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Research Article

The Effectiveness of Emotion-Focused Therapy and Schema Therapy on Physical Appearance Perfectionism in Women with Obesity

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Abstract

Background: Obesity, defined as a Body Mass Index (BMI) ≥ 30 kg/m^2, is a significant global health issue associated with psychological challenges, including intense concerns about physical appearance.

Objectives: This study aimed to evaluate and compare the effectiveness of emotion-focused therapy (EFT) and schema therapy (ST) in mitigating physical appearance perfectionism (PAP) among women diagnosed with obesity.

Methods: A randomized, controlled trial design involving three distinct groups (EFT, ST, and control) was implemented. The study participants comprised women with obesity seeking treatment at clinics and community health centers in Ahvaz, Iran, during 2023 - 2024. A sample of 60 eligible women were randomly assigned, with 20 participants allocated to each of the EFT, ST, and control groups. Both intervention groups received 12 weekly 90-minute sessions of their respective therapies, while the control group received standard care or a waitlist condition. The Physical Appearance Perfectionism Scale (PAPS) was utilized to collect data at pre-intervention, post-intervention, and a two-month follow-up. The collected data were analyzed using repeated measures analysis of variance (ANOVA) with post-hoc Bonferroni tests.

Results: At post-intervention and the two-month follow-up, the findings indicated that both the EFT and ST groups experienced statistically significant reductions in overall PAP scores, as well as on its hope for perfection and worry about imperfection subscales, compared to the control group ($P < 0.001$). The improvements observed in both active treatment groups were maintained at the two-month follow-up.

Conclusions: Both EFT and ST are effective interventions for reducing PAP in women with obesity, suggesting their potential integration into comprehensive obesity treatment programs to address psychological barriers to well-being.

Keywords: Obesity, Emotion-Focused Therapy, Schema Therapy, Perfectionism, Body Image

1. Background

Obesity, defined as a Body Mass Index (BMI) ≥ 30 kg/m^2, represents a significant global health challenge with profound physiological and psychological implications (1). Among these, psychological distress related to body image significantly affects the well-being of individuals with obesity. This condition is associated with pervasive body dissatisfaction, reduced self-esteem, and exposure to societal stigma, particularly among women, who face intensified pressure from media-driven ideals of thinness and cultural norms (2, 3). Such pressures often lead to internalized stigma and a persistent pursuit of an idealized physique, resulting in chronic emotional distress and social withdrawal, which impair quality of life. These psychological challenges can perpetuate unhealthy coping mechanisms, such as emotional eating or restrictive dieting, creating a cycle that exacerbates obesity-related issues (4). Addressing these psychological factors is essential for developing comprehensive intervention strategies.

Perfectionism, characterized by an unyielding drive for flawlessness, high standards, and overly critical self-evaluations, manifests across various domains (5). When directed toward physical attributes, it is termed physical appearance perfectionism (PAP), a construct marked by

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persistent self-scrutiny, preoccupation with perceived flaws, and fear of negative evaluation based on appearance (6). The Physical Appearance Perfectionism Scale (PAPS) measures two dimensions: "Hope for perfection", reflecting the aspiration to achieve an idealized appearance (e.g., striving for a specific body shape), and "worry about imperfection", capturing distress over perceived flaws (e.g., anxiety about failing to meet societal beauty standards) (6). Unlike general body dissatisfaction, PAP represents a more rigid, maladaptive trait that significantly disrupts an individual's body image relationship (7). In women with obesity, societal idealization of thinness amplifies self-criticism, intensifying perfectionistic tendencies and preoccupation with perceived imperfections (8). This can lead to heightened anxiety, depression, and disordered eating behaviors, such as rigid dieting or emotional eating, as well as social avoidance and reduced participation in health-promoting activities due to fear of judgment (9).

The psychological impact of obesity, particularly on body image and perfectionism, is well-documented, with studies linking PAP to disordered eating, anxiety, and depression (6, 8, 9). However, research specifically targeting PAP in women with obesity through structured psychological interventions remains limited. Existing studies often focus on general body dissatisfaction or weight loss, overlooking the nuanced cognitive and emotional patterns of PAP (10). Furthermore, comparative evaluations of specialized therapies addressing these patterns, such as emotion-focused therapy (EFT) and schema therapy (ST), are scarce, particularly in culturally specific contexts like Ahvaz, Iran, where appearance-related pressures may heighten PAP. This study addresses this gap by comparing EFT and ST, offering a novel contribution to the literature on psychological interventions for PAP in women with obesity.

The EFT, an empirically supported humanistic approach, posits that emotions are adaptive, guiding action and providing critical information (11). In addressing PAP, EFT aims to mitigate self-critical emotions, such as shame related to body image, by facilitating emotional processing and fostering self-compassion. The EFT techniques, including empathic attunement, emotion regulation, and two-chair work, help clients access, explore, and transform maladaptive emotional schemas. By distinguishing primary adaptive emotions from secondary reactive ones, EFT enables the processing of core feelings like shame or fear, which often underlie avoidance and self-criticism related to body image (12).

Schema therapy, an integrative approach combining cognitive-behavioral, psychodynamic, attachment, and Gestalt therapies, targets chronic psychological issues by addressing early maladaptive schemas (EMSs) — deeply ingrained dysfunctional patterns formed from unmet childhood emotional needs (13). For PAP, ST focuses on schemas like defectiveness/shame or unrelenting standards, which drive perfectionistic thoughts and behaviors. Through cognitive restructuring, experiential techniques (e.g., imagery rescripting, chair work), and behavioral pattern-breaking, ST replaces maladaptive coping styles (e.g., avoidance, overcompensation) with healthier alternatives (14, 15). By targeting these schemas, ST fosters more adaptive cognitive and emotional responses to appearance-related concerns.

This study's innovation lies in its comparative analysis of EFT and ST in addressing PAP among women with obesity in a culturally specific context. By examining their effectiveness in reducing both the aspirational and distress-related dimensions of PAP, it provides critical insights into tailored psychological interventions for this population.

2. Objectives

Consequently, this study aimed to evaluate and compare the effectiveness of EFT and ST on PAP, including its "hope for perfection" and "worry about imperfection" subscales, in women diagnosed with obesity.

3. Methods

This study employed a randomized controlled trial design, incorporating three distinct groups: The EFT, ST, and a control group, with assessments conducted at pre-test, post-test, and a two-month follow-up. The target population comprised women diagnosed with obesity who were seeking psychological or medical treatment in Ahvaz, Iran, from January 2023 to June 2024. A total of 60 eligible women were recruited through local clinics and public advertisements. The sample size was determined based on a power analysis assuming a medium effect size ($f = 0.25$), $\alpha = 0.05$, and power = 0.80, consistent with prior studies on psychological interventions for body image (10). Participants were randomly assigned to one of the three groups ($n = 20$ per group) using a computer-generated randomization sequence implemented by an independent researcher to ensure impartial allocation and minimize selection bias. Inclusion criteria for participants were: Female gender, a BMI greater than 30 kg/m^2 (indicating

obesity), age between 18 and 50 years, a PAPS score ≥ 36 to confirm clinically significant PAP, and willingness to provide informed consent and adhere to the full therapeutic protocol. Exclusion criteria included: A diagnosis of severe mental illness (e.g., psychosis, bipolar disorder, severe eating disorder requiring inpatient care), active substance abuse, concurrent engagement in other psychological interventions, cognitive impairment that would impede participation, or pregnancy/lactation. All participants provided written informed consent prior to data collection, ensuring their confidentiality and their inherent right to withdraw at any stage without penalty.

3.1. Instruments

3.1.1. Physical Appearance Perfectionism Scale

The PAPS is a meticulously designed self-report questionnaire used to assess perfectionistic tendencies specifically related to one's physical appearance. It comprises 12 items, rated on a 5-point Likert scale that ranges from "strongly disagree" to "strongly agree". The scale is structured with two primary subscales: "Hope for Perfection", which evaluates the active pursuit of an ideal appearance and the adherence to high personal standards; and "Worry about Imperfection", which measures concerns about perceived flaws, critical self-evaluation, and the fear of not meeting appearance standards. Higher scores on the PAPS and its subscales indicate greater levels of PAP (10). Previous research has consistently demonstrated the robust psychometric properties of the PAPS, including strong internal consistency, with Cronbach's alpha typically ranging from 0.89 to 0.90 for both the total score and its subscales (16).

3.2. Intervention Programs

Both EFT and ST interventions were delivered in structured, manualized formats by licensed psychotherapists with extensive experience. Each intervention group participated in 12 weekly sessions, with each session lasting 90 minutes, conducted in outpatient clinic settings. The control group received standard medical care, including routine consultations with dietitians and physicians for obesity management, but no specific psychological intervention during the study period. A concise overview of the key components and session progression for each intervention is provided in Table 1.

3.3. Data Analysis

All collected data were meticulously analyzed using SPSS (Version 26.0). The normality of data distribution was assessed using the Shapiro-Wilk test to ensure the appropriateness of parametric statistical methods. Descriptive statistics, including means and standard deviations, were computed for all relevant variables. To assess the effectiveness of the interventions and evaluate group differences across various time points, a series of repeated measures Analysis of Variance (ANOVA) tests were performed, with a significance level set at $\alpha = 0.05$. Post-hoc Bonferroni tests were then utilized to facilitate precise pairwise comparisons between groups.

4. Results

A total of 60 female participants diagnosed with obesity successfully completed the study protocols. The mean age of the participants was 28.5 ± 4.2 years, indicating a relatively young adult sample. Table 2 summarizes the descriptive statistics for the PAPS subscales — worry about imperfection and hope for perfection — across the EFT, ST, and control groups. At pre-test, groups showed comparable scores (worry about imperfection: $F = 0.12$, $P = 0.894$; hope for perfection: $F = 0.08$, $P = 0.921$), confirming effective randomization. Post-intervention and at the two-month follow-up, both the EFT and ST groups demonstrated notable reductions in scores for both subscales, whereas the control group's scores remained relatively stable or showed only minimal change.

Prior to conducting inferential analyses, the assumptions for repeated measures ANOVA were thoroughly checked. The normality of data distribution for all dependent variables across groups and time points was assessed using appropriate statistical tests, such as Shapiro-Wilk tests, in conjunction with visual inspection of Q-Q plots. Results confirmed that normality assumptions were largely met, with minor deviations not substantial enough to compromise the robustness of ANOVA. The results of the overall ANOVA for "worry about imperfection" and "hope for perfection" are presented in Table 3. For "worry about imperfection", the analysis revealed a significant effect ($P = 0.001$), indicating significant changes in this variable across the study. Similarly, for "hope for perfection", a significant effect was observed ($P = 0.001$), suggesting significant overall changes for this variable as well.

To precisely identify the specific differences between groups after the intervention, post-hoc pairwise comparisons using the Bonferroni correction were conducted, focusing exclusively on post-test scores.

Table 1. Overview of Intervention Programs for Emotion-Focused Therapy and Schema Therapy

Session/Phase	EFT	ST
Early sessions (1 - 3)	Establishing therapeutic alliance and providing psychoeducation on emotions; Developing awareness of emotions and identifying primary adaptive emotions; Accessing core painful emotions related to body image (e.g., shame, sadness, fear of judgment)	Conducting case conceptualization and providing psychoeducation on schemas and modes; Identifying relevant schemas (e.g., defectiveness/shame, unrelenting standards); Using schema questionnaires and imagery to elicit schemas
Middle sessions (4 - 7)	Evoking and processing intense body-related emotions (e.g., through two-chair work for self-criticism or empty-chair work for critical others); Addressing unmet needs underlying emotional pain; Promoting emotional transformation and fostering self-compassion	Engaging in experiential work (e.g., imagery rescripting to address childhood origins of schemas); Applying cognitive restructuring to challenge schema-driven thoughts; Addressing maladaptive coping styles (e.g., avoidance, overcompensation)
Late sessions (8 - 10)	Consolidating new emotional responses and promoting self-acceptance; Processing new emotional states in relational contexts; Developing self-soothing and self-validation skills to manage future body image challenges	Facilitating behavioral pattern breaking (e.g., confronting avoidance behaviors); Focusing on schema mode work (e.g., strengthening the healthy adult mode); Implementing relapse prevention strategies and planning for schema-driven behaviors

Table 2. Means and Standard Deviations of Physical Appearance Perfectionism Subscales by Group and Assessment Stage [a]

Variables and Groups	Pre-test	Post-test	Follow-up
Worry about imperfection			
EFT	24.67 ± 4.70	19.37 ± 4.58	20.01 ± 3.29
ST	25.07 ± 4.33	21.93 ± 4.06	20.88 ± 4.41
Control	25.20 ± 3.76	24.67 ± 3.90	24.30 ± 4.65
Hope for perfection			
EFT	19.53 ± 3.09	14.27 ± 4.20	14.098 ± 3.61
ST	19.27 ± 3.32	13.89 ± 4.16	14.00 ± 3.98
Control	19.47 ± 3.27	19.04 ± 3.49	19.80 ± 3.89

Abbreviations: EFT, emotion-focused therapy; ST, schema therapy.

[a] Values are expressed as mean ± SD.

Table 4 presents these results, including 95% confidence intervals for mean differences. For "worry about imperfection" at post-test, the EFT group demonstrated a significantly greater reduction in scores compared to the control group ($P = 0.001$). The ST group also exhibited a significant reduction when compared to the control group ($P = 0.001$). However, no statistically significant difference was observed between the EFT and ST groups ($P > 0.05$). Regarding "hope for perfection" at post-test, both the EFT group ($P = 0.001$) and the ST group ($P = 0.001$) demonstrated significantly lower scores compared to the control group. There was no statistically significant difference between the EFT and ST groups in "hope for perfection" at post-test ($P > 0.05$) (Table 4). These results collectively indicate that both interventions were effective in reducing PAP compared to the control group at the post-intervention assessment.

5. Discussion

This study investigated the effectiveness of EFT and ST in mitigating PAP among women with obesity. Specifically, the research focused on two key subscales: "Worry about imperfection" and "hope for perfection". The findings reveal that both EFT and ST significantly reduced PAP levels compared to a control group immediately post-intervention, and these improvements were sustained at a two-month follow-up. These results offer crucial insights into the psychological treatment of body image concerns in the context of obesity, particularly those driven by perfectionistic tendencies.

Our primary findings demonstrate that both EFT and ST led to significant reductions in scores on the "worry about imperfection" subscale when compared to the control group. This outcome aligns with the core principles of both therapeutic modalities. "Worry about imperfection" reflects a profound fear of failing to meet appearance standards and intense self-criticism (6). The EFT, by focusing on accessing, experiencing, and transforming maladaptive emotions such as shame, self-criticism, and anxiety related to body image, likely facilitated a reduction in this worry. This process enables participants to process underlying emotional pain and cultivate self-compassion (17, 18). Similarly, ST directly targets EMSs, such as defectiveness/shame and unrelenting standards, which are fundamental to

Table 3. Overall Analysis of Variance Results for Physical Appearance Perfectionism Subscales

Variables	SS	df	MS	F	P-Value	η^2
Worry about imperfection	317.76	1.33	238.57	28.69	0.001	0.51
Hope for perfection	300.56	1.95	154.30	21.47	0.001	0.43

Abbreviations: SS, sum of squares; MS, mean square; η^2, Eta-squared.

Table 4. Post-test Pairwise Comparisons (Bonferroni) for Physical Appearance Perfectionism Subscales

Variables and Groups	Mean Difference	SE	P-Value	95% CI
Worry about imperfection				
EFT-control	-5.30	1.15	0.001	[-7.60, -3.00]
ST-control	-2.74	1.15	0.012	[-5.04, -0.44]
EFT-ST	-2.56	1.15	0.069	[-4.86, 0.24]
Hope for perfection				
EFT-control	-4.77	0.98	0.001	[-6.73, -2.81]
ST-control	-5.15	0.98	0.001	[-7.11, -3.19]
EFT-ST	0.38	0.98	0.775	[-1.58, 2.34]

Abbreviations: EFT, emotion-focused therapy; ST, schema therapy; CI, confidence interval.

pervasive self-criticism and the pursuit of unattainable ideals (19). Through experiential techniques like imagery rescripting and chair work, ST aids individuals in confronting and healing these schema origins, thereby diminishing the intensity of their worry about perceived imperfections (20). These findings are consistent with previous research, such as Noroozi-Alou et al., who reported that EFT significantly reduced body image dissatisfaction in women with eating disorders by addressing shame and self-criticism (13). Similarly, Kopf-Beck et al. demonstrated that ST effectively reduced maladaptive schema-driven distress in individuals with depression, suggesting its applicability to appearance-related concerns (14). However, unlike the present study, which focused specifically on PAP in women with obesity, prior studies often targeted broader constructs like general body dissatisfaction or depression. The specificity of our intervention to PAP, combined with the culturally specific context of Ahvaz, Iran, where societal pressures on appearance may be particularly pronounced (3), may explain the robust effect sizes observed here compared to studies with more general populations or outcomes (10).

Furthermore, both interventions also yielded significant decreases in "hope for perfection" scores compared to the control group. This subscale denotes the active, often self-defeating, pursuit of an ideal appearance and excessively high personal standards (1). While seemingly positive, this relentless pursuit can paradoxically lead to chronic dissatisfaction and psychological distress. The emphasis of EFT on authentic emotional processing encourages individuals to relinquish external validation and unrealistic self-demands, fostering self-acceptance based on internal emotional cues rather than external appearance (21). Schema therapy addresses the cognitive-behavioral patterns driven by schemas, helping individuals recognize the self-defeating nature of unrelenting standards and facilitating a shift toward more balanced and compassionate self-views (22, 23). These results align with McComb and Mills, who found that interventions targeting perfectionistic tendencies in women exposed to idealized social media imagery reduced appearance-related aspirations (8). However, our study's focus on structured, manualized therapies (EFT and ST) contrasts with McComb and Mills' use of brief experimental interventions, potentially accounting for the sustained effects observed at the two-month follow-up in our study. Differences in outcomes may also stem from our sample's clinical diagnosis of obesity, which likely amplifies perfectionistic pressures due to societal stigma (2, 4), compared to non-clinical samples in prior research. The structured, multi-session format of our interventions, delivered by trained therapists, may have provided deeper emotional and cognitive restructuring than shorter or less intensive interventions (24).

The lack of significant differences between EFT and ST in reducing PAP may be attributed to their shared focus

on addressing deep-seated emotional and cognitive patterns, albeit through different mechanisms. The EFT emphasizes emotional transformation, while ST targets schema restructuring, yet both converge on reducing self-criticism and fostering self-compassion, potentially explaining their comparable efficacy (24). This finding is supported by meta-analytic evidence indicating that established psychotherapies, such as EFT and ST, often yield similar outcomes for specific psychological issues due to shared therapeutic factors, such as therapeutic alliance and emotional processing (25). For instance, Vatankhah et al. found comparable efficacy of EFT in reducing body image dissatisfaction in women with bulimia nervosa, suggesting that EFT's focus on emotional needs may be particularly effective for appearance-related concerns (25). The lack of significant differences between EFT and ST in our study may also reflect the specific cultural context of Iran, where appearance-related pressures are intensified by collectivist norms and gender-specific expectations (3), potentially making both therapies equally effective in addressing PAP. In contrast, studies in Western contexts, such as Lou et al., reported slightly greater efficacy for cognitive-based interventions over emotion-focused ones in addressing appearance perfectionism, possibly due to differences in cultural attitudes toward emotional expression (11).

The clinical implications of these findings are significant. Both EFT and ST can be integrated into obesity treatment programs, such as those offered in outpatient clinics or community health centers, to address psychological barriers like PAP that hinder weight management and well-being. By reducing PAP, these therapies may enhance adherence to lifestyle changes, improve body image, and reduce psychological distress, contributing to more sustainable health outcomes. The maintenance of effects, even at a two-month follow-up, is encouraging, although longer-term studies are warranted.

5.1. Conclusions

In conclusion, this study demonstrates that both EFT and ST significantly reduce PAP in women with obesity, offering effective psychological interventions to improve body image and mental well-being.

5.2. Limitations

Despite its contributions, this study has several limitations. The sample was restricted to women with obesity (BMI $\geq$ 30 kg/m^2) in Ahvaz, Iran, limiting generalizability to men or individuals with lower BMI ranges. Reliance on self-report measures could introduce social desirability bias; thus, future research could benefit from multi-method assessments. The specific cultural context necessitates further cross-cultural investigation. While a two-month follow-up was included, exploring longer-term durability of therapeutic effects (e.g., six months to one year) would provide stronger evidence. Future research should investigate specific mechanisms of change within each therapy, such as emotional regulation or schema modes, to better understand how improvements in PAPS occur. Comparative effectiveness research with larger, more diverse samples, including individuals with different levels of obesity or comorbidities, would strengthen the evidence base. Investigating the cost-effectiveness and feasibility of integrating these therapies into existing obesity management programs is also a crucial next step.

Footnotes

Authors' Contribution: M. A. A.: Study concept and design, acquisition of data, analysis and interpretation of data, and statistical analysis; Z. D. B. and P. A.: Administrative, technical, and material support, study supervision. Z. D. B. and S. S.: Critical revision of the manuscript for important intellectual content.

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Conflict of Interests Statement: The authors declare no conflict of interests.

Data Availability: All data generated or analyzed during this study will be available from the corresponding author on reasonable request.

Ethical Approval: This study received ethical approval from the Ethics Committee of the Islamic Azad University, Ahvaz Branch, Iran (IR.IAU.AHVAZ.REC.1403.385).

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