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Integrating Digital Tools into Compassion-Focused Therapy for Body Image and Eating Disorder Behaviors in Adult Women

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A B S T R A C T

Eating disorders (EDs) and body image disturbance remain major mental health concerns among adult women, and the persistence of shame, self-criticism, and relapse after standard treatment highlights the need for compassion-based interventions. This study investigated the effectiveness of Compassion-Focused Therapy (CFT) integrated with digital tools in improving body appreciation and self-compassion while reducing eating disorder psychopathology in adult women with disordered eating symptoms. Using a semi-experimental pretest–posttest design with a two-month follow-up, 60 women from Tehran, Iran, were randomly assigned to either an intervention group receiving 12 weekly group CFT sessions with digital support or a waitlist control group; 53 participants completed the study (26 in the intervention group and 27 in the control group). Outcomes were assessed using the Body Appreciation Scale-2 (BAS-2), the Eating Disorder Examination Questionnaire (EDE-Q), and the Self-Compassion Scale–Short Form (SCS-SF), and the data were analyzed using mixed ANOVA. The findings showed significant Time × Group interaction effects for all three outcomes, indicating superior improvement in the intervention group relative to controls. Body appreciation increased from 2.85 ± 0.71 at pretest to 3.92 ± 0.64 at posttest and remained stable at 3.88 ± 0.68 at follow-up, with a significant interaction effect, $F(1.68, 85.64) = 42.35$, $p < 0.001$, $\eta^2 = 0.45$. Eating disorder psychopathology declined markedly from 3.65 ± 0.89 to 2.10 ± 0.75 and was maintained at 2.15 ± 0.78, $F(1.72, 87.72) = 55.18$, $p < 0.001$, $\eta^2 = 0.52$. Self-compassion improved from 2.45 ± 0.62 to 3.55 ± 0.58 and remained at 3.50 ± 0.60, $F(1.85, 94.35) = 38.92$, $p < 0.001$, $\eta^2 = 0.43$. In contrast, the waitlist group showed no meaningful change across time. Overall, digitally supported CFT appears to be an effective and durable intervention for improving body image and reducing eating disorder symptoms in adult women.

Keywords: *Compassion-Focused Therapy (CFT); Body Image; Eating Disorders; Self-Compassion; Adult Women.*

1. Introduction

Eating disorders (EDs) are among the most serious and complex psychiatric disorders, with substantial consequences for physical health, psychological functioning, and quality of life. Their burden has continued to increase over time, particularly among females. Using Global Burden of Disease 2021 data, Liu et al. (2025) reported that the global age-standardized prevalence of eating disorders rose from 300.73 to 354.72 per 100,000

population between 1990 and 2021, with women showing a markedly higher prevalence than men (Liu et al., 2025). These patterns highlight the need for targeted and mechanism-based interventions, especially for adult women, who remain disproportionately affected by body image concerns and disordered eating. Body image disturbance is a central process in the onset, maintenance, and recurrence of eating pathology. It is no longer viewed as a peripheral correlate of disordered eating, but rather as a clinically meaningful vulnerability factor that is reinforced by social and digital environments. For example, Dane and Bhatia (2023), in a scoping review of 50 studies across 17 countries, concluded that social media use is consistently associated with body image concerns, disordered eating, and poorer mental health among young people (Dane & Bhatia, 2023). Similarly, Bonfanti et al. (2025) found in a systematic review and meta-analysis of 83 studies involving more than 55,000 participants that greater online social comparison was associated with higher body image concerns and more eating disorder symptoms, while also being linked to lower positive body image (Bonfanti et al., 2025). Together, these findings suggest that body dissatisfaction is deeply embedded in contemporary appearance-focused digital culture. Although cognitive behavioral therapy (CBT) remains the leading evidence-based treatment for many eating disorders, clinical outcomes are often incomplete, particularly for patients whose difficulties are strongly maintained by shame, self-criticism, or trauma-related vulnerability. In response to these limitations, Compassion-Focused Therapy (CFT) has emerged as a promising therapeutic approach. Rooted in evolutionary psychology and affect regulation theory, CFT aims to reduce psychopathology by addressing imbalances among the threat, drive, and soothing systems and by cultivating self-compassion and emotional safeness. A recent systematic review by Stock et al. (2025) concluded that CFT shows promising effects in reducing eating disorder psychopathology and improving body image and self-compassion, although the authors also emphasized the need for more rigorous comparative trials (Stock et al., 2025).

The relevance of CFT to eating disorders is strengthened by growing evidence that self-criticism and low self-compassion are not secondary features, but core maintaining mechanisms. In a meta-analysis, Paranjothy and Wade (2024) showed that disordered eating was robustly associated with higher self-criticism and lower self-compassion across studies (Paranjothy & Wade, 2024). This is clinically important because many individuals with eating disorders do not merely hold distorted beliefs about weight and shape; they also respond to distress with harsh self-judgment, emotional avoidance, and internal threat. CFT is especially well suited to this problem because it targets not only cognitive content, but also the emotional tone of the individual's relationship with the self. By helping patients respond to shame and perceived inadequacy with kindness rather than attack, CFT may be particularly beneficial for adult women with chronic body dissatisfaction and entrenched self-evaluative patterns.

At the same time, digital mental health tools are increasingly being used to extend and strengthen psychological interventions. Their relevance is especially clear in body image and eating disorder work, where between-session practice, self-monitoring, and accessibility are critical. In a meta-analytic review, Conboy et al. (2024) found that digital interventions for adult women produced small to medium beneficial effects on body image outcomes, including increased global body satisfaction and reduced cognitive body dissatisfaction (Conboy et al., 2024). In the broader eating disorder literature, Thomas et al. (2024) reported that effective digital interventions often include self-monitoring, feedback, and action planning, and that stronger theoretical grounding is associated with better outcomes (Thomas et al., 2024). Likewise, Pruessner et al. (2024) demonstrated in a randomized clinical trial that a web-based cognitive behavioral self-help intervention significantly reduced binge eating episodes and improved related outcomes in individuals with binge eating disorder (Pruessner et al., 2024). These findings suggest that digital tools can enhance treatment engagement, increase access, and support the consolidation of therapeutic gains. Despite these advances, an important gap remains at the intersection of compassion-based intervention, digital augmentation, and culturally responsive care for adult women with body image disturbance and disordered eating. Existing research supports CFT as a promising approach and digital tools as feasible adjuncts, yet relatively little work has examined their integration within a structured intervention in non-Western settings. The present study addresses this gap by investigating whether Compassion-Focused Therapy integrated with digital tools can improve body image and reduce eating disorder symptoms in adult women. By targeting both emotional mechanisms of change and the practical benefits of digital support, this study seeks to contribute to a more accessible, culturally adaptable, and mechanism-informed treatment model.

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2. Methods and Materials

2.1. Research Design

This study used a quasi-experimental pretest-posttest design with a two-month follow-up and a waitlist control condition. Participants were randomly assigned to either a Compassion-Focused Therapy (CFT) intervention group or a waitlist control group. This design was selected to evaluate whether a structured CFT program augmented with digital tools would improve body appreciation and self-compassion while reducing eating-disorder psychopathology over time.

2.2. Participants and Sampling

The target population comprised women aged 18 to 45 years living in Tehran, Iran, who reported body image disturbance and disordered eating symptoms. An a priori power analysis conducted in G*Power (version 3.1.9.7), assuming an effect size of d = 0.65, power of 0.90, and α = .05, indicated that 50 participants would be sufficient. To allow for attrition, 60 participants were enrolled.

Participants were recruited between September 2025 and January 2026 through announcements in university clinics, community health centers, and mental health channels on Instagram and Telegram. Recruitment followed a convenience sampling approach. Interested volunteers completed an online screening form and, if provisionally eligible, were invited for a clinical screening interview.

2.2.1. Eligibility Criteria

Inclusion criteria were female gender, age between 18 and 45 years, elevated scores on the Eating Disorder Examination Questionnaire (EDE-Q) and the Body Image Concern Inventory during screening, willingness to attend the intervention sessions, and provision of written informed consent. Exclusion criteria were current psychotic disorder, bipolar disorder, or substance dependence; concurrent psychotherapy focused on eating disorders or body image; severe medical conditions requiring immediate hospitalization; and pregnancy, because of potential physiological effects on eating and weight-related variables.

2.3. Procedure

Screening, allocation, intervention, and outcome assessment were completed in three phases. First, 127 volunteers expressed interest in the study. After screening, 67 individuals were excluded because they did not meet eligibility criteria or had incomplete screening data. The remaining 60 participants underwent a semi-structured clinical interview using the SCID-5 to confirm eligibility and rule out severe comorbid psychopathology (First et al., 2016). Eligible participants then completed the pretest assessment battery.

Second, participants were randomly assigned in blocks of four to the intervention group (n = 30) or the waitlist control group (n = 30). The randomization sequence was generated by an independent researcher using a computer-based random number generator. The intervention arm received 12 weekly group CFT sessions, each lasting 90 minutes. The waitlist control group received no active psychological intervention during the same period, although biweekly phone contact was maintained to monitor participant safety.

Third, all participants completed the posttest immediately after the 12-session period and a follow-up assessment two months later. During the study, four participants in the intervention arm and three participants in the control arm discontinued participation because of scheduling conflicts or limited engagement. The final analytic sample therefore included 53 participants (intervention: n = 26; control: n = 27).

2.4. Intervention Protocol

The intervention followed a group-based CFT protocol adapted from Gilbert's clinical model of compassionate mind training (Gilbert, 2010) and the eating-disorder adaptation developed by Goss and Allan (2014). Sessions 1 and 2 focused on psychoeducation, including the evolutionary model of emotion regulation and the role of shame and self-criticism in eating disorders (Goss & Allan, 2014). Sessions 3 to 5 introduced soothing rhythm breathing, compassionate imagery, and compassionate-self development. Sessions 6 to 9 emphasized compassionate engagement with the critical self, compassionate reasoning, compassionate letter writing, and work on fears of compassion. Sessions 10 to 12 focused on consolidation, relapse prevention, application of compassion to future triggers, and development of an individualized maintenance plan.

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2.4.1. *Digital Adjuncts*

Face-to-face CFT was supplemented with a smartphone-based digital package designed to support between-session practice. The digital adjunct included (a) daily monitoring of body dissatisfaction, eating-related symptoms, shame, and self-compassion; (b) a structured journaling tool for recording triggers, emotional responses, and compassionate responses; and (c) guided psychoeducational and skills-practice modules aligned with CFT principles, including soothing rhythm breathing and compassion-focused reflection exercises. Participants also received automated reminders, and usage metrics such as login frequency and module completion were tracked.

These features were consistent with current recommendations for digital mental health interventions, particularly the use of self-monitoring, feedback, and structured behavior change strategies to strengthen engagement and skill transfer (Thomas et al., 2024; Torous et al., 2020).

2.5. *Measures*

A demographic questionnaire was used to record age, education, marital status, body mass index (BMI), and history of psychological treatment.

The Structured Clinical Interview for DSM-5 Disorders, Clinician Version (SCID-5-CV), was used during screening to confirm eligibility and exclude severe psychiatric conditions (First et al., 2016). Body appreciation was measured with the Body Appreciation Scale-2 (BAS-2), a 10-item instrument assessing acceptance of, respect for, and positive attitudes toward the body (Tylka & Wood-Barcalow, 2015). Eating-disorder psychopathology was measured with the Eating Disorder Examination Questionnaire, version 6.0 (EDE-Q 6.0), a widely used self-report instrument assessing restraint, eating concern, shape concern, weight concern, and global eating-disorder psychopathology over the previous 28 days (Fairburn & Beglin, 2008). Self-compassion was assessed with the Self-Compassion Scale–Short Form (SCS-SF), a 12-item short form derived from the original Self-Compassion Scale and designed to capture the higher-order construct of self-compassion efficiently (Raes et al., 2011). Persian-language versions of all self-report measures were administered.

2.6. *Statistical Analysis*

All analyses were performed in SPSS version 27. Preliminary diagnostics included inspection of missing data, outliers, normality, homogeneity of variance, and sphericity. Missing data were limited (< 5%) and were handled using the Expectation-Maximization algorithm. Descriptive statistics were computed for all study variables. To test the study hypotheses, mixed analysis of variance (mixed ANOVA) was conducted for each outcome, with Time (pretest, posttest, follow-up) as the within-subject factor and Group (intervention vs. waitlist control) as the between-subject factor. Because Mauchly's test indicated violation of sphericity for the repeated factor, Greenhouse-Geisser-corrected results are reported for the Time × Group interaction. Effect sizes are presented as partial eta squared (ηp^2), and the significance threshold was set at $p < .05$.

3. Findings and Results

Baseline demographic characteristics are presented in Table 1. Independent-samples t tests and chi-square tests indicated no statistically significant between-group differences in age, education, marital status, or BMI at study entry. These findings support the comparability of the intervention and waitlist control groups before treatment.

Table 1

Demographic characteristics of participants by group

Variable	Categories	Experimental Group n (%)	Control Group n (%)	Total n (%)	Statistical Test
Age	Mean (SD)	28.42 (5.31)	29.15 (4.88)	28.79 (5.07)	t = 0.52, p = .60
Education	High school diploma	5 (19.2%)	6 (22.2%)	11 (20.8%)	χ^2 = 0.45, p = .93
	Bachelor's degree	14 (53.8%)	15 (55.6%)	29 (54.7%)	χ^2 = 0.45, p = .93
	Master's degree or higher	7 (26.9%)	6 (22.2%)	13 (24.5%)	χ^2 = 0.45, p = .93
Marital status	Single	16 (61.5%)	17 (63.0%)	33 (62.3%)	χ^2 = 0.02, p = .89
	Married	10 (38.5%)	10 (37.0%)	20 (37.7%)	χ^2 = 0.02, p = .89
BMI	Mean (SD)	24.15 (3.42)	23.89 (3.15)	24.02 (3.26)	t = 0.29, p = .77

Note. No statistically significant baseline between-group differences were observed.

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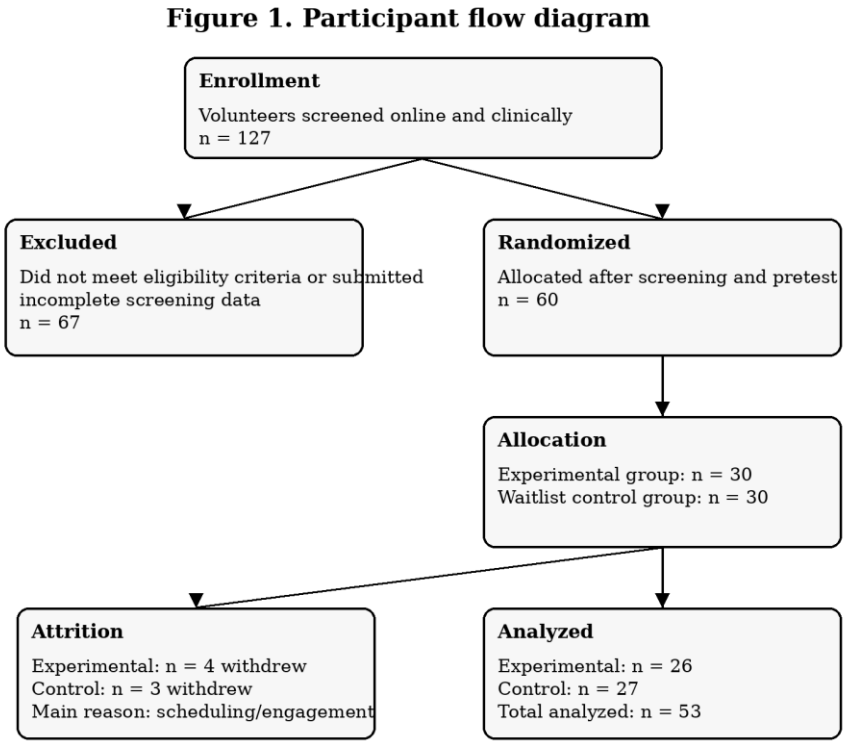
Figure 1

Paradigmatic model of the qualitative performance model of school principals in the Department of Education with a meritocracy approach



Note. Numbers are reproduced directly from the source manuscript.

Table 2 reports mean scores and standard deviations for the three study outcomes at pretest, posttest, and follow-up. The descriptive pattern was consistent across outcomes: participants in the intervention group showed higher body appreciation and self-compassion and lower eating-disorder psychopathology after treatment, and these gains were largely maintained at follow-up. In contrast, the waitlist control group remained relatively stable across the three assessments. Figure 2 visualizes these outcome trajectories over time.

Table 2

Descriptive statistics for study outcomes at pretest, posttest, and follow-up

Variable	Group	Pre-test M (SD)	Post-test M (SD)	Follow-up M (SD)
Body Appreciation (BAS-2)	Experimental	2.85 (0.71)	3.92 (0.64)	3.88 (0.68)
	Control	2.91 (0.68)	2.95 (0.72)	2.98 (0.70)
Eating Disorder Psychopathology (EDE-Q)	Experimental	3.65 (0.89)	2.10 (0.75)	2.15 (0.78)
	Control	3.58 (0.92)	3.52 (0.88)	3.55 (0.85)
Self-Compassion (SCS-SF)	Experimental	2.45 (0.62)	3.55 (0.58)	3.50 (0.60)
	Control	2.50 (0.59)	2.52 (0.61)	2.48 (0.63)

Note. Higher BAS-2 and SCS-SF scores indicate improvement; lower EDE-Q scores indicate improvement.

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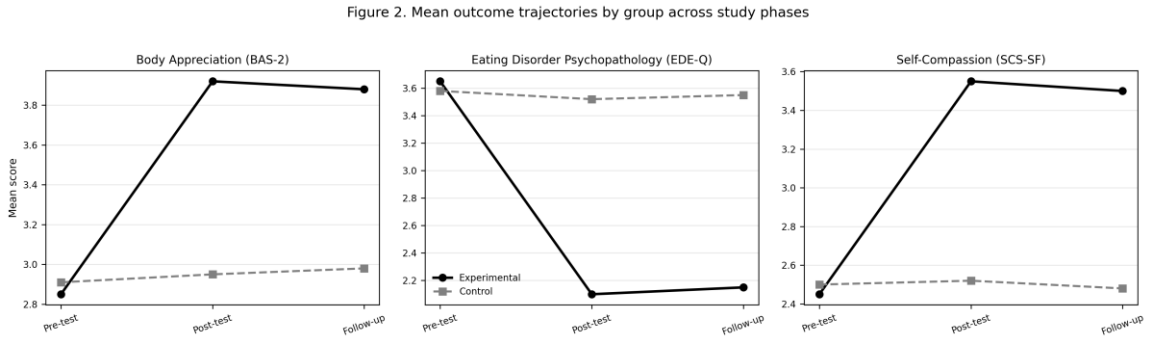
Figure 2

Mean outcome trajectories by group across study phases



Note. Plots are based on the means reported in Table 2.

Preliminary diagnostics indicated that the analytic assumptions for mixed ANOVA were adequately satisfied. Shapiro-Wilk tests performed on residuals were nonsignificant, supporting approximate normality. Levene's test indicated homogeneity of variance at baseline for all outcomes. Mauchly's test showed that the sphericity assumption was violated for the repeated time factor; accordingly, Greenhouse-Geisser-corrected degrees of freedom were used in the inferential analyses. Missing data were limited and were imputed using the Expectation-Maximization procedure described above.

The mixed ANOVA results are summarized in Table 3. For body appreciation, the Time × Group interaction was statistically significant, $F(1.68, 85.64) = 42.35$, $p < .001$, $\eta p^2 = .45$, indicating that the intervention group improved more over time than the waitlist control group. Body appreciation in the intervention group increased from 2.85 (SD = 0.71) at pretest to 3.92 (SD = 0.64) at posttest and remained high at follow-up, M = 3.88 (SD = 0.68). The corresponding control-group means were 2.91 (SD = 0.68), 2.95 (SD = 0.72), and 2.98 (SD = 0.70).

For eating-disorder psychopathology, the Time × Group interaction was also significant, $F(1.72, 87.72) = 55.18$, $p < .001$, $\eta p^2 = .52$. In the intervention group, EDE-Q global scores declined from 3.65 (SD = 0.89) at pretest to 2.10 (SD = 0.75) at posttest and were maintained at follow-up, M = 2.15 (SD = 0.78). The waitlist control group showed minimal change across the same period (Ms = 3.58, 3.52, and 3.55, respectively).

Self-compassion likewise showed a significant Time × Group interaction, $F(1.85, 94.35) = 38.92$, $p < .001$, $\eta p^2 = .43$. The intervention group improved from 2.45 (SD = 0.62) at pretest to 3.55 (SD = 0.58) at posttest and remained stable at follow-up, M = 3.50 (SD = 0.60). The waitlist control group remained essentially unchanged (Ms = 2.50, 2.52, and 2.48). Across all three outcomes, the interaction effect sizes were large, with the strongest effect observed for eating-disorder psychopathology. Figure 3 shows the magnitude of these interaction effects.

Table 3

Mixed ANOVA results for the Time × Group interaction

Dependent variable	df	Mean square	F	p	ηp^2
Body Appreciation	1.68	4.25	42.35	< .001	.45
Eating Disorder Psychopathology	1.72	5.82	55.18	< .001	.52
Self-Compassion	1.85	3.95	38.92	< .001	.43

Note. Greenhouse-Geisser-corrected degrees of freedom are reported because the sphericity assumption was violated.

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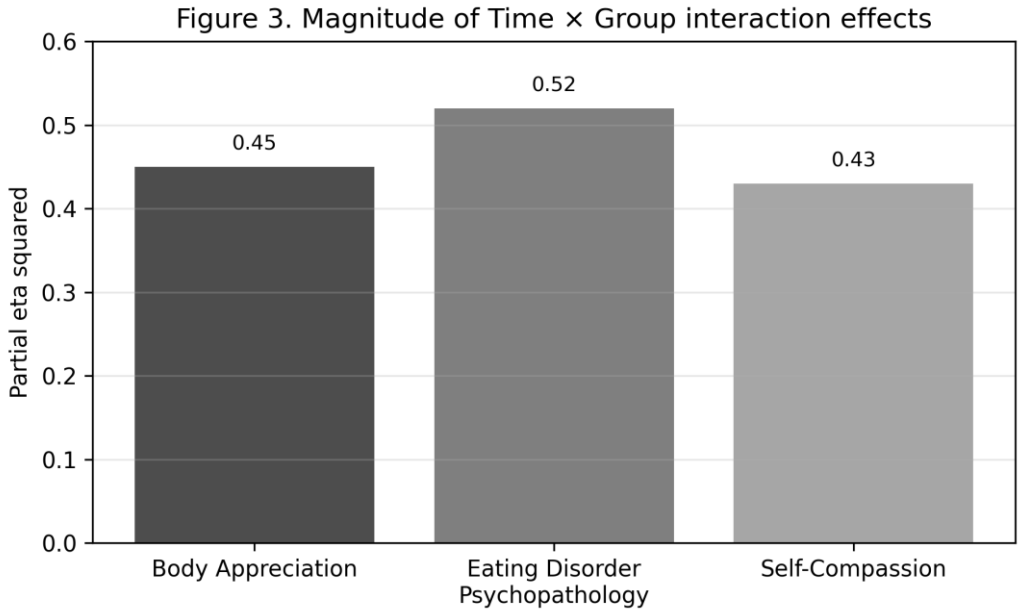
Figure 3

Magnitude of Time × Group interaction effects



Note. Effect sizes are reproduced from the mixed ANOVA results in Table 3.

4. Discussion

This study examined whether Compassion-Focused Therapy supplemented with digital tools could improve body appreciation and self-compassion while reducing eating-disorder psychopathology in adult women. The findings were consistent across all three primary outcomes. Compared with the waitlist control condition, participants who received the digitally supported CFT intervention showed marked posttreatment improvements and maintained these gains at the two-month follow-up. The pattern of results therefore suggests both immediate efficacy and short-term durability.

The improvement in body appreciation is in line with the emerging literature indicating that compassion-based approaches can strengthen positive body image by reducing shame and softening harsh appearance-based self-evaluation (Conboy et al., 2024; Goss & Allan, 2014; Stock et al., 2025). CFT is especially relevant in this context because it does not focus only on changing the content of negative body-related thoughts; it also aims to change the emotional relationship people have with themselves when appearance-related threat is activated (Gilbert, 2010). For women who experience persistent body dissatisfaction, this shift from self-attack to self-support may be clinically important.

The reduction in eating-disorder psychopathology is also consistent with prior evidence suggesting that compassion-focused interventions can reduce eating-related symptoms, especially when shame and self-criticism are prominent maintaining mechanisms (Kelly et al., 2017; Morgan-Lowes et al., 2023; Vrabel et al., 2024). From a theoretical perspective, this finding fits the CFT model, which proposes that many maladaptive behaviors are attempts to regulate distress within an overactivated threat system. By increasing access to soothing, self-reassurance, and compassionate self-correction, CFT may reduce the need to rely on restrictive, binge-eating, or other dysregulated responses to body-related distress (Gilbert, 2010; Millard et al., 2023).

The increase in self-compassion is central to interpreting the overall treatment effect. Self-compassion is not merely an associated wellness variable in eating disorders; it is strongly implicated in the maintenance of pathology and in recovery processes. Meta-analytic evidence shows that disordered eating is reliably associated with lower self-compassion and higher self-criticism (Morgan-Lowes et al., 2023; Paranjothy & Wade, 2024). In the present study, the rise in self-compassion occurred alongside reductions in

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eating-disorder symptoms and improvements in body appreciation, which is consistent with the idea that self-compassion may function as an important therapeutic change process rather than a peripheral outcome.

The digital adjuncts may have strengthened treatment effects by increasing repetition, accessibility, and daily application of compassion-based skills outside the therapy room. Contemporary reviews of digital eating-disorder interventions highlight the importance of theory-based content, self-monitoring, feedback, and action planning for improving outcomes (Thomas et al., 2024). Trial evidence further indicates that guided or minimally guided digital interventions can reduce eating-disorder psychopathology in clinically meaningful ways (Pruessner et al., 2024). In the present study, daily tracking, journaling, reminders, and guided exercises likely supported skill consolidation and may help explain why improvements were maintained at follow-up. Several limitations should be acknowledged. First, participants were recruited through convenience sampling from a single metropolitan setting, which limits generalizability beyond adult women in Tehran. Second, the study relied on self-report outcome measures, which may be vulnerable to recall bias and social desirability effects. Third, follow-up was limited to two months, so the long-term durability of treatment effects remains unclear. Fourth, the comparison group was a waitlist control rather than an active treatment condition, which prevents direct conclusions about comparative efficacy relative to established interventions such as CBT. Finally, although digital engagement was monitored, the present analysis did not test whether adherence to the digital components moderated outcomes. Future trials should include longer follow-up periods, active comparators, and formal analyses of digital adherence and mechanism-of-change variables.

5. Conclusion

In summary, the present findings indicate that Compassion-Focused Therapy enhanced with digital support can improve body appreciation and self-compassion while reducing eating-disorder psychopathology in adult women. The intervention effects were statistically robust, clinically coherent, and maintained at short-term follow-up. These results support further investigation of digitally augmented compassion-based interventions as accessible and culturally adaptable options for individuals struggling with body image disturbance and disordered eating.

Authors' Contributions

All authors contributed to the conception and design of the study. Material preparation, data collection, and analysis were performed by the author team. All authors contributed to drafting or critically revising the manuscript and approved the final version for submission.

Declaration

The authors declare that artificial intelligence tools were used only to assist with language editing, translation, and improvement of the manuscript's readability. All conceptualization, study design, data collection, data analysis, interpretation of findings, and final approval of the manuscript were performed by the authors. The authors take full responsibility for the accuracy, integrity, and originality of the content.

Transparency Statement

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

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Declaration of Interest

The authors report no conflict of interest.

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Ethics Considerations

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

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