

Original Article

Comparing the Effectiveness of Compassion-Focused Therapy (CFT) and Emotion-Focused Therapy (EFT) on the Fear of Negative Evaluation in Adolescent Girls with Psychosomatic Problems

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Abstract

Background and Aim: Psychosomatic disorders are characterized by a bidirectional manifestation of symptoms, encompassing both physical and psychological dimensions. A significant concern for adolescents experiencing psychosomatic issues is the fear of negative evaluation (FNE), which is primarily defined by an excessive and persistent fear of being negatively judged by others. This fear often leads to feelings of worthlessness and shame. The objective of this study is to compare the effectiveness of Compassion-Focused Therapy (CFT) and Emotion-Focused Therapy (EFT) in alleviating the fear of negative evaluation among adolescent girls with psychosomatic disorders.

Materials and Methods: The research method was semi-experimental with a pretest-posttest, a control group, and a one-month follow-up design. The sample consisted of 45 female students aged 14-18 years from Mashhad during the academic year 1402-1403, selected via convenience sampling. Participants were randomly assigned to one of three groups: experimental group 1 (CFT), experimental group 2 (EFT), and a control group that received no intervention. The instruments utilized for data collection included the Lowry Evaluation Fear Questionnaire and the Takata Psychosomatic Complaints Scale. In the pre-test phase, all groups were assessed using these instruments. Following this assessment, experimental group 1 underwent eight sessions of compassion-focused therapy, while experimental group 2 received eight sessions of emotion-focused therapy. The control group did not participate in any therapeutic intervention. Post-intervention evaluations were conducted for all groups, followed by a follow-up assessment one month later. To analyze the data, repeated measures analysis of variance was performed using SPSS26.

Results: The findings indicated a significant difference ($p < 0.001$) in reducing the fear of negative evaluation in the CFT and EFT groups. Notably, EFT was found to significantly decrease the fear of negative evaluation in adolescent girls with psychosomatic symptoms. These results remained stable throughout the follow-up period ($p < 0.001$).

Conclusion: The superior efficacy of emotion-focused therapy compared to compassion-focused therapy can be attributed to its emphasis on reframing issues by addressing negative cycles, underlying emotions, and attachment-related needs. It suggests that EFT may offer a more effective therapeutic approach for reducing the fear of negative evaluation in adolescents suffering from psychosomatic disorders.

Keywords: Compassion-focused therapy, Emotion-focused therapy, Fear of negative evaluation, Psychosomatic disorder

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Introduction

Adolescence is a critical developmental stage characterized by significant physical, psychological, and social changes (1). During this period, adolescents are particularly vulnerable to psychosomatic problems, where psychological distress manifests as physical symptoms and vice versa (2). A significant issue during adolescence is fear of negative evaluation (3). If unaddressed, these issues can lead to long-term difficulties in social adjustment, emotional well-being, and academic achievement (4, 5).

Fear of negative evaluation is an individual's concern about the evaluations of others, excessive anxiety about negative evaluations, avoidance of evaluation situations, and expectation of negative evaluations from others (6). Fear of negative evaluation is one of the most effective dysfunctional cognitions in the formation of social anxiety. Fear of negative evaluation is also the main subject of negative thoughts and imaginations in social anxiety disorder (7). The main characteristic of these individuals is excessive worry or fear of people who think unfavorably of them (8). It is a type of psychological fear that results from a lack of balance between situational or environmental demands (9). Fear of negative evaluation often causes individuals' attentional resources to be focused on threats and social evaluations, causing the individual to have poor cognitive performance. People who fear negative evaluation try to avoid expressing themselves and their abilities and being present in social spaces to avoid being evaluated by others (10).

Compassion-focused therapy is an approach that draws from Buddhism, evolutionary psychology, and neuroscience and is based on concepts such as threat identification, attachment, and incentive/resource (11). The basic tenets of compassion-focused therapy posit that the development of compassion is a central

process in emotion regulation and psychotherapy (12). Self-compassion is the willingness to engage with one's pain and suffering rather than avoiding or disconnecting from it, to resolve it, and to be kind to oneself (13). Compassion-focused therapy fosters a loving, accepting relationship with oneself by recognizing the inevitability of suffering and stress and adopting a soothing and compassionate perspective during stressful events (14).

Given the role of emotions in exacerbating psychosomatic problems, emotion-focused therapy can be effective in treating these problems (15). This therapy examines primary adaptive, maladaptive, and secondary reactive emotions (16). This approach helps individuals clarify their feelings and needs and have greater emotional acceptance (17). In emotion-focused therapy, the therapist focuses on bringing awareness to the client's denied or distorted mental content and creating new meaning influenced by the client's physical experience (18).

Therefore, this study aims to compare the effectiveness of compassion-focused therapy and emotion-focused therapy in reducing fear of negative evaluation among adolescent girls experiencing psychosomatic problems. Specifically, this research seeks to answer the question: "Is there a significant difference between compassion-focused therapy and emotion-focused therapy in reducing fear of negative evaluation in adolescent girls with psychosomatic problems?"

Methods

This semi-experimental study used a pretest-posttest design with a waiting list and a one-month follow-up. The statistical population included all female students with psychosomatic problems in the second year of secondary school in the 3rd district of Mashhad in the academic year 2023-2024, who were selected using non-random, accessible, and purposeful sampling.

The sample size was determined using G*Power software (with an alpha of 0.5, a power of 0.8, and an effect size of 0.71), with 15 people for each group. The method of selecting the study sample was such that a list was prepared from all the second year of secondary school girls in the 3rd district of Mashhad, which included 16 schools. Among the public schools, two girls' schools and one class from each grade were selected from each school, which made the total number of students 250. Then, 45 students with psychosomatic problems were selected from among them based on the inclusion and exclusion criteria (inclusion criteria: informed and voluntary participation in the study, scoring 61 to 90 on the psychosomatic complaints scale, not receiving any other psychological education or treatment during the study, being at least 15 years old and at most 18 years old. Exclusion criteria: absenteeism from more than two intervention sessions, unwillingness to receive treatment, and failure to complete homework). Next, they were randomly assigned to three groups: Compassion-Focused Therapy, Emotion-Focused Therapy, and a control group (15 people in each group). To observe ethical considerations, participants were informed of the purpose of the research, the confidentiality of their information, and the freedom to withdraw from the study.

Materials

Fear of Negative Evaluation Scale-Brief Form (FNE-B)

The Short Version of the Fear of Negative Evaluation Scale was designed by Lowry (1983) to measure the distinct levels of anxiety-provoking experiences of individuals in the face of possible future negative evaluations. In this scale, which consists of 12 questions, participants answer each on a 5-point Likert scale from 1 (never true) to 5 (almost always true). In this scale, positively scored questions (8 questions) and reverse-scored questions (4 questions) describe the presence of fear and worry, and higher scores

indicate the experience of higher levels of anxiety and fear (Lowry, 1983). Lowry examined the psychometric properties of this scale among students and showed a high correlation with the long form (0.96) and internal consistency with an alpha of 0.92, and test-retest reliability after four weeks was 0.75 (19). In a study, the internal consistency coefficients of the total score and the subscales of the positively and negatively scored questions were 0.80, 0.82, and 0.81, respectively (20). In the present study, the Cronbach's alpha of this questionnaire was 0.79.

SPSS versions 26.0 and Amos 24.0 were used to analyze the study data. Structural Equation Modeling (SEM) was used to test the hypothesis.

Psychosomatic Complaints Scale (PPS)

The Psychosomatic Complaints Scale was developed and validated by Takata et al. in 2004 in Japan (21). This scale consists of 30 questions with a single-factor structure to measure psychosomatic complaints. The questionnaire is scored on a 4-point Likert scale, with the options "never", "rarely", "sometimes", and "frequently", receiving scores of 0, 1, 2, and 3, respectively. A score range of 0 to 30 indicates weak psychosomatic complaints, a score of 31 to 60 indicates moderate, and a score of 61 to 90 indicates strong or severe psychosomatic complaints. The creators of this scale obtained its concurrent validity in two separate studies, 0.64 and 0.65, by calculating its correlation with the Gulberg Mental Health Scale. Also, factor analysis was used to examine the construct validity of the scale in two studies, and it was found that in the first study conducted in 1997, 34.1% and in the second study conducted in 1999, 31.1% of the variance of the sections was explained by one factor. The reliability of this scale using Cronbach's alpha was 0.93 in 1997, 0.91 in 1998, and 0.92 in 1999. The correlation between the sections of the scale was also reported as 0.50 or more in three different implementations by the scale's creators (Takata et al., 2004). In Hajloo's (2012) study, the content validity of the translated version of the Psychosomatic Complaints Scale was confirmed by two experts (psychologists).

Table 1. Dimensions and subscale items in the Fear of Negative Evaluation Scale

Factors	Internal consistency items
Fear and worry about negative evaluation by others	1-2-3-4-5-6-7-8
Absence of fear and worry about negative evaluation by others	9-10-11-12

To determine the face validity of the scale, 10 students were asked to complete the Psychosomatic Complaints Scale and provide their opinion on the difficulty of understanding the questions, but none reported any problems understanding the questions. The test-retest reliability of the scale was confirmed on a sample of 30 students administered twice a month apart ($r = 0.83$). The Cronbach's alpha coefficient obtained on the original sample was also 0.85, indicating high internal consistency for the sections of this scale (22). In the present study, the Cronbach's alpha of this questionnaire was 0.78.

Compassion-Focused Therapy Protocol

The participants in experimental group 1 in this study

underwent Gilbert's (23) compassion-focused therapy for eight sessions (one 90-minute session per week). Table 2 provides a summary of Gilbert's compassion-focused therapy protocol.

Emotion-Focused Therapy Protocol

Participants in Experimental Group 2 underwent emotion-focused therapy (24) for eight sessions (one 90-minute session per week). Table 3 provides a summary of the emotion-focused therapy protocol.

The analysis of variance method with repeated measures and the Bonferroni post hoc test were used in SPSS statistical software version 26 to analyze the data obtained from the three stages of pre-test, post-test, and follow-up in three groups.

Table 2. Content of Compassion-Focused Therapy Sessions (Gilbert, 2009)

Intervention sessions	Content of intervention sessions
1.	Conducting a pre-test, getting to know the therapist and group members, discussing the purpose of the sessions and their overall structure, reviewing expectations from the first session, getting to know the general principles of compassion-focused therapy and differentiating compassion from self-pity
2.	Explanation and description of compassion: what compassion is and how it can be used to overcome problems. Mindfulness training with the second session exercise, body and breathing examination, getting to know the brain systems based on compassion.
3.	Getting to know the characteristics of compassionate people, compassion for others, cultivating a sense of warmth and kindness towards oneself, cultivating and understanding that others also have shortcomings and problems (cultivating a sense of human commonality) in the face of self-destructive feelings. Training in increasing warmth and energy, mindfulness, acceptance, wisdom and strength, warmth and non-judgment.
4.	Encouraging the subjects to self-recognize and examine their personality as "compassionate" or "uncompassionate" with regard to educational topics, identifying the fourth session and applying the exercises of "cultivating a compassionate mind"
5.	Teaching the styles and methods of expressing compassion (verbal compassion, practical compassion, intermittent compassion and continuous compassion) and applying these methods in the fifth session in daily life and for parents, friends and acquaintances.
6.	Teaching compassion skills to participants in the areas of compassionate attention, compassionate reasoning, compassionate behavior, compassionate imagery, compassionate feeling and compassionate perception, playing the role of an individual in the three existential dimensions of self-criticism, self-criticism and self-compassionate using the Gestalt empty chair technique, finding the tone and intonation of the inner self-criticism and self-compassionate voice during internal dialogue and its similarity to the dialogue pattern of important people in life.
7.	Completing a weekly chart of critical thoughts, compassionate thoughts, and compassionate behavior. Finding compassionate colors, places, and music that can be components of compassionate imagery, working on the fear of self-compassion and obstacles to developing this trait. Teaching compassionate imagery techniques, rhythmic soothing breathing, mindfulness, and writing compassionate letters.
8.	Summarizing and concluding and answering members' questions and evaluating the entire session, thanking and appreciating members for participating in the sessions, conducting the eighth post-test session.

Table 3. Content of emotion-focused therapy training sessions (Lacey et al., 2010)

Intervention sessions	Content of intervention sessions
1.	Introduction and establishment of the therapeutic relationship; acceptance of group members and greeting; introduction of group members to each other and the counselor; general statement of the goals of emotion-focused therapy; statement of the rules and principles of the sessions; the importance of observing order and being active in discussions and doing assignments and agreeing on the time of meetings; their number and duration.
2.	Acceptance and reflection of the members' shared experiences (interactive and emotional), discovery of problematic interactions and identification of disruptive negative interaction cycles, determination of the relationship of members' emotional responses with their attachment levels, assessment of the attachment problem and obstacles
3.	Creation of a safe communication space for group members; discovery and identification of underlying and unexpressed feelings; expression of pure feelings and emotions; discovery of basic fears and insecurities in members' communication; helping members to re-experience emotions
4.	Reshaping the cycle of interactions, clarifying key emotional responses, coordination between the therapist and group members; Acceptance of the interaction cycle by members
5.	Acceptance of undefined feelings, identification of denied attachment needs, and emotions, integration of needs with interactions, helping members to be more self-disclosed
6.	Expanding the emotional experiences of each member, increasing acceptance of the experiences of those around them, ownership of emotions, increasing acceptance of new interactive responses, coordinating the therapist's diagnosis with group members
7.	Facilitating the expression of needs and desires to rebuild interactions based on new perceptions; interactions, changing harmful behaviors; reconstructing and facilitating new solutions to old and old problems and answering questions from group members
8.	Consolidating the currently established cycle; accepting new situations; reviewing the main learnings of the treatment by group members; discussing the positive and negative points of view of implementing the educational plan.

Results

In this study, 15 students were randomly selected and replaced in each group. Five students from the 10th, 11th, and 12th grades were replaced in the compassion-focused therapy group and the control group. However, four students from the 10th grade, five students from the 11th grade, and six students from the 12th grade were replaced in the emotion-focused therapy group.

The mean and standard deviation of the age of the participants in the compassion-focused therapy group and the control group were 17 and 0.845, respectively. The mean and standard deviation of the age of the participants in the emotion-focused therapy group were 17.3 and 0.834, respectively.

Table 4 shows that in the compassion-focused and emotion-focused therapy, the mean scores of fear of negative evaluation decreased in the post-test compared to the pre-test and increased in the follow-up compared to the post-test. In the control group, the mean scores of fear of negative evaluation decreased

in the post-test compared to the pre-test. As the results of Table 5 show, the effect of time is significant ($F = 17.427$, $p\text{-value} < 0.001$, $\eta^2 = 0.46$), meaning that there is a meaningful difference between the measures of fear of negative evaluation in pre-test, post-test, and follow-up. Also, the interaction effect of group and time is significant ($F = 4.616$, $p\text{-value} < 0.001$, $\eta^2 = 0.18$), meaning that the mean scores of fear of negative evaluation at different times differ according to the levels of the group variable. The results of the Mauchly test in Table 6 show that the assumption of sphericity does not hold, and the Greenhouse-Geisser test was used. As can be seen in Table 7, the effect of measurement time on the scores of fear of negative evaluation is significant ($p\text{-value} < 0.001$), so it can be stated that regardless of the intervention groups, there is a meaningful difference between the mean scores of pre-test, post-test, and follow-up, and the effect size is approximately 35 percent. Also, the interaction effect between time and group is significant ($p\text{-value} < 0.001$), so it can be stated that the difference in the mean scores of fear of negative evaluation at different times varies according to the variable levels of the group, and the

effect size is approximately 27 percent. Also, as can be seen in the rest of the table, the effect of the group is significant on the scores of fear of negative evaluation (p -value < 0.001), so we can conclude that regardless of the measurement time, there is a significant difference between the mean scores of the intervention and control groups, and the effect size is approximately 35 percent. To further examine the measurement time and experimental groups, the Bonferroni correction was used, the results of which are presented in Table 8.

As can be seen in Table 8, by comparing the three

groups, it was found that there was a significant difference between the two groups of Compassion-Focused Therapy and emotion-focused therapy, as well as between the two control groups and emotion-focused therapy. However, no significant difference was observed between the two control groups and Compassion-Focused Therapy. By examining the measurement time, we found a meaningful difference between the pre-test and post-test and the pre-test and follow-up, but there was no significant difference between the post-test and follow-up.

Table 4. The average and standard deviation of fear of negative evaluation in different groups

Variable	Time	Compassion-Focused Therapy		Emotionally Focused Therapy		Control Group	
		Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Fear of negative evaluation	Pre-test	46	6.89	46.6	6.89	51.66	7.78
	Post-test	25.6	10.82	25.73	10.89	46	8.29
	Follow-up	27.6	10	26.4	8.13	47.33	6.36

Table 5. Results of the multivariate repeated measures test of fear of negative evaluation

Source	Statistic	Value	F	Assumed DF	Error DF	Significance Level	Eta Square
Time	Wilkes Lambda Effect	0.459	17.427	2	41	0.001	0.459
Time* Group	Wilkes Lambda Effect	0.360	4.616	4	84	0.002	0.180

Table 6. Summary of the results of the Mauchly's sphericity test analysis of the variable fear of negative evaluation

Within-subjects effect	Mauchly	Chi-square	Error DF	Significance Level	Greenhouse-Geisser
Fear of negative evaluation	0.772	10.601	2	0.005	0.814

Table 7. Results of repeated measures analysis of variance for fear of negative evaluation

Variable	Source	Sum of Squares	DF	Mean Square	F	Significance Level	Eta Square
Fear of negative evaluation	Within group	Time	1.629	1829.219	22.206	0.001	0.346
		Time* Group	3.258	649.619	7.886	0.001	0.273
	Between group	Error	68.413	82.374			
		Error	3587.867	42	85.425	11.389	0.001

Table 8. Bonferroni correction of the fear of negative evaluation variable by time and group.

Group#p	2	Mean difference	Significance Level	Time		Mean difference	Significance Level
				1	2		
Compassion-Focused Therapy	Emotion-Focused Therapy	8.578	0.001	Pretest	Posttest	11.200	0.001
Compassion-Focused Therapy	Control	1.178	1.000	Pretest	Follow-up	7.889	0.001
Emotion-Focused Therapy	Control	7.4-	0.001	Posttest	Follow-up	3.311-	0.129

Discussion

The findings of this study showed a significant difference between the two groups of compassion-focused therapy and emotion-focused therapy, as well as between the two control and emotion-focused therapy groups; this means that emotion-focused therapy causes a greater reduction in fear of negative evaluation in adolescents with psychosomatic symptoms, and this difference is statistically significant.

Regarding the positive effect of compassion-focused therapy on improving fear of negative evaluation, the results are consistent with the findings of the research of Hayatifar *et al.* (24) and Tofangchi *et al.* (25). Hayatifar *et al.* in a study on the effect of compassion-focused therapy on fear of negative evaluation in married women concluded that this treatment improves negative evaluation. Also, the research of Tofangchi *et al.* (25) showed that compassion-focused therapy reduces self-criticism and fear of negative evaluation in women.

Also, in terms of the effect of emotion-focused therapy on improving fear of negative evaluation, the results of this study are consistent with the findings of the research of Piri *et al.* (26) and Ahghar Bazargan *et al.* (27). Piri *et al.* showed that emotion-focused therapy reduces fear of negative evaluation and psychological distress in women with social anxiety disorder. Given the higher effectiveness of emotion-focused therapy on improving fear of negative evaluation compared to compassion-focused therapy and considering the studies conducted by the researcher in domestic and foreign sources, no study was found that examined and compared the effectiveness of the two intervention methods on the variable of fear of negative evaluation. Due to their specific psychological characteristics, adolescents at this age have higher levels of self-criticism and fear of negative evaluation (28). Fear of negative evaluation involves a sense of apprehension and worry about the judgment of others, the anxiety resulting from these negative evaluations, and the expectation that others will judge one only negatively (29). It is a psychological fear resulting from a lack of balance between situational or environmental demands. In other words, fear of negative evaluation is a fear that

arises from the worry of being unfairly and hastily judged by others (30). Evidence suggests that having various unprocessed emotions, such as shame, worry, and embarrassment, can be associated with fear of negative evaluation (31). People who fear negative evaluation try to avoid expressing themselves and their abilities and being present in social spaces not to be evaluated by others (32). Therefore, it seems that addressing emotions and emotional awareness and regulation can reduce feelings of loneliness.

The emotion-centered perspective considers emotions as the most important factor in their formation. The main goal of this therapy is to help people clarify their emotions and needs and achieve emotional acceptance. One of the most effective methods of reducing negative emotions and increasing positive emotions and adaptive behavior is emotional regulation (33). Verbal persuasion can increase self-efficacy. It can be said that in emotion-centered therapy, accessing maladaptive emotional patterns and regulating them is one of the main tasks of the therapist (34). The main focus of treatment is on emotions. The experiential theory shows how emotional schemas organize emotions and how emotional processes operate in individuals. Emotional schemas are a process that is the basis of normal functioning and also the source of human dysfunction. Emotional processes are mostly made up of preverbal elements of bodily senses, visual images, smells, etc. Furthermore, they are rarely present in consciousness and require manifestation, exploration, expression, and reflection of experiences to be activated (35).

Fear of negative evaluation is more dependent on the individual's self-perception, cycle of negative interactions, and self-esteem than it is rooted in fear of the negative attitude and evaluation of others (36). Therefore, to repair this feeling of negative evaluation, individuals must learn how to reconstruct their emotions (such as shame, anger, sadness, etc.) and the interactive cycle that creates these emotions, and thus repair themselves. On the other hand, emotion-focused therapy is formulated in the form of nine therapeutic steps. The first four steps include initial assessment and limiting problematic interactive cycles. In the intermediate steps, the emphasis is on creating and generating specific and new events that, through their mediation, transform interaction patterns and create attachment-based experiences.

Conclusion

In emotion-focused therapy, a safe space is created for the client to identify their feelings and express them without fear of judgment, thereby increasing their self-esteem (37). Unlike compassion-focused therapy, which focuses on self-compassion and self-acceptance, emotion-focused therapy focuses on the child's early interaction cycle and attachment repair and tries to identify and repair negative interaction patterns by using attachment identification and repair and reparenting.

Through attachment repair, improving the interaction cycle associated with this attachment and creating new positive interactions help the fear of negative evaluation improve in adolescents (38). In other words, the effectiveness of emotion-focused therapy compared to compassion-focused therapy can reframe the problem by paying attention to the negative cycle, substructured emotions, and attachment-oriented needs. Therefore, emotion-focused therapy is more effective than other treatments in improving fear of negative evaluation in adolescent girls with psychosomatic symptoms.

Ethical Considerations

Ethics code number 162815315 has been received from the University Ethics Committee.

Conflict of Interest

The authors declare that they have no conflict of interest.

References

- 1- Aizpitarte A, Atherton OE, Zheng LR, Alonso-Arbiol I, Robins RW. Developmental precursors of relational aggression from late childhood through adolescence. *Child Dev.* 2019;90(1):117-26.
- 2- Lebailly T, Saint-André S, Laplace S, Lancien-Dereine AS, Gourbil A, Botbol M. A psychosomatic approach of anorexia nervosa. In: *Person centered approach to recovery in medicine: insights from psychosomatic medicine and consultation-liaison psychiatry.* 2019:249-60.
- 3- Trompeter N, Bussey K, Hay P, Mond J, Murray SB, Lonergan A, et al. Fear of negative evaluation and weight/shape concerns among adolescents: the moderating effects of gender and weight status. *J Youth Adolesc.* 2018;47:1398-408.
- 4- Dryman MT, Gardner S, Weeks JW, Heimberg RG. Social anxiety disorder and quality of life: how fears of negative and positive evaluation relate to specific domains of life satisfaction. *J Anxiety Disord.* 2016;38:1-8.
- 5- Dogan PK. Examining the relation between the fear of negative evaluation and the anxiety for social appearance in folk dancers. *J Educ Train Stud.* 2018 Mar;6(3):59-65.
- 6- Fredrick JW, Luebke AM. Fear of positive evaluation and social anxiety: a systematic review of trait-based findings. *J Affect Disord.* 2020;265:157-68.
- 7- McEvoy PM, Black A, Piesse E, Strachan L, Clarke PJ. The effect of positive and negative evaluation on state anxiety and repetitive negative thinking in social evaluative situations: an experimental study. *J Anxiety Disord.* 2023 Aug;98:102734.
- 8- Sohrabi Z, Dortaj F, Sa'dipour E. The effectiveness of training self-encouragement on cognitive slippage and fear of negative evaluation. *J Iran Psychol.* 2020;16(64):401-10.
- 9- Iqbal A, Ajmal A. Fear of negative evaluation and social anxiety in young adults. *Peshawar J Psychol Behav Sci.* 2018;4(1):45-53.
- 10- Bozdağ B. Examination of university students' fear of negative evaluation and academic dishonesty tendencies. *Particip Educ Res.* 2021;8(3):176-87.
- 11- Finlay-Jones A, Xie Q, Huang X, Ma X, Guo X. A pilot study of the 8-week mindful self-compassion training program in a Chinese community sample. *Mindfulness.* 2018;9(3):993-1002.
- 12- Inwood E, Ferrari M. Mechanisms of change in the relationship between self-compassion, emotion regulation, and mental health: a systematic review. *Appl Psychol: Health Well Being.* 2018;10(2):215-35.
- 13- Neff KD. Self-compassion: theory, method, research, and intervention. *Annu Rev Psychol.* 2023;74:193-218.
- 14- Jiang RD, Liu MQ, Chen Y, Shan C, Zhou YW, Shen XR, et al. Pathogenesis of SARS-CoV-2 in transgenic mice expressing human angiotensin-converting enzyme 2. *Cell.* 2020;182(1):50-8.
- 15- Sarabi MR, Jafari A. The effectiveness of emotion-focused therapy on alexithymia and psychosomatic complaints in patients of COVID-19 under home treatment. *Psychol Stud.* 2023;18(4).
- 16- Asano K. Emotion processing and the role of compassion in psychotherapy from the perspective of multiple selves and the compassionate self. *Case Rep Psychiatry.* 2019;2019:7214752.
- 17- Koechlin H, Coakley R, Schechter N, Werner C, Kossowsky J. The role of emotion regulation in chronic pain: a systematic literature review. *J Psychosom Res.* 2018;107:38-45.
- 18- Greenberg LS, Watson JC. Emotion-focused therapy for depression: Canadian contributions. *Can J Behav Sci.* 2022;54(2):152.
- 19- Leary MR. A brief version of the fear of negative evaluation scale. *Pers Soc Psychol Bull.* 1983;9(3):371-5.
- 20- Shokri O, Garavand F, Naqsh Z, Tarkhan RA, Paeizi M. Psychometric properties of the short form of the fear of negative evaluation scale. *Iran J Psychiatr Clin Psychol.* 2008;14(3):316-25.
- 21- Takata Y, Sakata Y. Development of a psychosomatic complaints scale for adolescents. *Psychiatry Clin Neurosci.* 2004;58(1):3-7.
- 22- Hajloo N. Psychometric properties of the Takata and Sakata psychosomatic complaints scale among students of Mohaghegh Ardabili University. *J Behav Sci Res.* 2012;10(3):1-10.
- 23- Gilbert P. Introducing compassion-focused therapy. *Adv Psychiatr Treat.* 2009;15(3):199-208.
- 24- Hayatifar J, Irvani M. The effectiveness of compassion-focused therapy on psychological distress and fear of negative evaluation in married women in Isfahan. *Women Psychol.* 2022;11(3):58-69.
- 25- Tofangchi M, Raisi Z, Omrani A, Rezaei Jamaloui H. Development of a distress tolerance promotion package and comparison of its effectiveness with compassion-based therapy on self-criticism, fear of negative evaluation, and anxiety in women

- with chronic tension-type headaches. *J Psychol Sci.* 2021;20(100):621-34.
- 26- Piri T, Zadeh Hassan J, Sadati SZ, Sheikhzadeh Kermani K, Moghadam P. Studying the effectiveness of emotion-focused therapy on reducing fear of negative evaluation and psychological distress in women with social anxiety disorder. *MEJDS.* 2023;13:36.
- 27- Bazargan Ahghar G, Sajjadian I. The effectiveness of emotional efficacy-based therapy on fear of negative evaluation and experiential avoidance in mothers of autistic children. *Iran J Pediatr Nurs.* 2024;10(2):25-35.
- 28- Jane-Frances A, Ebele I. Assessment of negative self-image and fear of negative evaluation among adolescents and young adults. *Psychol Res.* 2014;4(11):905-14.
- 29- Subbe CP, Royce R. Patient powered safety: reducing harm through co-production with patients. London: The Health Foundation; 2019.
- 30- Clevinger AM, Kleider-Offutt HM, Tone EB. In the eyes of the law: associations among fear of negative evaluation, race, and feelings of safety in the presence of police officers. *Pers Individ Dif.* 2018;135:201-6.
- 31- Wolniewicz CA, Tiamiyu MF, Weeks JW, Elhai JD. Problematic smartphone use and relations with negative affect, fear of missing out, and fear of negative and positive evaluation. *Psychiatry Res.* 2018;262:618-23.
- 32- MirMoeini P, Bayazi MH, Khlatabari J. Comparing the effects of acceptance and commitment therapy with compassion-focused therapy on the severity of worry and resilience of patients with multiple sclerosis. *J Arak Univ Med Sci.* 2022;25(1):88-103.
- 33- Atadokht A, Gharib Bolouk M, Mikaeli N, Samadifard HR. Effect of emotion-focused cognitive behavioral therapy on social adjustment and experiential avoidance in Iranian disabled veterans. *Mil Caring Sci.* 2019;6(3):182-92.
- 34- Ghafari Shahir M, Asadpour E, Zaharakar K. Comparison effect of cognitive behavioral therapy and emotion-focused therapy on loneliness in married women victims of domestic violence. *Adv Cogn Sci.* 2021;23(1):95-105.
- 35- Elliot AJ, Eder AB, Harmon-Jones E. Approach-avoidance motivation and emotion: convergence and divergence. *Emotion Rev.* 2013;5(3):308-11.
- 36- Ganesh Kumar J, Athilakshmi R, Maharishi R, Maya R. Relationship between fear of negative evaluation and anxiety. *Int J Indian Psychol.* 2015;3(1):74-80.
- 37- Greenberg LS. Emotion-focused therapy: a clinical synthesis. *Focus.* 2010;8(1):32-42.
- 38- Davoudi R, Manshaee G, Golparvar M. Comparing the effectiveness of adolescent-centered mindfulness with cognitive behavioral therapy and emotion-focused therapy on emotion regulation among adolescents girl with nomophobia. *J Health Promo Manag.* 2019;8(4):16-25.