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Development and Validation of the Body Neutrality Questionnaire

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ABSTRACT

Objective: Body neutrality has emerged as an alternative framework within the positive body image literature. This study developed the Body Neutrality Questionnaire (BNQ), the first validated measure of body neutrality for young adults.

Method: An initial item pool was developed using expert consultation and focus group review. This process resulted in 21 items which were administered online to young adults aged 18–25 years, 52.9% female ($N = 293$) in study 1, and to undergraduate psychology students aged 17–52 years, 82.2% female ($N = 231$) in study 2. Study 1 used exploratory factor analysis (EFA) to explore the structure of the construct, which was then examined using confirmatory factor analysis (CFA) in study 2.

Results: The EFA revealed a 12-item three-factor model: Self-Worth not Contingent on Body, Body Gratitude and Care, and Neutral Attitude toward Body, demonstrating good reliability and validity. This factor structure was replicated in the CFA, demonstrating good model fit, internal consistency and convergent validity, with the bifactor CFA model indicating the relevance of a single body neutrality factor. There was a strong, positive correlation between the BNQ and a measure of body appreciation.

Discussion: Findings provide support for the BNQ as a reliable and valid measure of body neutrality. These results represent an important first step in our ability to further our understanding of body neutrality, its conceptual similarities and differences to existing body image constructs, and its role in non-clinical samples. Future research should explore measurement invariance of the BNQ over time, in clinical samples, and for key demographic variables.

1 | Introduction

Body image is a multifaceted construct that includes body-related thoughts, feelings, perceptions and attitudes (Cash 2004). Negative body image (such as body dissatisfaction) and positive body image are conceptualized as related but distinct constructs, rather than simply representing opposite ends of a continuum (Tylka and Wood-Barcalow 2015a). Body dissatisfaction occurs when one experiences negative emotions and cognitions about their body, often as a result of it not aligning with an internalized ideal (McLean et al. 2022), and is an increased risk for disordered eating (Jiménez-Limas et al. 2022).

Various constructs have been postulated to promote healthier relationships with the body. These include positive body image, body positivity, and body neutrality. Positive body image is an overarching umbrella term which encompasses multiple constructs. This includes body appreciation (embracing, respecting, and valuing the body as it is), body image flexibility (the capacity to experience a range of body-related thoughts and feelings), functionality appreciation (valuing the body for its functions and what it can do), and body compassion (focusing on kindness to and understanding of the body; Tylka and Wood-Barcalow 2015a). Body positivity and body neutrality are often considered to be social movements (Wood-Barcalow et al. 2024),

with the former arising as early as the 1960s, connected with anti-fat activism by focusing on celebrating marginalized bodies (Mehdi and Frazieri 2021). However, social media posts using the hashtag body positivity have increasingly related to Western beauty ideals of thinness and are less representative of larger bodies and diverse cultural identities (Griffin et al. 2022; Lazuka et al. 2020). Furthermore, body positivity has also been co-opted by advertisers who increasingly have used it for commercial benefit (Rodgers et al. 2022). In the context of increasing criticisms of body positivity, body neutrality gained popularity from 2015 through social media. A website synthesis defined body neutrality as having three main components (Pellizzer and Wade 2023): (1) a neutral attitude (neither liking nor disliking) toward the body which is realistic, mindful, and flexible, (2) focusing on body functionality, appreciation, respect, and care, rather than appearance, and (3) self-worth influenced by a broad range of valued traits and skills without overreliance on appearance. Thus, while body neutrality emerged as a social movement, it is increasingly considered a body image construct.

Recent research has explored how body neutrality is understood across subgroups. Mulgrew and Hinz (2024) surveyed researchers, clinicians, individuals with lived experience of eating disorders, and members of the general community. Across groups, participants linked body neutrality with positive body image constructs such as functionality appreciation, body image flexibility, body acceptance, and body compassion. It was recognized as a "flexible coping strategy" for managing body image distress and perceived to be more achievable and inclusive than positive body image or body positivity (Mulgrew and Hinz 2024). Although drawing on existing psychological constructs, these findings support the growing view that body neutrality's unique construction, perceived achievability and inclusivity, and focus on decentring the importance of appearance, represents a meaningful contribution to the field.

There is debate in recent body image literature concerning whether body neutrality is a new construct, or just a repackaging of positive body image concepts without a strong empirical foundation (Wood-Barcalow et al. 2024). Body image expert Marika Tiggemann postulates that "positive body image and body neutrality are much more similar than different" however "they are not exactly the same" (Tiggemann 2024, 2). For instance, while both body neutrality and positive body image share overlapping aims, such as promoting inclusivity and reducing body shame, it has been suggested that their strategies and goals diverge meaningfully (Ladwig et al. 2024). Positive body image can include adaptive appearance investment (e.g., self-expression), whereas body neutrality de-emphasizes or sidelines appearance altogether (Tiggemann 2024). Although Wood-Barcalow et al. (2024) argue that positive body image is realistic and attainable (and hold concern that body neutrality discourages body flourishing), positive body image frameworks may not be equally attainable across all populations, for those with a lived experience of eating disorders, gender-diverse peoples, people living with chronic illness and/or disability, and members of the neurodivergent community.

A growing body of evidence supports the potential for body neutrality to improve one's relationship with their body. A case series of adolescents receiving eating disorder treatment found body neutrality content to contribute to the goals of reducing internalized weight stigma, appearance overvaluation, and supporting shifts in identity and self-worth (Kramer et al. 2025). Recent experimental research found that individuals exposed to body neutrality content on TikTok exhibited significantly higher levels of self-compassion than those who viewed thin-ideal or unrelated content (Seekis and Lawrence 2024). Similarly, text-based body neutrality content has been shown to reduce negative affect and body dissatisfaction (Ladwig et al. 2024). Qualitative research has highlighted how shifting focus from appearance to core body neutrality concepts in bodily comfort and functionality can affirm trans men's gender identity and support overall psychological well-being (Cahill et al. 2025). Body neutrality was further described as "meaningful to participants" (Cahill et al. 2025, 5), leading the authors to encourage continued exploration of body neutrality (and body functionality) as potentially beneficial for body image interventions, gender-affirming care, and psychosocial wellbeing (Cahill et al. 2025).

The aim of this research is to develop and validate the first measure of body neutrality, defined as holding a neutral attitude toward the body which is realistic, mindful, and flexible, focusing on appreciating, respecting, and caring for the functionality of the body, and developing self-worth that is not defined by appearance (Pellizzer and Wade 2023). Twenty-one items reflecting these dimensions were developed using an extensive approach including feedback from body image and eating disorder clinicians and researchers and young people. In study 1, these candidate items were included in exploratory factor analysis (EFA) to examine emergent factors and assess the reliability and validity of the BNQ. In study 2, confirmatory factor analysis (CFA) was conducted with an independent sample to replicate the factor structure and assess the reliability and validity of the BNQ. Conceptually, we see body neutrality as overlapping with and highly related to positive body image more broadly. However, body neutrality offers a unique perspective, particularly in de-centring and neutralizing the importance of appearance, which may be especially relevant for those with eating disorders. Thus, the present study is an important step forward in conceptualizing and measuring this construct.

2 | Method

2.1 | Questionnaire Development

The questionnaire development and evaluation were informed by best practice guidelines (Boateng et al. 2018). The project was approved by the Flinders University Human Research Ethics Committee (Project number 7506 and 8579).

2.1.1 | Item Development

To inform item development, we first pooled items from existing measures of mindfulness, functionality appreciation, and body image flexibility which were considered related to the three dimensions of body neutrality (Pellizzer and Wade 2023). Across three measures, the Comprehensive Inventory of Mindfulness Experiences (Johnson et al. 2017), Functionality Appreciation Scale (Alleva et al. 2017), and Body Image Acceptance and

Action Questionnaire (Sandoz et al. 2013), a total of 29 items (i.e., the sum total of all items from each questionnaire) were compiled for evaluation by experts.

Thirteen psychologists and/or researchers (PhD level minimum) with clinical experience or research focus in body image and/or eating disorders completed an online Qualtrics questionnaire. Following a two-page handout describing body neutrality, respondents were asked to rank how important each item (1 = *not at all important* to 5 = *very important*) was for the relevant body neutrality dimension. Experts provided feedback for revised wording and suggested new items. Guided by this feedback, the research team generated a new set of items, including uniquely worded items similar to those that were highly endorsed (average rating of 4 or above) and new items suggested by the experts. The components of body neutrality were also reviewed to ensure the item pool contained items covering each aspect of the proposed components, resulting in further generated items. All items were positively phrased to eliminate the need for reverse coding and clear expression was prioritized to ensure items were readily understandable to the target audience. This process resulted in a total of 60 new items that were considered to map onto the components of having a neutral attitude toward the body which is more realistic, mindful, and flexible ($n = 20$), focusing on body functionality, appreciation, respect, and care of the body rather than the body's appearance ($n = 17$), and self-worth that is influenced by a broad range of valued traits and skills without overreliance on appearance ($n = 23$).

These items were then evaluated by an in-person focus group ($N = 3$). Participants were Flinders University undergraduate students aged between 18 and 25 years. Participants were provided with the same body neutrality handout as previously provided to experts. Each domain of body neutrality was discussed as a group before participants independently ranked each item as to how important it was for the relevant component (1 = *not at all important* to 5 = *very important*). The average response (out of 5) from the focus group was generated for each item (an average rating of 3.67 or above was required as this is the midpoint from neutral to very important on the scale) in combination with qualitative feedback from participants. Although the focus group sample was small, it contributed important feedback regarding readability and clarity, as participants were representative of the intended population. Their input informed refinement of wording to ensure items were accessible, interpretable, and developmentally appropriate, complementing the more conceptual feedback by experts. The research team discussed possible revisions balancing the results from the focus group, effective coverage of the domain, inclusion of non-repetitive items and easily understood statements. This resulted in seven items for each domain (total $N = 21$ items).

2.2 | Study One

2.2.1 | Participants

The 21 items were administered to 293 participants, recruited via the online research platform Prolific. Inclusion criteria included being 18–25 years old and location was restricted to Australia, the United Kingdom, and the United States. Participants had a mean age of 22.04 years (SD = 2.05), more than half of the sample reported their biological sex as female (58.4%), gender identity as female (52.9%), and sexual orientation as heterosexual (69.3%). The most common cultural identity was coded as European/White (30.7%) and 21.5% of the sample responded yes to having a disability or chronic condition. See Table 1 for complete demographic information.

2.2.2 | Procedure and Measures

After viewing the study advertisement on Prolific, participants were re-directed to Qualtrics to access the information sheet. Once informed consent was provided, participants answered demographic questions and a battery of measures (for full details and psychometric information see Table 2) in addition to the 21-item Body Neutrality Questionnaire (BNQ). Demographic questions included age, biological sex, gender identity, sexuality, and cultural identity. Cultural identity was asked as an open-ended question to allow for wider variety of responses as participants were from Australia, America and the UK. We purposefully selected measures of positive body image, including the Body Appreciation Scale 2 (BAS-2; Tylka and Wood-Barcalow 2015a) and the Body Image Acceptance and Action Questionnaire (BI-AAQ; Sandoz et al. 2013) to assess convergent validity. In addition, we included measures of eating disorder psychopathology, mood, and related constructs such as self-compassion and self-objectification to further explore convergent and divergent validity in the context of our understanding of body neutrality (i.e., we expected a negative correlation with self-objectification and positive correlation with self-compassion). This included the Eating Disorder Examination Questionnaire 7-item short from (EDE-AQ7; Grilo et al. 2015), International Positive and Negative Affect Schedule Short Form (I-PANAS-SF; Thompson 2026), Objectified Body Consciousness—Surveillance subscale (OBC-S; McKinley and Hyde 1996), and the Self-Compassion Scale-Short Form (SCS-SF; Raes et al. 2011). Participants were reimbursed £3 (approximately AU$6) based on an estimated 30-min commitment consistent with Prolific reimbursement guidelines.

2.2.3 | Analyses

Factorability of items was assessed using the Kaiser-Meyer-Olkin (KMO) statistic and Barlett's test of sphericity. EFA was estimated using maximum likelihood estimation with robust standard errors (MLR) and oblique rotation to allow for mild violations to normality and correlated factors. Horn's parallel analysis was used to guide number of factors to extract, where the number of factors with eigenvalues exceeding those generated from random data are suggested, in combination with the comparative fit index (CFI ≥ 0.90), root mean-square error of approximation (RMSEA = 0.05–0.08), the standardized root mean-square residual (SRMR = 0.05–0.08), and factor interpretability. Items were considered for exclusion if they demonstrated weak-to-moderate primary loadings (< 0.50) on a single factor, cross-loadings (≥ 0.30) (Browne and Cudeck 2023), or redundancy with another item (≥ 0.40) where the item with the smaller factor loading within each pair was excluded.

TABLE 1 | Demographic information from studies one and two.

	Study one ($N = 293$)		Study two ($N = 231$)	
	Count (*n*)	**Percentage (%)**	**Count (*n*)**	**Percentage (%)**
Biological sex				
Female	171	58.4	199	86.1
Male	121	41.3	30	13.0
Prefer not to answer	1	0.3	1	0.4
Missing	—	—	1	0.4
Gender identity				
Female	155	52.9	189	81.8
Male	120	41.0	30	13.0
Non-binary	8	2.7	2	0.9
Transgender	3	1.0	3	1.3
Not sure	3	1.0	—	—
Gender queer	1	0.3	—	—
Genderfluid	1	0.3	4	1.7
Questioning	—	—	2	0.9
Transmasculine	1	0.3	—	—
Prefer not to disclose	1	0.3	—	—
Missing	—	—	1	0.4
Sexual orientation				
Heterosexual/Straight	203	69.3	—	—
Bisexual	37	12.6	—	—
Homosexual/Gay/Lesbian	18	6.1	—	—
Pansexual	10	3.4	—	—
Asexual	8	2.7	—	—
Queer	6	2.0	—	—
Do not use a label	5	1.7	—	—
Unsure/Questioning	3	1.0	—	—
Do not want to respond	2	0.7	—	—
Demisexual	1	0.3	—	—
Cultural identity				
European/White	90	30.7	154	66.6
Asian	51	17.4	27	11.7
African American/Black	40	13.7	6	2.6
Latino/Hispanic	34	11.6	2	0.9
Mixed	6	2.0	25	10.8
Middle Eastern	1	0.3	6	2.6
Aboriginal/Torres Strait Islander	—	—	2	0.9
Pacific Islander	—	—	2	0.9

(Continues)

TABLE 1 | (Continued)

	Study one ($N=293$)		Study two ($N=231$)	
	Count (*n*)	Percentage (%)	Count (*n*)	Percentage (%)
Legal Citizenship (e.g., American)	57	19.5	—	—
Unsure	7	2.4	—	—
Religion-based responses	5	1.7	1	0.4
Gender-based responses	2	0.7	—	—
Did not provide cultural background	—	—	8	3.5
Disability/Chronic condition				
No	226	77.1	191	82.7
Yes	63	21.5	32	13.9
Prefer not to answer	4	1.4	7	3.0
Missing	—	—	1	0.4

Internal consistency reliability of each subscale and the total BNQ scale were estimated using Cronbach's alpha and McDonald's omega, with values ≥0.80 and ≥0.90 interpreted as good and excellent reliability respectively (Dunn et al. 2014). For omega, 95% confidence intervals were obtained using non-parametric bootstrapping with 1000 resamples. Convergent validity was examined using Pearsons's correlations against similar scales, including the BAS-2 (Tylka and Wood-Barcalow 2015a), BI-AAQ (Sandoz et al. 2013), EDE-Q7 (Grilo et al. 2015), I-PANAS-SF (Thompson 2026), OBC-S (McKinley and Hyde 1996), and the SCS-SF (Raes et al. 2011). Correlation coefficients are interpreted as follows: values from 0.10 to 0.29 indicate small correlations, 0.30–0.49 indicate moderate correlations, and 0.50 and above indicate strong correlations (Cohen 1988).

2.3 | Study Two

2.3.1 | Participants

Participants were 231 first year undergraduate psychology students who participated in the study "perceived attainability of positive body image social media trends" (Goya and Pellizzer 2026). Participants had a mean age of 20.83 years (SD = 6.33), and most reported their biological sex as female (86.2%) and gender identity as female (81.8%). The most common cultural identity was coded as European/White (66.6%%) and 13.9% of the sample responded yes to having a disability or chronic condition. See Table 1 for complete demographic information.

2.3.2 | Procedure and Measures

Students were recruited online via the university research participation system. The sole inclusion criterion was enrolment as a first-year undergraduate psychology student. Participants were directed to Qualtrics to read the participation information sheet and provide informed consent, after which they completed demographic questions, a battery of measures (see Table 2), and additional questions specific to the main purpose of this study (perceptions of social media trends and positive body image). Only the BNQ and its relationship with BAS-2, BI-AAQ, ED-15, and FAS are reported here; perceptions of social media trends and positive body image will be reported elsewhere (Goya and Pellizzer 2026).

2.3.3 | Analyses

CFA models of the final factor structure solution identified in Study 1 were estimated using the weighted least squares mean, and variance adjusted (WLSMV) estimator appropriate for ordinal data. Model fit was evaluated using chi-square (χ^2; $p>0.05$), standardized root-mean-square residual (SRMR <0.08 [deemed acceptable, Hu and Bentler 1999]), root-mean-square error of approximation (RMSEA <0.05 (Hu and Bentler 1999)), comparative fit index (CFI >=0.95 (Bentler and Bonett 1980)), and Tucker–Lewis index (TLI >=0.95 (Bentler and Bonett 1980)). Interpretation of fit focused on CFI, TLI and SRMR given sensitivity of RMSEA to number of observed variables (Goretzko et al. 2024; Shi et al. 2019) and of the chi-square goodness of fit statistic to large sample sizes (Bentler and Bonett 1980). A bifactor CFA model was specified to consider scale dimensionality based on the proportion of reliable variance explained by the general factor relative to the specific factors using omega hierarchical (ω_h) (Rodriguez et al. 2016). Skewness and kurtosis of each item was used to assess univariate normality, noting that the WLSMV estimator provides robust parameter estimates and standard errors when normality assumptions are violated. Internal consistency reliability was again estimated using Cronbach's alpha and McDonald's omega including 95% CIs, and convergent validity was examined using Pearsons's correlations with the BAS-2 (Tylka and Wood-Barcalow 2015a), BI-AAQ (Sandoz et al. 2013), Eating Disorder-15 questionnaire (ED15; Tatham et al. 2015), BAS-2 (Tylka and Wood-Barcalow 2015a), and Functionality Appreciation Scale (FAS; Alleva et al. 2017) using the same interpretations as Study 1.

All analyses were conducted using R version 4.2.2 (R Core Team 2022) including packages lavaan (Rosseel 2012), semTools (Jorgensen et al. 2022), psych (Revelle 2023).

TABLE 2 | Reliability and validity of measures.

Measure M (SD), α/ω	Scale	Reliability and validity
Body Appreciation Scale 2[a] (BAS-2) Study 1: 3.26 (0.96), 0.96/0.96 Study 2: 3.34 (0.88), 0.95/0.95	Ten items rated on a 5-point scale (1 = never to 5 = always); scores averaged, higher scores reflecting greater body appreciation.	Good internal consistency for men and women (α = 0.94, 0.93) and appropriate 21-day test–retest reliability. Convergent and discriminant validity supported (Tylka and Wood-Barcalow 2015b)
Body Image Acceptance and Action Questionnaire[a] (BI-AAQ) Study 1: 3.59 (1.51), 0.95/0.95 Study 2: 4.59 (1.62), 0.96/0.96	Twelve items rated on a 7-point scale (1 = never true to 7 = always true); items are reverse-scored and averaged such that lower scores reflect higher levels of body image flexibility.	Strong internal consistency and good test–retest reliability. Strong convergent and divergent validity (Linardon et al. 2020; Pellizzer et al. 2018; Sandoz et al. 2013).
Eating Disorder-15 (ED-15)[c] Study 2: 2.51 (1.53), 0.94/0.95	Ten items measuring eating concern and shape and weight concern rated on a 7-point scale (0 = not at all to 6 = all the time). Items rated over the last week with higher scores indicating higher disordered eating.	Strong internal consistency, test–retest reliability, discriminant validity, convergent and divergent validity, and robust, replicated factor structure (Tatham et al. 2015; Zhou et al. 2024).
Eating Disorder Examination Questionnaire (EDE-Q7)[b] Study 1: 2.73 (1.56), 0.89/0.87	Seven items measuring dietary restraint ($N = 3$ rated from 1 = no days to 7 = every day), weight and shape concern ($N = 4$ rated from 0 = not at all to 6 = markedly). Items rated on previous 4 weeks (28 days). Higher scores indicate higher disordered eating.	Good internal consistency for both college-aged men and women. Adequate test–retest reliability. High correlation with full EDE-Q. The most robust, replicated factor structure of any EDE-Q variant (Jenkins and Davey 2020; Fairburn and Beglin 2008; Grilo et al. 2015).
Functionality Appreciation Scale (FAS)[c] Study 2: 4.19 (0.69), 0.93/0.93	Seven items assess appreciation, respect, and honor for ones body for what it can do, rather than how it looks, using a 5-point scale (strongly disagree to strongly agree). Higher scores indicate higher functionality appreciation.	Unidimensional factor structure, strong internal consistency and test–retest reliability, convergent validity, and predictive validity (Alleva et al. 2017; Linardon et al. 2020).
International Positive and Negative Affect Schedule Short Form (I-PANAS-SF)[b] Study 1: Positive Affect: 13.66 (4.41), 0.78/0.77 Negative Affect: 9.26 (4.54), 0.87/0.87	Ten items asking how people feel right now using a 5-point rating scale (1 = not at all to 5 = extremely). The measure is split into two subscales, the Positive Affect (PA) and the Negative Affect (NA); higher scores indicate greater PA or NA, respectively.	Good internal reliability (α = 0.78 and 0.76), $r = 0.65$ with the original 20-item PANAS; good test–retest reliability ($r = 0.84$) for both PA and NA at 8-week interval (Thompson 2026).
Objectified Body Consciousness—Surveillance subscale (OBC-SS)[b] Study 1: 4.65 (1.05), 0.82/0.81	Eight items rated on a 7-point scale ranging (1 = strongly disagree to 7 = strongly agree); scores averaged. Higher scores reflect higher levels of body surveillance (self-objectification).	High internal reliability and positive correlations with disordered eating and appearance anxiety (convergent validity; McKinley and Hyde 1996).
Self-Compassion Scale—Short Form (SCS-SF)[b] Study 1: 2.84 (0.69), 0.86/0.85	Twelve items rated on a 5-point scale (1 = almost never to 5 = almost always); higher scores indicate higher self-compassion.	Correlated with long form version of the scale and demonstrated internal consistency (α > 0.86; Hayes et al. 2016; Raes et al. 2011)

[a]Administered in both studies.
[b]Administered in study one only.
[c]Administered in study two only.

3 | Results

3.1 | Study One

3.1.1 | Preliminary Analyses

There were 327 survey responses, with 25 incomplete responses removed along with 9 that failed the comprehension and attention check, leaving a final sample of 293 (90% of the initial responses). All BNQ items violated normality assumptions confirming use of maximum likelihood estimation with robust standard errors. Descriptive data and reliability coefficients for all existing measures in the current study can be seen in Table 2, all demonstrated good to excellent internal consistency, with Cronbach's α and McDonald's ω values ranging from 0.77 to 0.96.

3.1.2 | Exploratory Factor Analysis

KMO indicated adequate sampling adequacy at both overall and item levels (0.95, range 0.89–0.97), and Bartlett's test of sphericity was significant ($\chi^2(210) = 4207.35$, $p < 0.001$), supporting the factorability of the correlation matrix. Horn's parallel analysis suggested a four-factor solution was appropriate. We therefore explored model solutions with one to four factors for the 21-item scale. The one-factor solution showed poor fit (RMSEA = 0.127 [95% CI: 0.118, 0.135], CFI = 0.785, TLI = 0.761, SRMR = 0.075). Fit improved as additional factors were included: two-factor solution was borderline acceptable (RMSEA = 0.083 [95% CI: 0.073, 0.093], CFI = 0.917, TLI = 0.897, SRMR = 0.043), three-factor solution demonstrated good fit (RMSEA = 0.073 [95% CI: 0.062, 0.084], CFI = 0.944, TLI = 0.921, SRMR = 0.036), four-factor model demonstrated best fit (RMSEA = 0.065 [95% CI: 0.053, 0.076], CFI = 0.961, TLI = 0.938, SRMR = 0.024). The fourth factor was not interpretable and included weak loadings, and so the three-factor solution was used to further examine factor structure of the BNQ. Nine items in total were removed. Seven had weak primary loadings—items 1 ($\lambda = 0.445$), 2 ($\lambda = 0.181$), 3 ($\lambda = 0.268$), 8 ($\lambda = 0.324$), 9 ($\lambda = 0.374$), 19 ($\lambda = 0.418$), 21 ($\lambda = 0.434$). Items 8 and 9 also had secondary cross-loadings, $\lambda = 0.312$ and $\lambda = 0.309$ respectively. A further two items showed item redundancy: 14 ($\lambda = 0.727$) with 13 ($\lambda = 0.790$), and 11 ($\lambda = 0.820$) with 12 ($\lambda = 0.912$). This resulted in a final set of 12 items with acceptable fit for the three-factor model (RMSEA = 0.072 [95% CI: 0.049, 0.095], CFI = 0.977, TLI = 0.955, SRMR = 0.021) loading cleanly on the a priori conceptually specified three factors, shortened to: (1) Self-Worth not Contingent on Body, (2) Body Gratitude and Care, and (3) Neutral Attitude toward Body. Descriptive statistics for the BNQ total and factors by demographic variables are presented in Table 3.

3.1.3 | Reliability

Internal consistency reliability for the total BNQ 12-item scale was excellent (Cronbach's $\alpha = 0.93$, 95% CI: 0.91, 0.94; McDonald's $\omega = 0.95$, 95% CI: 0.94, 0.96) and exceeded 0.86 for all subscales (Table 3).

3.1.4 | Validity

Table 4 presents correlations between total BNQ scores and established measures of body image and eating disorders. There were strong positive correlations from the BNQ with BAS-2, BI-AAQ, and SCS, small-to-moderate positive correlation with PA, and moderate-to-strong negative correlations with the EDE-Q7, OBC-SS, and NA.

3.2 | Study Two

3.2.1 | Preliminary Analyses

There were 253 survey responses, with 22 incomplete responses removed, leaving a final sample of 231 (91.3% of the initial responses). All BNQ items showed mild deviations from normality. Descriptive data and reliability coefficients for all existing measures in the current study can be seen in Table 2. All measures demonstrated good to excellent internal consistency, with Cronbach's α and McDonald's ω values ranging from 0.93 to 0.96.

3.2.2 | Confirmatory Factor Analysis

The three-factor, 12-item BNQ model identified in study 1 was specified and showed good model fit ($\chi^2(51) = 141.245$, $p < 0.001$, robust CFI = 0.959, robust TLI = 0.947, robust RMSEA = 0.104 [90% CI: 0.084, 0.124], SRMR = 0.031). All items loaded strongly on their intended factors (standardized loadings: factor 1 range $\lambda = 0.86$–0.92; factor 2 range $\lambda = 0.91$–0.94; factor 3 range $\lambda = 0.79$–0.91, see Table 5) and modification indices suggested one potential cross-loading, but given the overall fit and clear theoretical structure, no *post hoc* modifications were made to preserve parsimony. A bifactor CFA model was specified to estimate the variance explained by a general factor relative to each of the three specific factors controlling for the general factor. The bifactor model demonstrated superior fit ($\chi^2(42) = 80.126$, $p < 0.001$, robust CFI = 0.978, robust TLI = 0.966, robust RMSEA = 0.083 [90% CI: 0.060, 0.107], SRMR = 0.022) with all items loading strongly on the general factor (standardized loadings: general factor range $\lambda = 0.74$–0.87), with weaker loadings on each factor (standardized loadings: factor 1 range $\lambda = 0.15$–0.43; factor 2 range $\lambda = 0.37$–0.60; factor 3 range $\lambda = 0.25$–0.54). Omega hierarchical ($\omega_h = 0.81$) indicated that 81% of reliable variance was attributable to the general body neutrality factor, with the three specific factors contributing additional variance (factor 1 $\omega_s = 0.22$; factor 2 $\omega_s = 0.31$; factor 3 $\omega_s = 0.21$) suggesting that the BNQ can be considered as a unidimensional scale (Rodriguez et al. 2016). Descriptive statistics for the BNQ total and factors by demographic variables are presented in Table 6.

3.2.3 | Reliability

Internal consistency reliability for the total 12-item scale was excellent (Cronbach's $\alpha = 0.95$, 95% CI: 0.94, 0.96, McDonalds $\omega = 0.97$ (95% CI: 0.96, 0.97)) and all coefficients exceeded 0.90 for each subscale (Table 6).

TABLE 3 | Study 1: Means, standard deviations, and reliability coefficients for BNQ by demographic variables.

Group (*N*)	Factor 1 (Mean, SD)	Factor 2 (Mean, SD)	Factor 3 (Mean, SD)	Total scale (Mean, SD)
Total sample ($n = 293$)	3.22 (1.02)	3.88 (0.99)	3.42 (0.96)	3.45 (0.87)
Internal reliability α, ω	0.88, 0.89	0.89, 0.89	0.86, 0.86	0.93, 0.95
Biological sex				
Male ($n = 121$)	3.41 (1.01)	3.98 (1.03)	3.69 (0.94)	3.64 (0.84)
Female ($n = 171$)	3.07 (1.01)	3.81 (0.97)	3.22 (0.92)	3.31 (0.86)
Gender identity				
Male ($n = 120$)	3.41 (1.02)	3.98 (1.03)	3.70 (0.94)	3.65 (0.85)
Female ($n = 155$)	3.09 (0.98)	3.89 (0.92)	3.26 (0.91)	3.34 (0.84)
Disability/Chronic health condition				
Yes ($n = 63$)	2.83 (1.11)	3.29 (1.08)	2.97 (1.02)	2.99 (0.96)
No ($n = 226$)	3.35 (0.96)	4.08 (0.87)	3.57 (0.88)	3.61 (0.78)
Age in years				
19 ($n = 30$)	3.48 (0.84)	4.21 (0.85)	3.57 (0.75)	3.69 (0.67)
20 ($n = 30$)	3.09 (1.10)	3.46 (1.09)	3.16 (1.01)	3.20 (0.96)
21 ($n = 43$)	3.13 (0.92)	4.10 (0.83)	3.22 (0.90)	3.40 (0.78)
22 ($n = 51$)	3.37 (1.09)	3.88 (1.08)	3.44 (1.08)	3.52 (0.97)
23 ($n = 40$)	3.25 (0.99)	3.78 (1.18)	3.54 (0.92)	3.48 (0.88)
24 ($n = 42$)	2.99 (1.08)	3.71 (1.02)	3.43 (1.05)	3.32 (0.95)
25 ($n = 44$)	3.22 (1.12)	3.87 (0.83)	3.51 (0.93)	3.48 (0.86)

Note: Only groups with participants greater than or equal to 20 were included.

TABLE 4 | Study 1: Correlation matrix.

	EDEQ7	BAS-2	BIAAQ	OBC SS	SCS	PA	NA
BNQ	**−0.46**	**0.78**	**0.60**	**−0.48**	**0.61**	**0.31**	**−0.47**
EDEQ7		**−0.47**	**−0.71**	**0.45**	**−0.26**	−0.04	**0.40**
BAS-2			**0.56**	**−0.49**	**0.62**	**0.38**	**−0.45**
BIAAQ				**−0.45**	**0.43**	0.07	**−0.52**
OBC SS					**−0.45**	**−0.26**	**0.29**
SCS						**0.36**	**−0.40**
PA							0.02

Note: BOLD = correlation is significant at the 0.05 level; ** = correlation is significant at the 0.01 level. Cohen's guidelines, $r = 0.10–0.29$ small, $r = 0.30–0.49$ moderate, and $r \geq 0.50$ strong (Cohen 1988).
Abbreviations: BAS, Body Appreciation Scale; BIAAQ, Body Image Acceptance and Action Questionnaire; EDE-Q7, Eating Disorder Examination Questionnaire Seven Item; NA, Negative Affect; OBC SS, Objectified Body Consciousness Surveillance Subscale; PA, Positive Affect; SCS, Self Compassion Scale.

3.2.4 | Validity

Table 7 presents correlations between total BNQ scores and established measures of body image and eating disorders. There were strong positive correlations between the BNQ, BAS-2, BIAAQ, and FAS and a strong negative correlation with the ED-15.

4 | Discussion

The present study aimed to develop the first psychometrically sound measure of body neutrality, the Body Neutrality Questionnaire (BNQ). Findings from the EFA and CFA support the BNQ as a 12-item measure of body neutrality with correlated factors representing Self-Worth not Contingent on Body, Body Gratitude and Care, and a Neutral Attitude toward Body. The bifactor CFA model indicated that body neutrality has a strong general factor, with the three factors also contributing meaningful specific variance, supporting the unidimensional nature of the BNQ with additional meaningful contributions from the three subscales. The final questionnaire can be found in the Supporting Information.

Construct validity of the BNQ was supported through strong positive correlations with measures of body appreciation, body image

TABLE 5 | Study 2: Standardized CFA factor loadings and squared multiple correlations (R^2), for the final BNQ.

	Item loading	R^2
Factor 1: Self-Worth not Contingent on Body (5 items)		
The way my body looks does not determine my value	0.899	0.808
My thoughts and feelings about my weight shape don't interfere with having strong, meaningful interaction with others	0.897	0.805
I don't let my feelings about my body's appearance and weight affect how I feel about myself as a person	0.921	0.849
I think that my appearance is only one small aspect of the important facets about me that make me worthwhile	0.885	0.784
I don't judge myself negatively as a person, even if I dislike my appearance	0.864	0.746
Factor 2: Body Gratitude and Care (3 items)		
My body is on my team and doing its best to keep me safe and functioning optimally	0.906	0.822
I value that my body enables me to take part in the things that matter to me	0.940	0.884
I have gratitude for my body's functions and capabilities	0.919	0.845
Factor 3: Neutral Attitude toward Body (4 items)		
I feel like I can get on with life, even when I don't feel good about my body	0.788	0.621
I'm aware of my thoughts and feelings about my body, and I can step back and reflect on them calmly	0.883	0.780
I can notice my thoughts and feelings about my body without becoming overwhelmed	0.882	0.778
I can be aware of my thoughts and feelings about my body without them affecting my behaviors	0.909	0.827

flexibility, functionality appreciation, and self-compassion and negative correlations with weight and shape concern, disordered eating, negative affect, and objectified body surveillance, suggesting that body neutrality is meaningfully related to positive body image. This reinforces the idea that body neutrality fits within the broader positive body image framework (Tiggemann 2024). These findings align with previous research indicating that body neutrality shares important components with constructs such as body acceptance, functionality appreciation, and self-compassion (Mulgrew and Hinz 2024). The strong correlations observed suggest that while body neutrality emphasizes emotional neutrality and reduces the focus on appearance, it aligns with positive body image by potentially encouraging acceptance and fostering a more balanced, less judgmental relationship with the body. The moderate negative correlations with eating disorder symptomatology and body surveillance are consistent with theoretical expectations that body neutrality involves a reduced emphasis on appearance and promotes broader self-worth (Pellizzer and Wade 2023). The moderate negative correlation with negative affect and the small to moderate positive correlation with positive affect reflect the core idea of body neutrality: accepting all body-related emotions, not only positive feelings, nor simply the absence of negative ones. Together, the results support the BNQ's convergent validity within the broader context of body image and eating disorder related research.

Previous qualitative and theoretical work has proposed body neutrality as a meaningful alternative to other positive body image frameworks (Mulgrew and Hinz 2024; Tiggemann 2024). While current frameworks of positive body image remain a valuable and often aspirational goal, they may not be realistic or achievable for everyone, particularly those with complex relationships to their bodies due to eating disorders, trauma, disability, chronic health conditions or gender dysphoria (Cahill et al. 2025; Perry et al. 2019). For instance, both body appreciation and body neutrality are part of the broader adaptive body image landscape, but they diverge in terms of emphasis and approach. Body appreciation includes holding favorable opinions, acceptance, respect, and acceptance of the body (Avalos et al. 2005). In contrast, body neutrality promotes a reduced focus on appearance altogether, emphasizing body gratitude and care, mindfulness, and the decentring and neutralizing of appearance in self-worth (Pellizzer and Wade 2023). These conceptual distinctions are reflected in item content: BNQ items focus on bodily awareness and non-appearance-based self-worth (e.g., "I can be aware of my thoughts and feelings about my body without them affecting my behaviours"), whereas the BAS-2 includes items reflecting positive feelings toward bodily appearance (e.g., "I feel like I am beautiful even if I am different from media images of attractive people (e.g., models, actress/actors)"). While both constructs are highly correlated, these conceptual distinctions are important because they may address different needs, particularly for individuals who experience appearance-related distress or for whom positive evaluations of appearance feel unattainable.

Body neutrality is most like, and encompasses, body functionality appreciation. To date, research has found body functionality appreciation to be associated with both positive and negative body image and eating disorder symptom severity for people with eating disorders (Engel et al. 2023; Ramesh et al. 2026). In addition, a qualitative study of a body functionality appreciation

TABLE 6 | Study 2: Means, standard deviations, and reliability coefficients for BNQ by demographic variables.

Group	Factor 1 mean (SD)	Factor 2 mean (SD)	Factor 3 mean (SD)	Total scale mean (SD)
Total sample ($n = 231$)	3.48 (1.05)	3.85 (0.94)	3.54 (0.97)	3.59 (0.91)
Internal reliability α, ω	0.93, 0.93	0.91, 0.91	0.90, 0.90	0.95, 0.97
Biological sex				
Male ($n = 30$)	3.41 (1.13)	3.94 (0.91)	3.73 (0.89)	3.65 (0.87)
Female ($n = 199$)	3.49 (1.04)	3.84 (0.95)	3.51 (0.98)	3.58 (0.91)
Gender identity				
Male ($n = 30$)	3.50 (1.15)	3.98 (0.93)	3.79 (0.92)	3.72 (0.89)
Female ($n = 189$)	3.48 (1.03)	3.83 (0.95)	3.51 (0.97)	3.58 (0.90)
Disability/Chronic health condition				
Yes ($n = 32$)	3.06 (1.09)	3.35 (0.86)	3.13 (0.94)	3.16 (0.89)
No ($n = 191$)	3.58 (1.02)	3.95 (0.91)	3.64 (0.95)	3.69 (0.88)
Age in years				
17 ($n = 18$)	3.48 (0.85)	3.78 (0.89)	3.47 (0.93)	3.55 (0.84)
18 ($n = 78$)	3.37 (1.02)	3.79 (1.01)	3.45 (1.03)	3.50 (0.95)
19 ($n = 58$)	3.47 (1.11)	3.86 (0.93)	3.50 (0.93)	3.58 (0.92)
20 ($n = 27$)	3.44 (1.12)	3.91 (0.78)	3.34 (1.00)	3.53 (0.86)
> 20 ($n = 49$)	3.67 (1.05)	3.92 (0.97)	3.84 (0.89)	3.79 (0.86)

Note: Only groups with participants greater than or equal to 20 were included.

TABLE 7 | Study 2: Correlation matrix.

	ED-15	BAS-2	BIAAQ	FAS
BNQ	**−0.72**	**0.85**	**0.71**	**0.74**
ED-15		**−0.70**	**−0.88**	**−0.49**
BAS-2			**0.68**	**0.73**
BIAAQ				**0.50**

Note: BOLD = correlation is significant at the 0.05 level. Cohen's guidelines, $r = 0.10–0.29$ small, $r = 0.30–0.49$ moderate, and $r \geq 0.50$ strong (Cohen 1988). Abbreviations: BAS-2, Body Appreciation Scale 2; BIAAQ, Body Image Acceptance and Action Questionnaire; ED-15, Eating Disorder-15; FAS, Functionality Appreciation Scale.

intervention found adolescent girls with eating disorders were able to appreciate their bodies for their functions and what they can do, rather than only focusing on appearance (Weiland et al. 2026). In this study, several participants (10 of 58) did write about appearance despite there being no instruction to do so (Weiland et al. 2026). Indeed, clinicians and people with eating disorders perceive both body functionality appreciation and body compassion approaches to be useful additions to treatments but ensuring careful adaptation to be well suited to this context (Mulgrew et al. 2024). The emerging literature in this area supports the use of and alignment of body neutrality with clinical goals, including body functionality appreciation, but extending this to include emotional neutrality and reduced appearance focus. In clinical practice, offering a range of body image frameworks is essential to meet clients where they are in their recovery journey.

While informative, these results must be considered within the context of several limitations. First, the focus group sample was limited in size but provided important and helpful insights from people representative of the measure's target population. Second, experts evaluated items drawn from existing measures rather than those generated during the current study. This was a pragmatic, feasible approach that allowed understanding of the relevance of existing, similar items. Although their insights were instrumental in the creation of this list, the expert group did not evaluate the final list of newly generated items. Additionally, the survey was administered to participants primarily from Western countries, although cultural identity within the sample showed greater diversity. We encourage future work to evaluate the measure with samples of diverse cultures, genders, and ages. The battery of measures did not include tools to assess discriminant validity; while this decision aimed to reduce participant burden, future studies should address this gap through inclusion of measures such as self-criticism (Gilbert et al. 2004). Finally, the sample size in either study did not permit invariance testing over time or by different demographic groups such as age, gender, and disability status; while we present descriptive statistics by demographic variables for transparency, we caution against interpreting these as evidence of group differences in the absence of established invariance across these groups. These should be considered in future research in addition to assessing the BNQ and its predictive validity for disordered eating in clinical populations, such as individuals with eating disorders, chronic health conditions, and in those who identify as non-binary or transgender.

This study has developed and validated the first measure of body neutrality, the Body Neutrality Questionnaire (BNQ). It establishes body neutrality as a theoretically grounded, multidimensional construct that is psychometrically sound and that may be of relevance to a range of conditions including eating disorder risk. These findings suggest that body neutrality holds promise as a realistic, flexible, and inclusive framework that expands on our conceptualisation of body image. Results presented here support the use of both the total and the three subscale scores. With continued research, it has the potential to become a vital addition to the therapeutic toolbox for the promotion of a sustainable and compassionate relationship with the body.

Author Contributions

Laura Edney: formal analysis, writing – original draft, writing – review and editing. **Amelia Kimpton:** conceptualization, methodology, formal analysis, investigation, writing – original draft. **Tracey D. Wade:** writing – review and editing, conceptualization, methodology, supervision. **Charles Goya:** validation, writing – review and editing, investigation. **Mia L. Pellizzer:** conceptualization, methodology, formal analysis, writing – original draft, writing – review and editing, supervision, project administration, funding acquisition.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are openly available in the Open Science Framework at https://osf.io/fsnw5/overview.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** eat70122-sup-0001-Supinfo1.docx.