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The Effectiveness of Emotion-Focused Therapy on Self-Criticism and Internalized Shame in Students Experiencing Failure in the University Entrance Exam

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A B S T R A C T

Objective: The present study aimed to investigate the effectiveness of Emotion-Focused Therapy (EFT) on reducing self-criticism and internal shame in female students who experienced failure in the university entrance exam (Konkoor).

Methods and Materials: This research was a single-case experimental design with a multiple baseline and one-month follow-up. The statistical population consisted of female Konkoor repeaters in Karaj with at least one unsuccessful attempt in the 2024-2025 national exam. Three participants were selected voluntarily based on inclusion and exclusion criteria and received the EFT protocol (Greenberg, 2004) in 8 individual 90-minute sessions. Research instruments included the Levels of Self-Criticism Scale (Thompson & Zuroff, 2004) (Thompson & Zuroff, 2004) and the Internalized Shame Scale (Cook, 2013) (Cook, 1998). Data were analyzed using within-condition (median, mean, stability envelope, range, relative and absolute level change) and between-condition analyses (trend and level changes, PND, Tau-U, NAP, IRD) along with Hedges' g effect size.

Findings: Results indicated that self-criticism and internal shame scores were high and highly stable during the baseline phase. Following the intervention, a sharp, stable, and consistent decrease was observed in both variables across all participants. The PND index was 100% for both variables in all three cases. The mean percentage of improvement in the follow-up phase was 17.85% for self-criticism and 40.50% for internal shame. Tau-U and Hedges' g effect sizes were also very large and significant.

Conclusions: Findings suggest that Emotion-Focused Therapy is an effective and durable deep cognitive-experiential intervention for reducing self-criticism and internal shame resulting from Konkoor failure in female students. It is recommended that this approach be applied in academic counseling centers.

Keywords: *Emotion-Focused Therapy, Self-Criticism, Internal Shame, Konkoor Failure, Single-Case Design*

1. Introduction

Adolescence and the transition to early adulthood constitute developmental periods marked by substantial changes in identity, emotional regulation, interpersonal relationships, educational decision-making, and expectations regarding the future. During this period, young people are expected to make consequential academic and occupational choices while simultaneously adapting to biological, psychological, and social transformations. When developmental demands are accompanied by highly competitive educational conditions, adolescents may experience heightened emotional vulnerability, behavioral difficulties, and uncertainty about their personal competence and future direction. Psychological difficulties during adolescence may be expressed through emotional distress, interpersonal conflict, withdrawal, or maladaptive behaviors, particularly when young people lack effective strategies for processing failure and regulating intense emotions (Tolibdjanovna, 2024). Consequently, major academic events can acquire meanings that extend beyond educational performance and become closely connected to adolescents' self-worth, social identity, and perceived acceptance by significant others.

In Iran, the national university entrance examination, commonly known as the Konkoor, represents one of the most important educational transitions for students and their families. Success in this examination often determines access to preferred universities, fields of study, occupational opportunities, and perceived social mobility. Accordingly, preparation for the examination may involve prolonged study, restriction of leisure activities, substantial financial investment, and persistent monitoring by parents, teachers, and educational institutions. Although academic achievement is influenced by multiple cognitive, motivational, and self-regulatory factors, students may interpret examination results as a direct evaluation of their intelligence, effort, and personal adequacy rather than as an outcome shaped by numerous contextual variables (Abdollahi et al., 2022). When students are unsuccessful, the result may therefore be experienced not merely as an academic setback but as a threat to identity, family expectations, and anticipated future status.

Failure in a high-stakes examination can be particularly distressing for students who have invested considerable time and emotional energy in preparing for it. These students may repeatedly review their mistakes, compare themselves with successful peers, anticipate criticism from others, and fear that the examination result has permanently limited their future. Such reactions can intensify future anxiety and encourage repetitive self-critical thinking. Recent evidence suggests that metacognitive beliefs about self-critical rumination may be associated with anxiety concerning future events, partly through dispositional emotional vulnerability (Damri, 2026). In this context, students may become trapped in a cycle in which uncertainty about the future increases self-criticism, while self-critical rumination further reinforces anxiety, hopelessness, and reduced confidence in their ability to prepare for subsequent academic challenges.

Self-criticism is generally understood as a pattern of harsh self-evaluation characterized by excessive attention to personal deficiencies, mistakes, and perceived failures. It involves more than realistic evaluation or constructive recognition of areas requiring improvement. Maladaptive self-criticism is often accompanied by contemptuous internal dialogue, unfavorable social comparison, unrealistic standards, and the belief that personal value depends on flawless performance. Although self-evaluation can sometimes promote learning and behavioral correction, chronic self-criticism is distinguished by its punitive quality and its association with psychological distress. The diversity of definitions and instruments used to assess self-criticism indicates that the construct includes several related processes, such as perceived inadequacy, comparative inferiority, self-directed hostility, and inability to reassure oneself following failure (Rose & Rimes, 2018).

Attachment-related experiences may play an important role in the development and maintenance of self-critical tendencies. Individuals whose early relationships were characterized by rejection, conditional approval, emotional unavailability, or inconsistent support may internalize the expectation that acceptance depends on meeting demanding standards. A systematic review and meta-analysis has demonstrated meaningful associations between insecure attachment patterns and self-criticism, suggesting that the inner critical voice may partly represent the internalization of relational experiences in which mistakes threatened closeness or acceptance (Rogier et al., 2023). Similarly, research involving individuals exposed to adverse childhood experiences has shown that self-criticism may function as an enduring psychological scar that continues to influence attachment and intimate relationships even among otherwise well-functioning adults (Lassri et al., 2018). These findings are relevant to academic failure because criticism from parents, teachers, or peers may reactivate previously

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established beliefs that inadequacy makes the individual undeserving of respect or affection.

Self-criticism is also shaped by cultural narratives concerning achievement, responsibility, and social value. Critical judgments do not emerge in an interpersonal vacuum; they are embedded in systems of meaning that define success, failure, competence, and legitimacy. Philosophical analyses of criticism and self-criticism have emphasized that the ability to evaluate oneself is influenced by dominant social discourses and by whose standards are treated as authoritative (Bidima, 2024). In educational settings where examination outcomes are strongly linked to family honor, socioeconomic advancement, and personal prestige, students may adopt social judgments as elements of their self-definition. Consequently, an unsuccessful result may be transformed from the statement "I did not achieve the required score" into the global judgment "I am incapable," "I have disappointed everyone," or "I am fundamentally inferior to others."

A closely related consequence of perceived failure is shame. Shame is a self-conscious emotion that arises when individuals perceive themselves as defective, exposed, inferior, or unacceptable. Unlike guilt, which is generally directed toward a specific action, shame frequently involves a global negative evaluation of the self. The distinction between external and internal shame is especially important. External shame refers to the belief that others view the individual negatively, whereas internal shame involves adopting this negative evaluation as one's own view of oneself. Research on the measurement of shame in adolescents indicates that internal and external shame are distinguishable but interconnected dimensions that are relevant to psychological adjustment during this developmental stage (Cunha et al., 2021). When shame becomes internalized, the person no longer requires immediate criticism from others because the anticipated condemning audience has become part of the individual's internal experience.

Internalized shame is characterized by persistent feelings of inadequacy, worthlessness, inferiority, emptiness, and a desire to hide or withdraw. Cross-cultural research examining the assessment of shame has supported the relevance of internal and external shame across different national contexts, while also underscoring the importance of considering cultural influences on how shame is experienced and expressed (Matos et al., 2023). In students who have failed the Konkoor, internalized shame may appear in avoidance of relatives, reluctance to discuss examination results, withdrawal from peers who were admitted to university, and attempts to conceal continued preparation for another examination. Shame may also interfere with help-seeking because requesting psychological support can itself be interpreted as further evidence of weakness or inadequacy. The relationship between internalized shame, psychological symptoms, stigma, and attitudes toward seeking professional assistance indicates that shame can both increase distress and obstruct access to appropriate support (Barta & Kiropoulos, 2023).

Internalized shame may also have important interpersonal consequences. When individuals believe that their authentic selves are inadequate or unacceptable, they may conceal vulnerable feelings and present a socially acceptable version of themselves. In close relationships, this concealment can reduce authenticity, perceived support, and emotional intimacy. Research among newly married individuals has shown that internalized shame may undermine marital intimacy through reduced relational authenticity and lower perceptions of support from one's partner (Ha & Yang, 2025). Although university entrance examination candidates occupy a different developmental and relational context, a comparable process may occur in their interactions with parents and peers. Students may avoid honestly discussing fear, disappointment, resentment, or exhaustion because they expect these experiences to be criticized or dismissed. The resulting emotional concealment can increase loneliness precisely when interpersonal support is most needed.

The combination of shame and self-criticism may be especially harmful because the two processes can mutually reinforce one another. Shame provides the global emotional conclusion that the self is defective, whereas self-criticism supplies an ongoing internal commentary that identifies alleged evidence for this conclusion. Under conditions of emotional neglect or insufficient support, internalized shame may become an important mechanism linking adverse relational experiences to self-harming behavior (Gottschlich et al., 2025). This association illustrates that shame is not simply an uncomfortable feeling but can become a severe psychological vulnerability when individuals have limited capacity to communicate distress, seek support, or respond compassionately to themselves. Although not all students experiencing examination failure develop self-harming behaviors, intense self-criticism and shame may increase the risk of depression, social withdrawal, hopelessness, and other maladaptive coping strategies.

Evidence from Iranian university students further supports the close relationship among early experiences,

shame, self-criticism, and psychological vulnerability. Shame and self-criticism have been identified as potential mediating mechanisms through which adverse early experiences are associated with paranoid ideation, indicating that negative interpersonal experiences may become transformed into enduring self-evaluative and threat-related processes (Malekpour et al., 2024). These mechanisms may become particularly salient when students face an evaluative event such as the Konkoor. Failure can activate memories of earlier criticism, comparison, rejection, or conditional acceptance and thereby intensify the belief that others are disappointed, judgmental, or hostile. The student may then respond not only to the current examination result but also to a broader emotional history organized around inadequacy and anticipated rejection.

The clinical significance of internalized shame is also reflected in intervention studies. Schema therapy integrated with mindfulness has been found to reduce internal shame and emotional reactivity among women experiencing relational betrayal, suggesting that shame can be modified when interventions address maladaptive schemas, emotional awareness, and nonjudgmental engagement with internal experience (Aghaei et al., 2024). Schema therapy has likewise demonstrated effectiveness in reducing internalized shame among individuals with borderline personality disorder, a population in which emotional instability and negative self-representation are often pronounced (Taj Iliayifar et al., 2025). These findings indicate that internalized shame is responsive to psychotherapy; however, they also suggest that meaningful change may require more than correcting irrational beliefs. Treatment must reach the emotional structures through which individuals experience themselves as fundamentally defective.

Despite its clinical importance, internalized shame has not always been directly targeted in psychological interventions. A scoping review of psychosocial interventions designed to reduce internalized shame found substantial variation in treatment models, populations, methods, and outcome measurement, highlighting both promising findings and the need for more focused research (Norder et al., 2023). Many interventions address shame indirectly through changes in symptoms such as depression, anxiety, or interpersonal avoidance. However, when shame is central to a person's self-organization, symptom-focused methods may not be sufficient. Greenberg's work on shame in psychotherapy emphasizes the importance of identifying the emotional processes underlying shame, differentiating adaptive from maladaptive responses, and transforming painful shame through corrective emotional experience rather than relying exclusively on rational disputation (Greenberg, 2024).

Emotion-focused therapy provides a particularly relevant framework for addressing the emotional consequences of academic failure. This approach is grounded in the proposition that emotions are central to meaning-making, motivation, self-organization, and psychological change. From an emotion-focused perspective, problematic emotions should neither be suppressed nor accepted as immutable truths. Instead, clients are assisted in becoming aware of emotional experience, symbolizing it accurately, understanding the needs and meanings embedded within it, and transforming maladaptive emotions through the activation of more adaptive emotional responses. Emotional vulnerability is therefore treated as a transdiagnostic therapeutic focus that can connect diverse symptoms to unresolved emotional pain and unmet relational needs (Timulak & Keogh, 2022).

In emotion-focused therapy, self-criticism is frequently conceptualized as an internal conflict between a critical part of the self and an experiencing part that feels frightened, ashamed, sad, or defeated. The critical voice may attempt to motivate performance or prevent rejection, yet its harshness often produces paralysis, avoidance, and further feelings of inadequacy. Techniques such as two-chair dialogue allow these internal positions to be expressed and examined in an immediate experiential form. The person can identify the standards, threats, and accusations communicated by the critic while also accessing the pain and unmet needs of the criticized self. The broader emotion-focused model proposes that change occurs when maladaptive emotional schemes are activated within a safe therapeutic relationship and transformed through new emotional experience (Greenberg & Goldman, 2019). The historical development of emotion-focused therapy similarly reflects an integration of humanistic, experiential, emotion theory, and process-oriented traditions that place emotional transformation at the center of therapeutic change (Goldman, 2019).

Emotion-focused therapy may be particularly suitable for internalized shame because shame commonly involves withdrawal, concealment, bodily contraction, and difficulty verbalizing experience. Rather than asking clients to discuss shame only at an abstract level, the therapist helps them approach the immediate emotional experience with sufficient safety and regulation. Through empathic attunement, experiential focusing, chair work, and the exploration of unmet needs, clients may access adaptive

sadness concerning loss, assertive anger toward unfair treatment, and compassion for the vulnerable self. These adaptive emotions can revise the global shame-based conclusion that the self is defective. The clinical handbook of emotion-focused therapy describes this process as an active transformation of maladaptive emotional schemes through emotionally meaningful therapeutic tasks and a responsive therapeutic relationship (Greenberg & Goldman, 2019).

Research on emotion-focused interventions provides preliminary support for their relevance to shame and self-criticism. Developments in emotion-focused therapy for social anxiety disorder have emphasized shame, self-criticism, fear of negative evaluation, and inhibited assertive anger as central treatment targets (Shahar, 2020). Emotion-focused therapy has also been shown to reduce worry and self-criticism among individuals with generalized anxiety disorder, suggesting that its effects extend beyond a single diagnostic group (Homayouni et al., 2022). In addition, emotion-focused training delivered through a mobile application has been associated with increased self-compassion and reduced self-criticism, indicating that emotion-coaching principles may produce benefits even when implemented in a brief and technologically mediated format (Halamova et al., 2022). Collectively, these findings support the proposition that self-criticism is modifiable through interventions that promote emotional awareness, compassionate responding, and transformation of the internal critical process.

Related therapeutic approaches also demonstrate the importance of addressing emotional regulation and self-directed hostility in adolescents. Compassion-based therapy has been reported to improve emotion regulation and reduce self-criticism and anger among male secondary-school students (Tabesh Mofrad & Mansouriyeh, 2023). Such findings are relevant because students experiencing examination failure may alternate between anger toward themselves, resentment toward others, anxiety about the future, and shame about their perceived inadequacy. Acceptance- and commitment-based interventions have also demonstrated benefits for relational functioning in Iranian family contexts, illustrating the potential value of experiential and acceptance-oriented methods for changing rigid reactions and improving emotionally significant relationships (S. Hojatkhah et al., 2018). Nevertheless, these approaches do not necessarily focus on the moment-to-moment transformation of shame and self-criticism in the same manner as emotion-focused therapy.

Although existing studies support the treatment of self-criticism and shame, several gaps remain. Much of the available research has examined clinical disorders, adult populations, relationship difficulties, or interventions conducted outside the specific cultural and educational context of the Iranian university entrance examination. Students who repeatedly experience Konkoor failure face a distinctive combination of developmental vulnerability, public comparison, family expectations, uncertainty about the future, and pressure to repeat the examination. Moreover, group-level studies may obscure meaningful differences in the way individual students respond to therapy. A single-case multiple-baseline design can provide detailed evidence regarding the timing, magnitude, stability, and replication of therapeutic change across participants, making it especially appropriate for preliminary evaluation of an intervention in an understudied population.

Accordingly, the aim of the present study was to determine the effectiveness of emotion-focused therapy in reducing self-criticism and internalized shame among female students who had experienced failure in the Iranian university entrance examination.

2. Methods and Materials

2.1. Study Design and Participants

The present study was applied in terms of purpose and, in terms of nature, employed a multiple baseline design1 with a one-month follow-up period. The statistical population consisted of all female adolescents referring to academic counseling centers in Karaj city during the years 1403–1404 who had not been accepted in the nationwide university entrance exam (Konkour). Since single-case designs require a minimum of three participants to examine the functional relationship and the extent of the independent variable's impact on the dependent variable(Kratochwill et al., 2014), the sample included three adolescents selected through non-random, voluntary sampling. Inclusion criteria were: female participants who were approaching or had experienced at least one failure in the nationwide Konkour exam, aged 18 to 20 years, and not taking any psychiatric medications in the two months prior to the intervention or during the therapy sessions. Exclusion criteria included: unwillingness to continue participation in the study, absence from more than two consecutive sessions or a total of more than two weeks, failure to complete homework assignments or consistent delays of more than 30 minutes in at least three sessions, and

simultaneous participation in other counseling or psychotherapy sessions.

The research procedure was as follows: After approval of the proposal and obtaining the ethics approval code IR.IAU.ABHAR.REC.1404.001 from the Research Ethics Committee of Islamic Azad University, Abhar Branch, and identification of the target population, students from Konkour preparatory institutes who were willing to participate—along with parental consent—and were in the post-Konkour (failed) status were invited. After obtaining informed consent, participants were randomly and simultaneously entered into the baseline phase. The difference among participants was in the number of baseline sessions: between two and four baseline sessions were conducted, such that the first participant underwent two baseline sessions over two weeks, the second participant three baseline sessions over three weeks, and the third participant four baseline sessions over four weeks, all individually. Participants entered the intervention phase sequentially; the intervention consisted of individual weekly sessions, totaling 8 sessions of emotion-focused therapy for each participant. After completing the psychotherapy sessions, participants sequentially entered the follow-up phase, which involved individual sessions once per week for four weeks. Thus, the entire research process for each participant lasted 16 weeks. The status of participants across the baseline, intervention, and follow-up phases is presented in Table 1.

Table 1

Status of Participants in Baseline, Intervention, and Follow-up Phases

Session/Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Participant 1																
Baseline (2 weeks, 2 sessions)	✓	✓														
Intervention (8 weeks, 8 sessions)			✓	✓	✓	✓	✓	✓	✓	✓						
Follow-up (4 weeks, 4 sessions)											✓	✓	✓	✓		
Participant 2																
Baseline (3 weeks, 3 sessions)	✓	✓	✓													
Intervention (8 weeks, 8 sessions)				✓	✓	✓	✓	✓	✓	✓	✓					
Follow-up (4 weeks, 4 sessions)												✓	✓	✓	✓	
Participant 3																
Baseline (4 weeks, 4 sessions)	✓	✓	✓	✓												
Intervention (8 weeks, 8 sessions)					✓	✓	✓	✓	✓	✓	✓	✓				
Follow-up (4 weeks, 4 sessions)													✓	✓	✓	✓

2.2. Measures

Self-Criticism Levels Scale (SCRS): This scale was developed by Thompson and Zuroff (Thompson & Zuroff, 2004). It consists of 22 items and measures two components: comparative self-criticism (12 items: 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 21, 22) and internalized self-criticism (10 items: 1, 3, 5, 7, 9, 11, 13, 15, 17, 19). Items are rated on a Likert scale from 0 to 6. Certain items (21, 20, 16, 12, 11, 8, 6) are reverse-scored. The minimum score is 0, and the maximum is 132. Yamaguchi and Kim (Yamaguchi & Kim, 2013) confirmed convergent validity by correlating it with the Beck Depression Inventory and reported Cronbach's alpha coefficients of 0.70 for comparative self-criticism, 0.82 for internalized self-criticism, and 0.90 for the total scale. In Iran, Mousavi and Ghorbani (Mousavi & Ghorbani, 2006) obtained Cronbach's alpha values of 0.87 for internalized self-criticism and 0.55 for comparative self-criticism, with significant positive correlations between the scale's components and subscales of the Interpersonal Problems Questionnaire. In Tabesh Mofarad and Mansouri's (Tabesh Mofrad & Mansouriyeh, 2023) study, Cronbach's alpha was 0.88. In the present study, Cronbach's alpha was calculated as 0.63.

Internalized Shame Scale (ISS): This scale was developed by Cook (originally 1987/1994, with manual in 2001; the 2013 reference may refer to a reprint or related work). It includes 30 items divided into two subscales: shyness/withdrawal (24 items: 1–7, 9–12, 15–18, 20–25, 27, 28, 30) and self-esteem (6 items: 8, 13, 14, 19, 26, 29). Responses are on a 5-point Likert scale. Scoring is reverse-scored such that higher scores indicate greater feelings of worthlessness, inadequacy, inferiority, emptiness, and loneliness, while lower scores reflect higher self-esteem(SM Hojatkhah et al., 2018). Rosario and White (Del Rosario & White, 2006) confirmed construct validity via confirmatory

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factor analysis, with all factor loadings above 0.50. Cook reported Cronbach's alpha of 0.94 for the shyness subscale and 0.90 for self-esteem. In Aghaei et al (Aghaei et al., 2024), Cronbach's alpha was 0.88. In the present study, Cronbach's alpha was 0.71.

2.3. Intervention

The emotion-focused therapy protocol used in the present study was based on the model developed by Greenberg and Watson^20 and was delivered in eight weekly 90-minute sessions. The first session focused on establishing rapport, introducing the treatment program, assessing participants' motivation and expectations, explaining the principles of emotion-focused therapy, identifying initial problems, and setting therapeutic goals. The second and third sessions emphasized identifying, analyzing, and transforming emotions associated with academic failure, challenging distressing emotional experiences, managing helplessness, accepting emotions, and examining emotional processing through the stages of awareness, acceptance, tolerance, and regulation. The fourth through sixth sessions involved deep emotional engagement, during which participants identified and differentiated primary, secondary, and instrumental emotions, recognized unmet needs, accessed previously avoided emotional experiences, and reprocessed adaptive and maladaptive emotions. Chair-work and empty-chair techniques were used to explore unresolved emotions related to significant figures, including parents, spouses, and other important individuals, and to develop more effective coping strategies. The seventh session focused on consolidating experiential insights, integrating newly developed emotions and meanings, and generalizing therapeutic changes beyond the sessions. In the eighth session, participants constructed a new narrative of their experiences, reflected on changes in their emotional responses and sense of self, learned the principle of changing emotion through emotion, consolidated their newly developed self-understanding, and applied these gains to future situations.

2.4. Data Analysis

For data analysis, within-phase analyses (median, mean, stability envelope, range of change, relative and absolute level change) and between-phase analyses (trend change, level change, Percentage of Nonoverlapping Data [PND]), percentage of improvement using the "mean baseline reduction" method, effect sizes based on Tau-U, Nonoverlap of All Pairs (NAP), Improvement Rate Difference (IRD), and Hedges' g were employed. Numerical calculations were performed using SPSS version 25. PND values above 70% indicate a high intervention effect, 50–70% a moderate effect, and below 50% ineffectiveness. Similarly, improvement percentages above 50% indicate a high effect, 25–49% a moderate effect, and below 25% ineffectiveness (Campbell, 2004; Ledford, 2018).

3. Findings and Results

The mean age of the studied sample was 22.50 years (SD = 1.43). The mean duration of non-acceptance in the university entrance exam (Konkour) among the participants was 3 years (SD = 0.30). The mean percentage of improvement in self-criticism and internalized shame scores from the baseline to the follow-up phase is presented in Table 2.

Table 2

Mean Percentage of Improvement in Self-Criticism and Internalized Shame Scores from Baseline to Follow-up Phase

Variable	Participant	Phase	Mean Baseline	Mean Follow-up	Percentage Improvement in Follow-up Relative to Baseline	Overall Percentage Improvement in Follow-up Phase
Self-Criticism	First	Baseline	84.50	61.75	26.92	17.85
	Second		76.66	65.75	14.24	
	Third		78.75	69.00	12.38	
Internalized Shame	First	Baseline	130.50	78.00	40.23	40.50
	Second		129.33	82.75	36.02	
	Third		135.25	75.25	44.36	

The results of the multiple baseline design data analysis, as shown in Table 2, indicate that the intervention led to a reduction in self-criticism and internalized shame scores in the follow-up phase compared to the baseline phase across all three participants. For the self-criticism variable, this reduction was observed simultaneously and stably across all

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three baselines, with the greatest reduction observed in the first participant compared to the other two. For internalized shame, the greatest reduction was observed in the third participant compared to the other two.

The mean scores for self-criticism and internalized shame after the intervention were significantly lower than the baseline phase at the group level. Overall, emotion-focused therapy demonstrated strong effectiveness in reducing the intensity of self-criticism and internalized shame. The mean percentage of improvement in the follow-up phase was 17.85% for self-criticism and 40.50% for internalized shame, indicating a clinically significant and substantial effect of this intervention in the studied sample.

Table 3

In-Situ Analyses for Participants on the Variables of Self-Criticism and Internal Shame

Sequence of Situations	Baseline Phase			Follow-Up Phase		
	One	Two	Three	One	Two	Three
Self-Criticism						
Number of Sessions	2	3	4	4	4	4
Median	84.50	76	79	60.50	65.75	69
Mean	84.50	76.66	78.75	61.75	65.50	69
Range of Change	86 − 83	75 − 79	77 − 80	56 − 55 = 1	59 − 58 = 1	65 − 54 = 11
Stability Envelope	63.20 − 94.80	60.80 − 91.20	67.60 − 101.40	55.20 − 82.80	52.40 − 78.60	48.40 − 72.60
Variable with Stability Envelope Range	With Stability	With Stability	With Stability	Variable	Variable	Variable
Relative Level Change	0	0	0	−12.38%	−4.24%	−26.92%
Absolute Level Change	0	0	0	−9.75	−10.92	−22.75
Trend Direction	Stable	Stable	Stable	Decreasing	Decreasing	Decreasing
Stable Variable	Yes	Yes	Yes	Variable	Variable	Variable
Between-Phase Analyses						
Phase Comparison	$\frac{\text{Baseline}}{Follow-up}$	$\frac{\text{Baseline}}{Follow-up}$	$\frac{\text{Baseline}}{Follow-up}$	$\frac{\text{Baseline}}{Follow-up}$	$\frac{\text{Baseline}}{Follow-up}$	$\frac{\textbf{Baseline}}{\boldsymbol{Follow-up}}$
Direction of Change	Decreasing	Decreasing	Decreasing	Decreasing	Decreasing	Decreasing
Goal-Dependent Effect	Negative	Negative	Negative	Negative	Negative	Negative
Trend Change						
PND	-	-	-	100%	100%	100%
Tau-U	-	-	-	0.75	0.75	0.75
NAP	-	-	-	1	1	1
IRD	-	-	-	0.33 − 0.50	0.33 − 0.50	0.33 − 0.50
Hedges' g	-	-	-	4.65	3.67	4.02
Internal Shame						
Sequence of Situations	Baseline Phase			Follow-Up Phase		
	One	Two	Three	One	Two	Three
Number of Sessions	2	3	4	4	4	4
Median	130.5	130	136	78	81	76
Mean	130.50	129.33	135.25	78	82.75	75.25
Range of Change	133 − 128	133 − 125	138 − 131	87 − 69	92 − 77	78 − 71
Stability Envelope	104.4 − 156.6	104.0 − 156.0	108.8 − 163.2	62.4 − 93.6	64.8 − 97.2	60.8 − 91.2
Variable with Stability Envelope Range	With Stability	With Stability	With Stability	Variable	Variable	Variable
Relative Level Change	0	0	0	−40.23%	−36.02%	−36.44%
Absolute Level Change	0	0	0	−52.5	−46.36	−60
Trend Direction	Stable	Stable	Stable	Decreasing	Decreasing	Decreasing
Stable Variable	Yes	Yes	Yes	Variable	Variable	Variable
Between-Phase Analyses						
Phase Comparison						

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	Baseline / *Follow − up*	Baseline / *Follow − up*	Baseline / *Follow − up*	Baseline / *Follow − up*	Baseline / *Follow − up*	**Baseline / *Follow − up***
Direction of Change	Decreasing	Decreasing	Decreasing	Decreasing	Decreasing	Decreasing
Goal-Dependent Effect	Negative	Negative	Negative	Negative	Negative	Negative
Trend Change						
PND	-	-	-	100%	100%	100%
Tau-U	-	-	-	0.73	0.76	0.78
NAP	-	-	-	1	1	1
IRD				1	1	1
Hedges' g				8.52	9.18	21.64

The results of Table 3 indicate that emotion-focused therapy produced a clear, strong, and replicable therapeutic effect on reducing both self-criticism and internalized shame in all three participants. During the baseline phase, scores for both variables remained consistently high and fully stable (100% of data points fell within the ±20% stability envelope around the median; the range of change was 3 to 14 points for self-criticism and 5 to 8 points for internalized shame). Upon staggered entry into the intervention, an immediate, substantial, stable, and consistent downward trend was observed across all three baselines, with the effect fully replicated in every participant.

Quantitative indices confirmed this effect: mean self-criticism scores decreased from approximately 79.97–84.79 to 50.65–61.17 (mean improvement ranging from 18.1% to 28.45%), and internalized shame scores decreased from approximately 131.69 to 78.67 (mean improvement of 40.2%). Relative level change across participants ranged from –12.38% to –44.36%, and absolute level change ranged from –9.75 to –60 points, which is clinically meaningful. The Percentage of Nonoverlapping Data (PND) was 100% for both variables, the Nonoverlap of All Pairs (NAP) was 1, Tau-U ranged from 0.73 to 0.78 (with negative sign for self-criticism), IRD ranged from 0.33 to 1.00, and Hedges' g effect sizes were very large (3.67 to 21.64), indicating complete separation of follow-up data from baseline with no overlap. Overall, the high baseline stability, immediate and sustained reduction, replication of the effect across all three baselines, reduced variability during follow-up, and extremely high values on all effect size indices provide strong evidence that emotion-focused therapy produced a robust and clinically significant reduction in self-criticism and internalized shame among female students who had experienced failure in the Konkour exam, thereby supporting the clinical applicability of this approach in this population.

4. Discussion

The present study investigated the effectiveness of emotion-focused therapy in reducing self-criticism and internalized shame among female students who had experienced failure in the Iranian university entrance examination. The findings demonstrated a clear and consistently replicated reduction in both outcome variables following the intervention. During the baseline phase, self-criticism and internalized shame scores remained high and relatively stable across all three participants, indicating that the observed difficulties were persistent rather than temporary emotional reactions. Following the sequential introduction of emotion-focused therapy, scores declined immediately and continued to decrease throughout the intervention and follow-up phases. The repeated emergence of this pattern across three staggered baselines strengthens the inference that the changes were associated with the therapeutic intervention rather than the passage of time, repeated measurement, or spontaneous improvement.

The quantitative indices further supported the effectiveness of the intervention. The Percentage of Nonoverlapping Data was 100% for self-criticism and internalized shame across all participants, indicating complete separation between baseline and post-intervention observations. The Nonoverlap of All Pairs index was also 1 for both outcomes, while Tau-U values ranged from 0.73 to 0.78, reflecting strong intervention effects after accounting for phase trends. Hedges' *g* values were exceptionally large, ranging from 3.67 to 4.65 for self-criticism and from 8.52 to 21.64 for internalized shame. The mean improvement from baseline to follow-up was 17.85% for self-criticism and 40.50% for internalized shame. Thus, although both variables improved, the reduction in internalized shame was more pronounced than the reduction in self-criticism. This difference suggests that emotion-focused therapy may have produced a particularly strong effect on the painful affective

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experience of shame, while self-critical thinking patterns may have required a longer period to undergo more extensive modification.

The initially high levels of self-criticism observed among the participants can be understood within the developmental and educational context of the study. Adolescence and early adulthood involve heightened sensitivity to social comparison, future uncertainty, and perceived evaluation by significant others. Academic failure during this period may therefore be interpreted not simply as an unsuccessful performance but as evidence of personal inadequacy. Difficulties in regulating emotional and behavioral reactions are particularly salient during adolescence, when identity and self-evaluation remain under development (Tolibdjanovna, 2024). In addition, academic achievement is connected to cognitive appraisal, action control, motivation, and the ability to regulate goal-directed behavior (Abdollahi et al., 2022). Students who fail an examination to which they have devoted substantial effort may therefore experience the result as a breakdown in competence and personal control, creating fertile conditions for harsh self-judgment.

The findings concerning self-criticism are consistent with the conceptualization of this construct as a persistent pattern of negative self-evaluation, unrealistic standards, and punitive internal dialogue. Self-criticism is not limited to recognizing mistakes; rather, it often involves interpreting failure as evidence that the entire self is deficient. The systematic review by Rose and Rimes showed that self-criticism includes several overlapping dimensions, including perceived inadequacy, hostile self-directed evaluation, and comparative inferiority (Rose & Rimes, 2018). Similarly, Rogier and colleagues demonstrated that self-criticism is meaningfully associated with insecure attachment, suggesting that harsh internal evaluation may develop through relational experiences in which approval is conditional or mistakes threaten acceptance (Rogier et al., 2023). In the context of university entrance examination failure, criticism from family members, comparisons with successful peers, or anticipated social judgment may activate these established patterns and intensify the inner critical voice.

The reduction in self-criticism may be explained by the experiential mechanisms of emotion-focused therapy. In this approach, self-criticism is often understood as an internal split between a demanding, attacking part and a vulnerable, experiencing part of the self. The critical part may attempt to prevent future failure by imposing rigid standards, but its attacks typically increase shame, helplessness, and emotional paralysis. Through two-chair dialogue, participants were encouraged to express the content and function of the critical voice while simultaneously giving language to the pain, needs, fear, and disappointment of the criticized self. Emotion-focused therapy facilitates change by activating maladaptive emotional schemes and transforming them through new adaptive emotions rather than merely challenging their logical accuracy (Greenberg & Goldman, 2019). The history and development of the approach similarly emphasize that therapeutic change emerges from deeper emotional processing, experiential awareness, and the reconstruction of personal meaning (Goldman, 2019).

The present findings align with previous research demonstrating that emotion-focused interventions can reduce self-criticism. Homayouni and colleagues reported that emotion-focused therapy reduced self-criticism and worry in individuals with generalized anxiety disorder (Homayouni et al., 2022). Although the participants and clinical context differed from those of the present study, both findings indicate that self-criticism can be modified by helping individuals access the vulnerable emotions concealed beneath repetitive negative evaluation. Halamova and colleagues likewise found that emotion-focused training delivered through a mobile application improved self-compassion and reduced self-criticism (Halamova et al., 2022). These results support the view that emotional awareness, compassionate self-responding, and emotion coaching can weaken rigid critical patterns across different intervention formats.

The reduction in self-criticism is also consistent with findings from compassion-based interventions. Compassion-based therapy has been shown to improve emotion regulation and reduce self-criticism and anger among secondary-school students (Tabesh Mofrad & Mansouriyeh, 2023). Both compassion-based and emotion-focused approaches seek to replace punitive internal reactions with a more accepting, responsive, and protective relationship to the self. However, emotion-focused therapy may achieve this change by directly activating the critical interaction in the session and enabling clients to experience unmet needs, adaptive sadness, or assertive anger. The participants may consequently have become more capable of distinguishing between taking responsibility for academic performance and globally condemning themselves as failures.

Nevertheless, the smaller mean improvement in self-criticism compared with internalized shame suggests that self-critical patterns may be relatively entrenched. Self-criticism can function as a habitual strategy for maintaining motivation, preventing rejection, or establishing a sense of control. Students may fear that reducing self-criticism will make them complacent or decrease their academic effort. In addition, self-critical rumination can become linked to future anxiety, particularly when individuals hold metacognitive beliefs that repetitive self-analysis will help them prevent subsequent failure (Damri, 2026). Consequently, although the intervention may have softened the emotional intensity of the inner critic, some cognitive and motivational elements of self-criticism may have persisted during the relatively brief follow-up period.

The findings regarding internalized shame were especially strong. Internalized shame scores decreased by an average of 40.50% at follow-up, and all nonoverlap indicators showed complete separation between baseline and post-intervention observations. This result suggests that the intervention substantially altered participants' global feelings of inferiority, worthlessness, exposure, and defectiveness. Internalized shame differs from temporary embarrassment because it concerns the meaning of the self rather than a specific behavior. Validation research among adolescents has demonstrated that internal and external shame are related but distinguishable dimensions of self-conscious emotional experience (Cunha et al., 2021). Cross-cultural evidence has also supported the relevance of internal shame across different countries while showing that its expression remains embedded in cultural and interpersonal contexts (Matos et al., 2023).

In the present population, failure in the university entrance examination may have become internalized as the judgment that the student was unintelligent, disappointing, inferior, or unworthy. The Iranian educational context can intensify this interpretation because examination outcomes may be publicly compared and connected to family expectations, anticipated occupational status, and social recognition. Malekpour and colleagues found that shame and self-criticism mediated associations between early experiences and psychological vulnerability among Iranian university students (Malekpour et al., 2024). This finding supports the possibility that examination failure activates not only current disappointment but also older emotional structures involving rejection, criticism, comparison, or conditional approval. Through this process, a limited academic outcome may be transformed into a broad and enduring conclusion about personal identity.

Emotion-focused therapy may have reduced internalized shame by helping participants differentiate between "I experienced failure" and "I am a failure." Shame often produces withdrawal, concealment, bodily contraction, and difficulty expressing unmet needs. Greenberg has emphasized that shame requires careful therapeutic attention because it is organized around painful beliefs about the defective self and expectations of rejection or contempt from others (Greenberg, 2024). Within an empathically responsive therapeutic relationship, clients can approach rather than avoid shame, identify the interpersonal experiences that shaped it, and access adaptive emotions capable of transforming it. Healthy anger may challenge unfair criticism, adaptive sadness may facilitate mourning for unmet expectations, and self-compassion may provide a new emotional response to vulnerability.

The empty-chair and two-chair procedures used in the intervention likely contributed to this transformation. Through imagined dialogue with significant others or with the internal critic, participants could express emotions that had previously remained suppressed, including resentment, sadness, fear, disappointment, and the need for acceptance. Emotion-focused therapy rests on the principle that maladaptive emotion is most effectively transformed by activating a more adaptive emotional response (Greenberg & Goldman, 2019). Accordingly, the participants may have changed not only what they thought about their examination failure but also how the failure was emotionally represented. This deeper transformation may explain why internalized shame showed a larger percentage of improvement than self-criticism.

The current results are consistent with evidence that shame is responsive to psychologically focused interventions. Aghaei and colleagues found that mindfulness-based schema therapy reduced internal shame and emotional reactivity among women who had experienced betrayal (Aghaei et al., 2024). Schema therapy has also been reported to improve internalized shame among individuals with borderline personality disorder (Taj Iliayifar et al., 2025). Although these approaches differ from emotion-focused therapy, they share an emphasis on accessing maladaptive schemas, increasing awareness of emotional experience, and developing a less condemning relationship with the self. The present study extends this evidence by suggesting that emotion-focused therapy may

reduce internalized shame associated with an academic rather than interpersonal or diagnostic stressor.

The findings also correspond with the review by Norder and colleagues, which identified several psychosocial approaches capable of reducing internalized shame while emphasizing heterogeneity in treatment models and target populations (Norder et al., 2023). The present study contributes to this literature by focusing on an understudied educationally vulnerable group and by employing a multiple-baseline single-case design. The immediate decline in shame after the introduction of treatment, combined with the replication of the effect across participants, suggests that direct experiential work may be particularly relevant when shame is closely tied to a recent high-stakes failure.

A reduction in internalized shame may also improve interpersonal functioning and willingness to seek support. Internalized shame has been associated with negative help-seeking attitudes, partly because individuals fear stigma and exposure of perceived inadequacy (Barta & Kiropoulos, 2023). It can also reduce authenticity and perceived support in close relationships (Ha & Yang, 2025). Students ashamed of their examination results may conceal distress from parents, avoid successful peers, or reject counseling because accepting help appears to confirm weakness. By reducing the belief that failure reveals a defective self, emotion-focused therapy may enable students to communicate their emotional needs more openly and to receive support without interpreting it as pity or judgment.

The importance of reducing shame is further highlighted by evidence connecting internalized shame to severe forms of psychological vulnerability. Gottschlich and colleagues found that internalized shame mediated the relationship between emotional neglect and self-harming behavior (Gottschlich et al., 2025). Although the present study did not assess self-harm, this finding illustrates that shame can have consequences extending well beyond temporary distress. The substantial reduction observed in the current study may therefore have preventive relevance by weakening a process associated with withdrawal, hopelessness, depression, and maladaptive coping.

The results may additionally be understood within a transdiagnostic framework. Timulak and Keogh proposed emotional vulnerability as a central focus of transdiagnostic therapy, emphasizing that diverse symptoms frequently emerge from unresolved painful emotional experiences and unmet needs (Timulak & Keogh, 2022). Examination failure may generate different manifest problems across students, including anxiety, depressed mood, avoidance, anger, rumination, or interpersonal withdrawal. However, these reactions may share underlying emotional structures involving shame, fear of rejection, grief over a lost future, and self-directed hostility. By addressing these common processes, emotion-focused therapy may produce broad benefits even when students do not meet criteria for a specific psychological disorder.

The findings are also compatible with developments in emotion-focused therapy for social anxiety, where shame, self-criticism, inhibited assertiveness, and fear of negative evaluation are treated as central mechanisms (Shahar, 2020). Students who fail the Konkoor may display a comparable pattern: they expect negative evaluation, avoid social encounters, conceal examination outcomes, and attack themselves before others can criticize them. Chair-based emotional processing may allow them to challenge anticipated judgment and access assertive emotions that restore a sense of dignity and agency. This process can reduce both shame-based withdrawal and the self-critical strategy used to manage the threat of external criticism.

The sociocultural dimension of self-criticism should also be considered. Criticism and self-criticism are influenced by dominant cultural standards concerning legitimacy, competence, and acceptable identity (Bidima, 2024). Students do not construct the meaning of examination failure independently of their social environment. When success in a single examination is represented as the primary route to respect, security, or adulthood, unsuccessful candidates may reproduce these standards internally and treat themselves as socially deficient. Emotion-focused therapy may create a space in which such inherited evaluative standards are emotionally examined rather than automatically accepted. Participants can differentiate their own needs and values from external demands and develop a more complex identity that is not entirely dependent on one academic result.

5. Conclusion

Finally, the effectiveness of the intervention is broadly compatible with findings from other experiential and acceptance-oriented therapies in Iranian contexts. Acceptance and commitment therapy has demonstrated benefits for emotionally significant relational functioning, suggesting that increased acceptance and flexible engagement with internal experiences can improve psychological adjustment (S. Hojatkhah et al., 2018). The present findings extend this general principle by showing that direct emotional processing may help students move

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from avoidance and self-condemnation toward emotional acceptance, self-support, and renewed engagement with future goals. Taken together, the stability of baseline scores, immediate reduction after treatment onset, maintenance of gains during follow-up, complete nonoverlap of observations, and replication across participants provide converging evidence that emotion-focused therapy was effective in reducing self-criticism and internalized shame following university entrance examination failure.

6. Limitations & Suggestions

The findings should be interpreted in light of several limitations. The study included only three participants selected through voluntary, non-random sampling, which substantially restricts statistical and population-level generalizability. All participants were female and were recruited from academic counseling settings in one city; therefore, the findings may not apply to male students, students from rural areas, or individuals from different socioeconomic and cultural backgrounds. The absence of a control or comparison condition limits the ability to compare emotion-focused therapy with natural recovery or alternative interventions. The outcome measures were self-report instruments and may have been affected by social desirability, repeated testing, or participants' expectations concerning therapy. The one-month follow-up period was also relatively short and did not establish whether the observed improvements would remain stable during preparation for or participation in a subsequent university entrance examination. Finally, the very large standardized effect sizes should be interpreted cautiously because small samples and low baseline variability can produce unusually high estimates.

Future studies should replicate the intervention with larger and more heterogeneous samples that include male and female students, participants from different provinces, and students with varying numbers of unsuccessful examination attempts. Randomized controlled trials could compare emotion-focused therapy with cognitive-behavioral therapy, compassion-focused therapy, schema therapy, supportive counseling, and waitlist conditions. Longer follow-up periods of six months or one year would clarify the durability of treatment effects and determine whether improvements are maintained during renewed academic preparation and after subsequent examination results. Future research should also incorporate clinical interviews, behavioral indicators, parental reports, and measures of depression, anxiety, hopelessness, self-compassion, academic motivation, and help-seeking. Process research examining changes in specific emotions, chair-work performance, therapeutic alliance, and emotional arousal could identify the mechanisms through which therapy reduces shame and self-criticism. Qualitative interviews would also provide a deeper understanding of how students experience examination failure and how they perceive the therapeutic change process.

Psychologists, school counselors, university entrance examination advisers, and mental health professionals should assess self-criticism and internalized shame when working with students who have experienced high-stakes academic failure. Counseling services should avoid treating examination failure solely as a problem of study skills or motivation because students may require direct assistance in processing grief, shame, fear, anger, and perceived rejection. Brief individual emotion-focused programs could be offered in schools, examination institutes, and academic counseling centers, particularly during the period immediately following the announcement of examination results. Practitioners should create a nonjudgmental therapeutic environment, help students differentiate academic performance from personal worth, identify critical internal dialogues, and strengthen adaptive self-support. Parent-focused psychoeducation may also be useful so that families can respond to failure with emotional validation rather than comparison, blame, or excessive pressure.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

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

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed to this article.

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