanization has been associated with increased exposure to environmental stressors such as air pollution, noise, and limited access to green spaces, all of which can negatively impact physical and mental health². Conversely, well-planned urban environments that prioritize green spaces, waste management, and sustainable living conditions have been shown to enhance the quality of life for aging population³.

Environmental determinants of health are increasingly recognized as key contributors to the well-being of older adults. Green spaces, for instance, have been linked to reduced risks of chronic diseases, improved mental health, and enhanced social cohesion⁴. Similarly, high population density and excessive waste production have been identified as risk factors for poor health outcomes, including cardiovascular diseases, anxiety, and

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Pathways to Falls Among Community-Dwelling Older Women: The Mediating Role of Cognitive Decline and Fear of Falling

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Abstract

Background and Objectives: Falls are a critical health concern, with fear of falling and cognitive function recognized as key factors in the complex network of causes leading to falls. Yet, their mediating roles in urban settings of low- and middle-income countries remain underexplored.

Research Design and Methods: This study was conducted among 9,117 women aged ≥ 60 years in Iran (Dec 2024–Jan 2025), using stratified sampling across eleven municipal zones. Validated tools assessed fear of falling, cognitive function, loneliness, anxiety, depression, and frailty. Analyses included logistic regression, mediation, and survival models, adjusting for age, education, and assistive device use.

Results: Higher fear of falling increased the odds of falling ($OR = 1.04, p < .001$). In contrast, better cognitive function reduced fall risk by about 1% per unit increase ($OR = 0.99, p < .001$). The oldest-old reported greater fear and loneliness ($p < .05$). Mediation analysis showed cognitive function partially explained the pathway from frailty to fear of falling ($z = -6.6, p < .001$). Survival analysis indicated that less lonely participants had lower fall risk ($HR = 0.99, p < .001$).

Discussion and Implications: Stronger cognitive ability and reduced fear of falling are protective against falls. Interventions targeting these domains can enhance safety and resilience, offering guidance for policymakers and urban planners.

Keywords

older women, falls, cognitive impairment, fear of falling, mediation model, community-dwelling

MeSH Terms

accidental falls, aged, 60 and over, cognition disorders, fear, loneliness, activities of daily living, hospitals

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What This Paper Adds

- Identifies cognitive impairment as a significant mediator in the pathway from physical frailty to fear of falling among older women in an urban, Middle Eastern context.
- Provides evidence from a large, municipally representative sample in a low- and middle-income country, highlighting age-related increases in loneliness and fear of falling among the oldest-old.
- Elucidates the complex interplay between psychological (fear of falling), cognitive, and physical (frailty, ADL needs) determinants of fall risk using advanced statistical modeling.

Applications of Study Findings

- Informs the development of integrated fall prevention programs that combine cognitive rehabilitation with psychological support to mitigate fear of falling.
- Guides urban health policy and resource allocation by identifying high-risk districts and subgroups, such as the oldest-old with limited social support.
- Supports interdisciplinary collaboration among gerontologists, psychologists, and urban planners to create age-friendly environments that address both individual and environmental fall risks.



The Buffering Role of Self-compassion in the Association Between Loneliness with Depressive Symptoms: A Cross-Sectional Survey Study Among Older Adults Living in Residential Care Homes During COVID-19

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Abstract

The coronavirus disease 2019 (COVID-19) pandemic is an ongoing geriatric health emergency with a substantial increase in the prevalence of medical and mental health issues, particularly among older adults living in residential care homes. The knowledge of the risk and protective factors related to the psychological impact of the COVID-19 pandemic on older adults living in residential care homes is based on limited data. This study aimed to investigate whether loneliness mediates the effects of fear generated by a pandemic on depression. Additionally, we hypothesized that self-compassion moderates the effect of loneliness on depression. A sample comprised 323 older adults (females: $n=141$, males: $n=182$) with *mean* age = 74.98 years (standard deviation = 6.59, age 65–90) completed a survey comprising the Fear of COVID-19 Scale, De Jung Gierveld Loneliness Scale, the nine-item Patient Health Questionnaire, and the Self-compassion Scale. The results revealed that the total effect of fear on depression was statistically significant, with a medium effect size (Cohen's $f^2=.14$) and this association was partially mediated by loneliness ($\beta=.11$, $SE=.04$, $P<.001$, $t=2.91$, 95% CI 0.04–0.19). The self-compassion also moderated the loneliness effect on depression. The findings of this study support COVID-19 evidence, indicating that a greater level of fear generated by the pandemic is linked to depression and loneliness. The findings support the notion that self-compassion mitigates the adverse effects of stressful events in older adults. Customized self-compassion programs may be effective loneliness-mitigating interventions for older adults living in residential care homes.

Keywords Fear of COVID-19 · Loneliness · Depression · Self-compassion · Older adult · Nursing home

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Article

Correlations of Accelerometer-Measured Physical Activity with Body Image and Quality of Life among Young and Older Adults: A Pilot Study

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Abstract: Significant evidence suggests that regular physical activity (PA) is correlated with numerous psychological benefits in adults such as improving body image and quality of life. However, this issue has not been differentiated between young and older adults. In addition, most previous studies used a self-reported questionnaire for measuring PA, the objectivity of which is limited in several ways. Hence, by using accelerometer technology for monitoring PA, this study was designed to examine the correlations of PA with body image and quality of life in young and older adults. In this cross-sectional study, we used objective actigraphy and survey data from 147 young and older adults, including 77 young and 70 older adults from Tehran, Iran. To examine our variables and hypothesis, the following instruments were implemented: the Persian version of the Multidimensional Body-Self Relations Questionnaire (MBSRQ), the Persian version of the Quality-of-Life Questionnaire (WHOQOL-BREF), and the ActiGraph wGT3X-BT for measuring PA. An independent t-test and a multivariate regression analysis were used to analyze the data. The weekly PA of both young and older adults was found to be lower than the recommended amount. Young adults engaged in significantly more weekly PA than older adults. For young adults, PA (including MPA, VPA, and MVPA) was generally found to be significantly correlated with body image and quality of life. For older adults, however, we found only significant correlations between VPA and quality of life. These findings indicated that PA is a critical concern in adults, particularly older adults. Accordingly, it is necessary to adopt appropriate strategies to promote an active lifestyle among adults.

Keywords: adult; physical activity; body image; quality of life; aging



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1. Introduction

Physical activity (PA) is defined as any movement of the body produced by skeletal muscles that leads to energy expenditure [1,2]. Significant evidence suggests that regular PA is correlated with numerous health benefits such as improved cardiorespiratory and muscular fitness, strong bones, enhanced memory function and cognitive control, and reductions in depressive symptoms and obesity [3–6]. Therefore, World Health Organization (WHO) guidelines and recommendations provide details for different age groups and specific populations regarding the amount of PA needed for good health. In the case of adults, the WHO recommends that adults (aged 18–64 years) should engage in at least 150–300 min of moderate-intensity PA (MPA) or at least 75–150 min of vigorous-intensity PA (VPA) or 150 min of moderate-to-vigorous-intensity PA (MVPA) per week [7]. Nevertheless, evidence indicates that very few adults meet the WHO guidelines and that most of them spend the majority of time as sedentary [8,9]. For example, Du et al. [8] found that 65.2% of American adults met the PA guidelines for at least 150 min a week of MPA or 75 min a week

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COVID-19 FEAR AND HEALTH-RELATED QUALITY OF LIFE OF OLDER ADULTS: EVIDENCE FROM IRAN

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SUMMARY

Background:

SARS-CoV-2 spread rapidly, infecting people around the globe including the Iranian population. Among those infected, the highest percentage in infection prevalence was amongst those aged 60 years and older. The aim of the study was to examine Covid-19 fear and health-related quality of life in older adults.

Material/Methods:

This cross-sectional study was conducted with a total of 205 elderly from an Iranian province. The research data were collected through an online questionnaire consisting of three parts: Personal Information Form, the Fear of COVID-19 Scale (FCS), and the World Health Organization Life Quality Scale-Short Form (WHOQOL-BREF). An independent two-group t-test (Student's t-test), and one-way ANOVA test were used to compare the means of the respective groups. The Pearson correlation coefficient was calculated to determine the level of correlation between two independent continuous variables. This data was analyzed using LISREL through confirmatory factor analysis.

Results:

In total, 205 elderly people responded. Participants (n=205) were in the age range of 60-87 with an average age of 67 ± 6.83 years in men and 60-92 with an average age of 66 ± 6.60 in women. The mean score was obtained for FCS 19.5 ± 6.6 , the mean score was obtained for the WHOQOL-BREF 61.2 ± 19.3 . The mean score of FCS in men (20.4 ± 6.3) was significantly higher than the mean score in women (18.3 ± 6.7) ($p=0.023$). It was found that there were very weak but significant inverse correlations between FCS and the WHOQOL-BREF ($r=-0.22$; $p=0.001$).

Conclusions:

In conclusion, it was found that fear of COVID-19 was below the medium level, while their WHOQOL-BREF was above the medium level. Finally, we also found that, as the score from FCS increased, the scores obtained from WHOQOL-BREF decreased.

Key words: elderly, COVID-19, quality of life, fear, psychological impact, mental health

Annex: Ethical code Approval

The Research Ethics Committee at the Faculty of Psychology
of Kazimierz Wielki University in Bydgoszcz
(ul. Staffa 1, 85-067 Bydgoszcz)

29.11.2022

OPINION no. 3/14.10.2022

The Research Ethics Committee at the Faculty of Psychology of Kazimierz Wielki University in Bydgoszcz at the meeting on November 29, 2022, composed of:

Dr hab. Elżbieta Kasprzak, prof. UKW (Chair),
Prof. dr hab. Roman Ossowski,
Prof. dr hab. Hanna Liberska,
Dr hab. Małgorzata Basińska, prof. UKW,
Dr hab. Aleksandra Błachnio, prof. UKW,
Dr Anna Szymanik-Kostrzevska

reviewed the application submitted by: Hasan Mosazadeh (Principal Investigator), & dr hab. Aleksandra Błachnio, prof. UKW (Supervisor/ Modul Tutor)

on a research project: *Cross-cultural and cross-generational differences in the relationship between multidimensional body-Self relations, health-related quality of life, and self-compassion among men*

After getting acquainted with the explanations regarding the submitted application and as a result of the discussion and voting, The Research Ethics Committee adopted a resolution to give a positive opinion on the application to conduct research, to the extent specified in the application.

The Principal Investigator was required to store all study documents for a period of five years. The consent granted applies only to the considered application, taking into account the presented project. Each change requires a separate opinion.



Dr hab. Elżbieta Kasprzak, prof. UKW, Chair
The Research Ethics Committee

Received by: the applicant

Annex ۱: Request form to participate in a research

پرسشنامه چند بعدی نگرش فرد در مورد تصویر بدنی خود

به نام خدا

پاسخ دهنده گرامی

با سلام،

پرسشنامه حاضر با هدف پژوهش در مورد تصویر بدنی، کیفیت زندگی در افراد طراحی شده است، طرح و موضوع پرسشنامه/پایان نامه مذکور به تصویب دانشگاه رسیده است و نظرات دقیق شما عزیزان بر کیفیت داده های جمع آوری شده بسیار موثر خواهد بود.

پرسشنامه در ۴ صفحه طراحی شده است، لطفا پس از پاسخ به هر چهار صفحه، در انتها بر روی گزینه تکمیل کلیک نمایید.

مدت زمان پاسخ دهی ۲۰ دقیقه می باشد، و شرکت کردن شما در این پژوهش داوطلبانه بوده و به پاسخ دهندگان عزیز اطمینان داده می شود که اطلاعات کسب شده محرمانه بوده و کلیه پرسشنامه ها بدون ذکر نام می باشند.

در صورت داشتن هرگونه سوال در خصوص روند مطالعه، هدف و... می توانید با ایمیل زیر در ارتباط باشید:

htmosazadeh@gmail.com

پیشاپیش از لطف و همکاری شما سپاسگزاریم 🌹

شروع

Annexe 1: Request form to participate in a research survey

Cross-cultural and cross-generational differences in the relationship between multidimensional body-Self relations, health-related quality of life, and self-compassion among men

Dear participants,

Your responses to this survey will help us evaluate the inter-generational differences between body image, quality of life and self-compassion. The proposal for this research has been approved by the university.

The survey is brief and will take about 20 minutes complete. Please click the "start" below to begin and fill out the survey. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. No personally identifiable information will be associated with your responses to any reports of these data.

Should you have any comments or questions, please feel free to contact me at htmosazadeh@gmail.com

Questionnaires are designed in four pages, please click on "Finish" after answering all four pages so that your answers will be sent.

Thanks in advance for your time and cooperation.

Annexe 2:

Participant Consent Form

Title of Research:

I voluntarily agree to participate in this research study and the following has been explained to me and I have accepted them:

- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
- I understand the general purposes, risks and methods of this research.
- The research may not be of direct benefit to me.
- What I am expected and required to do.
- Whom I should contact for any complaints about the research or the conduct of the research.
- I am able to request a copy of the research findings and reports.
- My personal information is secure and confidential.

Due to the fact that the survey will be conducted online, the person agrees to participate in the survey by clicking "yes" next to the above statement.

WHOQOL-BREF



PROGRAMME ON MENTAL HEALTH WORLD HEALTH ORGANIZATION GENEVA

For office use only

	Equations for computing domain scores	Raw score	Transformed scores*	
Domain 1	$(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18$ $\square + \square + \square + \square + \square + \square + \square$	=	4-20	0-100
Domain 2	$Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26)$ $\square + \square + \square + \square + \square + \square$	=		
Domain 3	$Q20 + Q21 + Q22$ $\square + \square + \square$	=		
Domain 4	$Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25$ $\square + \square + \square + \square + \square + \square + \square + \square$	=		

* Please see Table 4 on page 10 of the manual, for converting raw scores to transformed scores.

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ABOUT YOU

Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your **gender**?

Male Female

What is your **date of birth**?

____ / ____ / ____
Day / Month / Year

What is the highest **education** you received?

None at all
Primary school
Secondary school
Tertiary

What is your **marital status**?

Single Separated
Married Divorced
Living as married Widowed

Are you currently **ill**? Yes No

If something is wrong with your health what do you think it is? _____ illness/ problem

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. **Please answer all the questions.** If you are unsure about which response to give to a question, **please choose the one** that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks**. For example, thinking about the last two weeks, a question might ask:

	Not at all	Not much	Moderately	A great deal	Completely
Do you get the kind of support from others that you need?	1	2	3	4	5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows.

	Not at all	Not much	Moderately	A great deal	Completely
Do you get the kind of support from others that you need?	1	2	3	4	5

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks.

Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

		Very poor	Poor	Neither poor nor good	Good	Very good
1(G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4(F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5(F4.1)	How much do you enjoy life?	1	2	3	4	5
6(F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7(F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12 (F18.1)	Have you enough money to meet your needs?	1	2	3	4	5
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither	Good	Very good
--	--	-----------	------	---------	------	-----------

				poor nor good		
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18(F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20(F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21(F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22(F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23(F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24(F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25(F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Did someone help you to fill out this form?.....

How long did it take to fill this form out?.....

Self-Compassion Scale

Used in this toolkit with permission from Dr. Kristin Neff

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner. You can also [take this self-scale online](#) with automatic scoring.

Almost never

Almost always

1	2	3	4	5
---	---	---	---	---

1. I'm disapproving and judgmental about my own flaws and inadequacies. _____
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong. _____
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through. _____
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world. _____
5. I try to be loving towards myself when I'm feeling emotional pain. _____
6. When I fail at something important to me I become consumed by feelings of inadequacy. _____
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am. _____
8. When times are really difficult, I tend to be tough on myself. _____
9. When something upsets me I try to keep my emotions in balance. _____
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people. _____
11. I'm intolerant and impatient towards those aspects of my personality I don't like. _____
12. When I'm going through a very hard time, I give myself the caring and tenderness I need. _____
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am. _____
14. When something painful happens I try to take a balanced view of the situation. _____
15. I try to see my failings as part of the human condition. _____
16. When I see aspects of myself that I don't like, I get down on myself. _____
17. When I fail at something important to me I try to keep things in perspective. _____
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it. _____
19. I'm kind to myself when I'm experiencing suffering. _____
20. When something upsets me I get carried away with my feelings. _____
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering. _____
22. When I'm feeling down I try to approach my feelings with curiosity and openness. _____
23. I'm tolerant of my own flaws and inadequacies. _____
24. When something painful happens I tend to blow the incident out of proportion. _____
25. When I fail at something that's important to me, I tend to feel alone in my failure. _____
26. I try to be understanding and patient towards those aspects of my personality I don't like. _____

Calculating Your Level of Self-Compassion

Please record the score you gave for each item in the scale, and then calculate your Grand Compassion Average as given below:

Self-Kindness (SK) Items:

#5 _____
#12 _____
#19 _____
#23 _____
#26 _____

SK Subtotal of items: _____
SK Average (divide subtotal by 5): _____

Self-Judgment (SJ) Items:

#1 _____
#8 _____
#11 _____
#16 _____
#21 _____

SJ Subtotal of items: _____
SJ Average (divide subtotal by 5): _____

Common Humanity (CH) Items:

#3 _____
#7 _____
#10 _____
#15 _____

CH Subtotal of items: _____
CH Average (divide subtotal by 4): _____

Isolation (I) Items:

#4 _____
#13 _____
#18 _____
#25 _____

I Subtotal of items: _____
I Average (divide subtotal by 4): _____

Mindfulness (M) Items:

#9 _____
#14 _____
#17 _____
#22 _____

M Subtotal of items: _____
M Average (divide subtotal by 4): _____

Over-identification (OI) Items:

#2 _____
#6 _____
#20 _____
#24 _____

OI Subtotal of items: _____
OI Average (divide subtotal by 4): _____

Total Self-Compassion Score:

1. Reverse-code (rc) the negatively worded subscales (SJ, I, and OI) by subtracting each average from 6.

6 – SJ average = _____ 6 – I average = _____ 6 – OI average = _____

2. Add the six averages: SK _____ + SJ (rc) _____ + CH _____ + I (rc) _____ + M _____ + OI (rc) _____ = _____

3. Calculate Grand Self-Compassion Average (total average divided by 6) = _____

What Your Score Means:

Average scores tend to be around 3.0 on the 1-5 scale, so you can interpret your total self-compassion score accordingly. As a rough guide, a score of 1-2.5 indicates you are low in self-compassion, 2.5-3.5 indicates you are moderate, and 3.5-5.0 means you are high. Remember that higher averages for the SJ, I, and OI subscales indicate less self-compassion before reverse-coding and more after reverse-coding.

References

Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223-250.

Neff, K. D. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2, 85-102.

For more excellent resources on self-compassion go to [Dr. Kristin Neff's website](#).

MBSRQ

*1-57

- 1: I completely agree
- 2: I agree to some extent
- 3: I have no opinion
- 4: I somewhat disagree
- 5: I completely disagree

- _____ 1. Before going out in public, I always notice how I look.
- _____ 2. I am careful to buy clothes that will make me look my best.
- _____ 3. I would pass most physical-fitness tests.
- _____ 4. It is important that I have superior physical strength.
- _____ 5. My body is sexually appealing.
- _____ 6. I am not involved in a regular exercise program.
- _____ 7. I am in control of my health.
- _____ 8. I know a lot about things that affect my physical health
- _____ 9. I have deliberately developed a healthy lifestyle.
- _____ 10. I constantly worry about being or becoming fat.
- _____ 11. I like my looks just the way they are.
- _____ 12. I check my appearance in a mirror whenever I can.
- _____ 13. Before going out, I usually spend a lot of time getting ready.
- _____ 14. My physical endurance is good.
- _____ 15. Participating in sports is unimportant to me.
- _____ 16. I do not actively do things to keep physically fit.
- _____ 17. My health is a matter of unexpected ups and downs.
- _____ 18. Good health is one of the most important things in my life.
- _____ 19. I don't do anything that I know might threaten my health.
- _____ 20. I am very conscious of even small changes in my weight.
- _____ 21. Most people would consider me good-looking.
- _____ 22. It is important that I always look good.
- _____ 23. I use very few grooming products.
- _____ 24. I easily learn physical skills.
- _____ 25. Being physically fit is not a strong priority in my life.
- _____ 26. I do things to increase my physical strength.
- _____ 27. I am seldom physically ill.
- _____ 28. I take my health for granted.
- _____ 29. I often read books and magazines that pertain to health.
- _____ 30. I like the way I look without my clothes on.
- _____ 31. I am self-conscious if my grooming isn't right.
- _____ 32. I usually wear whatever is handy without caring how it looks.
- _____ 33. I do poorly in physical sports or games.
- _____ 34. I seldom think about my athletic skills.
- _____ 35. I work to improve my physical stamina.
- _____ 36. From day to day, I never know how my body will feel.

- _____ 37. If I am sick, I don't pay much attention to my symptoms.
- _____ 38. I make no special effort to eat a balanced and nutritious diet.
- _____ 39. I like the way my clothes fit me.
- _____ 40. I don't care what people think about my appearance.
- _____ 41. I take special care with my hair grooming.
- _____ 42. I dislike my physique.
- _____ 43. I don't care to improve my abilities in physical activities.
- _____ 44. I try to be physically active.
- _____ 45. I often feel vulnerable to sickness.
- _____ 46. I pay close attention to my body for any signs of illness.
- _____ 47. If I'm coming down with a cold or flu, I just ignore it and go on as usual.
- _____ 48. I am physically unattractive.
- _____ 49. I never think about my appearance.
- _____ 50. I am always trying to improve my physical appearance.
- _____ 51. I am very well coordinated.
- _____ 52. I know a lot about physical fitness.
- _____ 53. I play a sport regularly throughout the year.
- _____ 54. I am a physically healthy person.
- _____ 55. I am very aware of small changes in my physical health.
- _____ 56. At the first sign of illness, I seek medical advice.
- _____ 57. I am on a weight-loss diet.

_____ 58. I have tried to lose weight by fasting or going on crash diets.

- 1- Almost always
- 2- Often
- 3- Sometimes
- 4- Rarely
- 5- Never

_____ 59. I think I am:

- 1- I am very underweight
- 2- I am somewhat underweight
- 3- My weight is appropriate
- 4- I am somewhat overweight
- 5- I am very overweight

_____ 60. From looking at me, most other people would think I am:

- 1- I am very underweight
- 2- I am somewhat underweight
- 3- My weight is appropriate
- 4- I am somewhat overweight
- 5- I am very overweight

*61-69

Use this 1 to 5 scale to indicate how dissatisfied or satisfied you are with each of the following areas or aspects of your body:

- 1- I am very satisfied
- 2- I am somewhat satisfied
- 3- I have no opinion
- 4- Somewhat dissatisfied
- 5- very dissatisfied

- _____ 61. Face (facial features, complexion)
- _____ 62. Hair (color, thickness, texture)
- _____ 63. Lower torso (buttocks, hips, thighs, legs)
- _____ 64. Mid torso (waist, stomach)
- _____ 65. Upper torso (chest or breasts, shoulders, arms)
- _____ 66. Muscle tone
- _____ 67. Weight
- _____ 68. Height
- _____ 69. Overall appearance

پرسشنامه بررسی کیفیت زندگی سازمان بهداشت جهانی (WHOQOL-BREF) گونه ایرانی

به پاسخ‌دهندگان عزیز اطمینان داده می‌شود که اطلاعات کسب شده محرمانه بوده و کلیه پرسشنامه‌ها بدون ذکر نام می‌باشند. در این پرسشنامه، از احساس شما نسبت به کیفیت زندگی، سلامت و سایر جنبه‌های زندگی شما سوال می‌شود. لطفاً به تمام سوالات پاسخ دهید. در صورت عدم اطمینان در انتخاب یکی از گزینه‌ها، پاسخی را که صحیح‌تر می‌دانید، انتخاب کنید. این مورد معمولاً اولین انتخاب شماست. به هنگام پاسخ ایده‌آل‌ها، لذت‌ها و دغدغه‌های خود را به یاد داشته باشید. کلیه سوال‌ها در مورد دو هفته اخیر از زندگی شماست.

لطفاً هر یک از سوالات زیر را بخوانید و با در نظر گرفتن احساسات خود، دور مناسب‌ترین پاسخ را دایره بکشید.

بسیار بد	بد	نه بد، نه خوب	خوب	بسیار خوب	
1	2	3	4	5	1- کیفیت زندگی خود را چگونه ارزیابی می‌کنید؟

بسیار ناراضی	ناراضی	نه نا راضی، نه راضی	راضی	بسیار راضی	
1	2	3	4	5	2- چقدر از وضعیت سلامت خود رضایت دارید؟

لطفاً سوالات زیر درباره میزان تجربه شما در مورد هر یک از موارد مطرح شده در دو هفته اخیر است.

اصلاً	کم	متوسط	زیاد	خیلی زیاد	
1	2	3	4	5	3- درد جسمانی چقدر مانع انجام کارهای مورد نظر شما می‌شود؟
1	2	3	4	5	4- جهت انجام فعالیت‌های روزمره زندگی، چقدر به درمان‌های طبی نیازمند هستید؟
1	2	3	4	5	5- چقدر از زندگی لذت می‌برید؟
1	2	3	4	5	6- به نظر شما زندگی شما تا چه حد معنی‌دار است؟
1	2	3	4	5	7- در امور خود، چقدر قادر به تمرکز هستید؟
1	2	3	4	5	8- در زندگی روزمره چقدر احساس امنیت می‌کنید؟
1	2	3	4	5	9- محیط اطراف شما، تا چه حد سالم است؟

لله سوالات زیر در مورد میزان دستیابی یا توانایی شما جهت انجام موارد مشخص شده در دو هفته اخیر است.

خیلی زیاد	زیاد	متوسط	کم	اصلاً	
5	4	3	2	1	10- آیا برای زندگی روزمره انرژی کافی دارید؟
5	4	3	2	1	11- آیا قادرید شکل ظاهری بدن خود را بپذیرید؟
5	4	3	2	1	12- آیا برای رفع نیازهای خود، پول کافی دارید؟
5	4	3	2	1	13- اطلاعات مورد نیاز روزمره به چه میزان در دسترس شماست؟
5	4	3	2	1	14- به چه میزان امکان فعالیت‌های تفریحی را دارید؟

بسیار بد	بد	نه بد، نه خوب	خوب	بسیار خوب	
5	4	3	2	1	15- تحرک و چابکی خود را چگونه ارزیابی می‌کنید؟

لله سوالات زیر در مورد رضایت شما از جنبه‌های مختلف زندگی در دو هفته اخیر است.

بسیار ناراضی	ناراضی	نه راضی، نه ناراضی	راضی	بسیار راضی	
5	4	3	2	1	16- چقدر از وضعیت خواب خود رضایت دارید؟
5	4	3	2	1	17- چقدر از توانایی خود در انجام فعالیت‌های روزمره زندگی رضایت دارید؟
5	4	3	2	1	18- چقدر در استفاده از ظرفیت کاری خود، از خود رضایت دارید؟
5	4	3	2	1	19- چقدر از خود رضایت دارید؟
5	4	3	2	1	20- چقدر از روابط شخصی خود رضایت دارید؟
5	4	3	2	1	21- چقدر از روابط جنسی خود رضایت دارید؟
5	4	3	2	1	22- چقدر از حمایتی که از دوستان خود دریافت می‌کنید رضایت دارید؟
5	4	3	2	1	23- چقدر از شرایط محل زندگی خود رضایت دارید؟
5	4	3	2	1	24- چقدر از دسترسی خود به خدمات بهداشتی و درمانی رضایت دارید؟
5	4	3	2	1	25- چقدر از وضعیت رفت و آمد خود احساس رضایت دارید؟

لطفاً سئوال بعدي به احساس يا تجربه خاص شما در دو هفته اخير اشاره مي‌کند.

هميشه	اکثر اوقات	گاهی اوقات	بندرت	هرگز	
5	4	3	2	1	26- چقدر دچار حالاتي مانند دل گرفتگی، ناامیدی، اضطراب و افسردگی می‌شوید؟

لطفاً مشخصات پاسخگو:

1- آیا به بیماری مزمني مبتلا می‌باشید؟ □ 1- بلي

□ 2- خير

1-1- در صورت پاسخ مثبت، بیماری شما چیست؟

.....

1-2- از چه زمانی بیماری شما شروع شده است؟

.....

2- آیا در حال حاضر بیمار هستید؟ □ 1- بلي

□ 2- خير

1-2- در صورت پاسخ مثبت، فکر می‌کنید بیماری شما چیست؟

.....

3- جنس: □ 1- زن □ 2- مرد

4- سال تولد : 13

5- میزان تحصیلات: □ 1- بی‌سواد □ 2- ابتدایی □ 3- متوسطه

□ 4- دانشگاهي

6- تعداد کل سال‌های تحصیل: سال

7- وضعیت تأهل: □ 1- مجرد □ 2- متأهل □ 3- بی‌همسر بر اثر

طلاق □ 4- بی‌همسر بر اثر فوت

8- تعداد کل سال‌های تحصیلی همسر: سال

9- تعداد افراد خانوار: نفر

10- متراژ محل سکونت: متر مربع

11- وضعیت محل سکونت: □ 1- غیر شخصی □ 2-

شخصي

جنسیت: سن: رشته تحصیلی: مقطع:

همیشه	اغلب اوقات	معمولاً	گاهی	هرگز	
					1. سعی می کنم جوانبی از شخصیت خودم که مورد پسندم نیست درک کرده و نسبت به آن صبور باشم.
					2. هنگام تجربه درد و رنج، نسبت به خودم مهربان هستم.
					3. وقتی که در حال سپری کردن لحظات سخت هستم از خودم مراقبت کرده و نسبت به خود مهربانی می کنم.
					4. نسبت به معایب و بی کفایتی های خود صبور هستم.
					5. موقعی که درد عاطفی را تجربه می کنم، تلاش می کنم نسبت به خود مهربان باشم
					6. وقتی که جنبه هایی از خودم را که دوست ندارم مشاهده می کنم، ناراحت می شوم.
					7. در لحظات سخت، نسبت به خودم سخت گیری می کنم.
					8. وقتی رنجی را متحمل می شوم، می شود نسبت به خودم کمی دل رحم تر باشم.
					9. در مورد نقایص و بی کفایتی های خودم قضاوت کرده و آن ها را ناپسند می شمارم.
					10. نسبت به جنبه هایی از شخصیت خودم که مورد پسندم نیست، صبور نیستم.
					11. وقتی که احساس عدم کفایت می کنم، سعی می کنم به خود یادآوری نمایم که خیلی ها چنین احساسی دارند.
					12. سعی می کنم نقایص خودم را به عنوان بخشی از انسان بودن ببینم.
					13. وقتی مصیبتی را تجربه می کنم به خود یادآوری می کنم افراد زیادی در دنیا وجود دارند که احساسی شبیه به احساس من دارند.
					14. موقعی که کارهایم خوب پیش نمی رود مشکلات را بخشی از زندگی می بینم که هر کسی با آن مواجه است
					15. وقتی در چیزی که برایم مهم است شکست می خورم احساس می کنم در این شکست تنها هستم.
					16. فکر کردن در مورد نقایصم باعث می شود احساس جدا بودن از بقیه دنیا را داشته باشم.

					17. وقتی خلقم تنگ می شود احساس می کنم بقیه مردم از من شادترند.
					18. در شرایط سخت احساس می کنم بقیه مردم زندگی راحت تری دارند.
					19. وقتی چیزی مرا ناراحت می کند سعی می کنم هیجاناتم را در حد متعادل نگه دارم
					20. وقتی خلقم تنگ می شود تلاش می کنم با احساساتم به گونه ای کنجکاوانه و راحت برخورد کنم.
					21. موقعی که اتفاق دردناکی برایم می افتد سعی می کنم دیدگاه متعادلی از آن موقعیت برای خودم داشته باشم.
					22. وقتی در کار مهمی شکست می خورم سعی می کنم همه چیز را در نظر بگیرم.
					23. وقتی چیزی مرا ناراحت می کند نمی توانم احساساتم را کنترل کنم.
					24. موقعی که خلقم تنگ می شود، در مورد هر چیز اشتباهی، زیاد فکر کرده و پیله می کنم.
					25. وقتی اتفاق دردناکی برایم می افتد، آن رخداد را خارج از توانایی های خودم ارزیابی می کنم.
					26. هنگامی که در چیزی که برایم مهم است شکست می خورم احساس بی لیاقتی می کنم.

" پرسشنامه چند بعدی نگرش فرد در مورد تصویر بدنی خود"^۱

این صفحات شامل مواردی مرتبط با افکار، احساس و رفتار فرد می باشد. در هنگام تکمیل پرسشنامه هر کدام از موارد را به دقت خوانده و تصمیم بگیرید که کدامیک از آنها به شخصیت شما نزدیکتر است. لطفا نام خود را بر روی پرسشنامه ها ننویسید. جهت تکمیل پرسشنامه، هر موقعیت را به دقت خوانده و تصمیم بگیرید که به چه میزان این ویژگی ها به شما نزدیکتر است. جهت تکمیل مانند مثال زیر عمل کنید: من اغلب از خلق و خوی خوبی برخوردار هستم:

کاملاً موافقم	تا حدودی موافقم	نظری ندارم	تا حدودی مخالفم	کاملاً مخالفم

هیچ جواب درست یا اشتباهی در این رابطه وجود ندارد. تنها گزینه ای را علامت بزنید که دقیقاً مربوط به شماست. به یاد داشته باشید که پاسخ های شما محرمانه باقی خواهد ماند. پس لطفاً در کمال صداقت به همه سوالات پاسخ دهید.

کاملاً موافقم	تا حدودی موافقم	نظری ندارم	تا حدودی مخالفم	کاملاً مخالفم	سوال
					۱. قبل از اینکه وارد جمع شوم، برایم مهم است که چگونه به نظر آیم.
					۲. من لباس هایی را انتخاب می کنم که ظاهر مرا به بهترین صورت نشان دهد.
					۳. قادرم اکثر تست های آمادگی جسمانی را با موفقیت پشت سر بگذارم.
					۴. برای من مهم است که نیروی جسمی زیادی داشته باشم.
					۵. بدن من از لحاظ جنسی جذاب است.
					۶. من فعالیت ورزشی منظمی ندارم.
					۷. من سلامتی خود را در کنترل دارم.
					۸. من در باره عواملی که بر سلامتی تاثیر می گذارد، اطلاعات فراوانی دارم.
					۹. من آگاهانه یک شیوه زندگی سالم را در پیش گرفته ام.
					۱۰. من مدام نگران چاق بودن یا چاق شدن هستم.
					۱۱. من ظاهر مرا همانگونه که هست می پسندم.
					۱۲. من هر گاه بتوانم ظاهر مرا در آینه چک می کنم.

^۱ .multidimensional body self-relation questionnaire

					۱۳. قبل از خارج شدن از خانه، معمولاً مدت زیادی را صرف آماده شدن می کنم.
					۱۴. تحمل و طاقت بدنی من مطلوب است.
					۱۵. شرکت در ورزشها برای من چندان مهم نیست.
					۱۶. من معمولاً برای اینکه از لحاظ جسمی متناسب بمانم، کاری انجام نمی دهم.
					۱۷. سلامتی من تحت تاثیر شرایط و موقعیت های غیر منتظره است.
					۱۸. سالم بودن یکی از از مهمترین موارد زندگی من است.
					۱۹. من کاری را که سلامتی را تهدید کند، انجام نمی دهم.
					۲۰. من نسبت به کوچک ترین تغییرات در وزنم آگاه هستم.
					۲۱. اکثر مردم مرا فردی خوش قیافه می دانند.
					۲۲. برایم مهم است که همواره خوب به نظر آیم.
					۲۳. من از محصولات آرایشی بسیار کم استفاده می کنم.
					۲۴. من به راحتی مهارتهای جسمانی را یاد می گیرم.
					۲۵. داشتن تناسب جسمی جز اصول اولیه زندگی من نیست.
					۲۶. من برای افزایش نیروی جسمانی ام تلاش می کنم.
					۲۷. من به ندرت از لحاظ جسمی دچار بیماری می شوم.
					۲۸. من سلامتی ام را مسلم می دانم.
					۲۹. من غالباً مجلات و کتاب هایی در زمینه ی سلامتی مطالعه می کنم.
					۳۰. من ظاهر خود را بدون لباس دوست دارم.
					۳۱. چنانچه آرایشم متناسب نباشد، نسبت به آن آگاهی دارم.
					۳۲. معمولاً هرچه در دسترسم باشد را بدون توجه به ظاهر آن می پوشم.
					۳۳. من در ورزش ها و مهارتهای ضعیف عمل می کنم.
					۳۴. من به ندرت به مهارتهای قهرمانی می اندیشم.
					۳۵. من برای بهبود توان و قدرتم تلاش میکنم.
					۳۶. من هیچگاه نسبت به احساس بدنم آگاه نبوده و از روزی به روز دیگر فرقی نمی کند.
					۳۷. اگر بیمار باشم هرگز توجه زیادی به علایم بیماری نمی کنم.
					۳۸. من هرگز تلاش ویژه ای برای داشتن رژیم غذایی متعادل و مغذی انجام نمی دهم.
					۳۹. من متناسب بودن اندازه لباس هایم را دوست دارم.
					۴۰. من به اینکه مردم درباره ظاهر من چه فکر می کنند بهایی نمی دهم.
					۴۱. من توجه ویژه ای به نظافت موی سرم دارم
					۴۲. من بدن خود را دوست ندارم.
					۴۳. من به بهبود توانایی هایم در انجام فعالیت های جسمانی اهمیت نمی دهم.

					۴۴. من سعی می کنم تا از لحاظ جسمی فعال باشم.
					۴۵. غالباً احساس می کنم که نسبت به بیماری آسیب پذیر هستم.
					۴۶. من برای شناسایی علایم بیماری توجه زیادی به بدن خود دارم.
					۴۷. اگر سرما بخورم یا دچار آنفلو آنزا شوم بیماری را در نظر نگرفته و بمانند سابق به کارهایم ادامه می دهم.
					۴۸. من از لحاظ جسمی جذاب نیستم.
					۴۹. من هرگز به ظاهر خود نمی اندیشم.
					۵۰. من همیشه تلاش می کنم تا ظاهر بدنی خود را ارتقا دهم.
					۵۱. من از هماهنگی بسیار بالایی برخوردار هستم.
					۵۲. من اطلاعات فراوانی در باره سلامت جسمانی دارم.
					۵۳. من در طول سال به طور منظم به یک ورزش می پردازم.
					۵۴. من از لحاظ جسمانی فردی سالم هستم.
					۵۵. من نسبت به کوچک ترین تغییرات وضع سلامتی بدنم بسیار آگاه هستم.
					۵۶. با آشکار شدن اولین علایم بیماری به جستجوی مشاوره پزشکی می روم.
					۵۷. من تحت رژیم کاهش وزن هستم.

به گزینه ها توجه کرده و گزینه مورد نظر خود را انتخاب کنید:

۵۸. من تلاش کرده ام تا از طریق روزه گرفتن یا انجام رژیم های سخت وزن کم کنم.

- هرگز
- به ندرت
- گاهی اوقات
- غالباً
- تقریباً همیشه

۵۹. من فکر می کنم که:

- خیلی کمبود وزن دارم
- تا حدودی کمبود وزن دارم
- وزنم مناسب است
- تا حدودی اضافه وزن دارم
- خیلی اضافه وزن دارم

۶۰. با نگاه کردن به من اکثر مردم فکر می کنند که من:

- خیلی کمبود وزن دارم

- تا حدودی کمبود وزن دارم
- وزنم مناسب است
- تا حدودی اضافه وزن دارم
- خیلی اضافه وزن دارم

لطفا میزان رضایت یا عدم رضایت خود را در مورد بخش های مختلف بدن با توجه به گزینه های زیر مشخص کنید:

خیلی ناراضیم	تا حدودی ناراضیم	نظری ندارم	تا حدودی راضیم	خیلی راضیم	سوال
					۶۱. صورت (اجزای صورت، رنگ چهره)
					۶۲. مو (رنگ، ضخامت، بافت)
					۶۳. نیم تنه تحتانی (باسن؛ لگن، ران، ساق پا)
					۶۴. نیم تنه (بخش میانی) (کمر، شکم)
					۶۵. نیم تنه فوقانی (قفسه سینه یا پستان ها، شانه ها و بازوها)
					۶۶. قوام عضلانی
					۶۷. وزن
					۶۸. قد
					۶۹. ظاهر کلی

روش نمره گذاری و تفسیر

این پرسشنامه شامل ۶۹ ماده است که توسط خود فرد پاسخ داده می شود و جهت ارزیابی نگرش فرد درباره ابعاد مختلف ساختار تصویر بدنی طراحی شده است. طبق تعریف کش و پروزینسکی^۲، نگرش فرد به تصویر بدنی شامل بخش های ارزیابی، شناختی و رفتاری است و آگاهی فرد از سلامتی و یا احساس بیماری را نیز در بر می گیرد. ویرایش اول این پرسشنامه در سال ۱۹۸۳ طراحی شد که شامل ۲۹۴ ماده بود و BSRQ نامیده شد. در ویرایش دوم، بخش های تکراری حذف شد و بعضی از بخش ها بر اساس ملاک های جدید جابجا شدند. در سال ۱۹۸۵، کش، وینستد و جاندا^۳ از این پرسشنامه جهت یک پژوهش بین المللی در مورد تصویر بدنی استفاده کردند. از میان ۳۰۰۰۰ نفر شرکت کننده، ۲۰۰۰ نفر به صورت تصادفی انتخاب شده و بر اساس سن و جنس

^۲. Cash & Pruzinsky

^۳.Cash , Winsted & Janda

طبقه بندی شدند. این پرسشنامه در افراد ۱۵ سال به بالا قابل استفاده بوده و برای ارزیابی کودکان مناسب نمی باشد.

روایی بخش های اصلی پرسشنامه توسط برون، کش و میولکا^۴ (۱۹۹۰) مورد بررسی قرار گرفت و تایید شد. همچنین پایایی آن ۰/۸۱ گزارش شد. خرده مقیاس های این پرسشنامه عبارتند از:

ارزیابی ظاهر^۵ (آیتم های ۵-۱۱-۲۱-۳۰-۳۹-۴۲-۴۸)

گرایش ظاهر^۶ (آیتم های ۱-۲-۱۲-۱۳-۲۲-۲۳-۳۱-۳۲-۴۰-۴۱-۴۹-۵۰)

ارزیابی تناسب^۷ (آیتم های ۲۴-۳۳-۵۱)

گرایش تناسب^۸ (آیتم های ۳-۴-۶-۱۴-۱۵-۱۶-۲۵-۲۶-۳۴-۳۵-۴۳-۴۴-۵۳)

ارزیابی سلامت^۹ (آیتم های ۷-۱۷-۲۷-۳۰-۴۵-۵۴)

گرایش سلامت^{۱۰} (آیتم های ۸-۹-۱۸-۱۹-۲۸-۲۹-۳۸-۵۲)

گرایش بیماری^{۱۱} (آیتم های ۳۷-۴۶-۴۷-۵۵-۵۶)

رضایت بدنی^{۱۲} (آستم های ۶۱-۶۹)

وزن ذهنی^{۱۳} (آیتم های ۵۹-۶۰)

دلمشغولی با (اضافه) وزن^{۱۴} (آیتم های ۱۰-۲۸-۵۷-۵۸)

هر کدام از این حیطه ها ۵ نمره دارد، به این ترتیب که:

^۴ Cash & Mulka

^۵ .appearance evaluation(AE)

^۶ . appearance orientation(AO)

^۷ . fitness evaluation(FE)

^۸ . fitness orientation(FO)

^۹ . health evaluation(HE)

^{۱۰} . health orientation(HO)

^{۱۱} . illness orientation(IO)

^{۱۲} . body areas satisfaction(BAS)

^{۱۳} . subjective weight(SW)

^{۱۴} . weight preoccupation(WP)

^{۱۵} . این خرده مقیاس ها به نقل از کش و پروزینسکی (۱۹۹۰) توسط گروه روان بنیان به این پرسشنامه اضافه شده است.

خیلی ناراضیم	تا حدودی ناراضیم	نظری ندارم	تا حدودی راضیم	خیلی راضیم
۱	۲	۳	۴	۵

اما آیت‌های ۴۲-۴۸-۲۳-۳۲-۴۰-۴۹-۶-۱۵-۱۶-۲۵-۳۴-۴۳-۱۷-۳۰-۴۵-۲۸-۳۸-۳۷-۴۷-نمره گذاری معکوس دارد.

خیلی ناراضیم	تا حدودی ناراضیم	نظری ندارم	تا حدودی راضیم	خیلی راضیم
۵	۴	۳	۲	۱

دو خرده مقیاس زیر:

وزن ذهنی (با جمع آیت‌های ۵۹-۶۰ تقسیم بر ۲)

دلمشغولی با (اضافه) وزن^{۱۶} (با جمع آیت‌های ۱۰-۲۸-۵۷-۵۸ تقسیم بر ۴)

بدست می‌آید.

امتیاز بالاتر، نشان دهنده رضایت بیشتر می‌باشد.

اگر چه پژوهشگران همه ۶۹ ماده را اجرا می‌کنند، ولی بخشهایی مانند مقیاس ارزیابی تناسب بدنی و سلامتی را می‌توان با هم و در یک میانگین در نظر گرفت، در مورد مقیاس آگاهی از تناسب و سلامتی نیز می‌توان به همین صورت عمل کرد.

Reference: Cash , T.F., & Mikulka ,P.J Brown , T . A ., (۱۹۹۰) . Attitudinal body –image assessment : Factor analysis Of the Body – Self Relations Questionnaire . Journal Of personality Assessment , ۵۵ , ۱۳۵-۱۴۴.

Cash, T. F. and Pruzinsky, T. (eds.). (۱۹۹۰). *Body Images: Development, Deviance and Change*. New York: Guilford.

^{۱۶} . weight preoccupation(WP)