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Comparison of the Effectiveness of Reality Therapy and Compassion-Focused Therapy on Emotion Regulation in Gifted High School Girls

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A B S T R A C T

The aim of the study was to determine the difference in the effectiveness of reality therapy and compassion-focused therapy on emotion regulation in gifted high school girls. This research employed a quasi-experimental design of the pre-test, post-test type with a control group and included a follow-up phase. The statistical population of this research consisted of all gifted high school girls in the city of Behshahr, who were studying at the Farzanegan School of Exceptional Talents in the 2023-2024 academic year. The research sample, based on purposive and convenience sampling, included 45 individuals, who were randomly assigned to three groups: reality therapy (n = 15), compassion-focused therapy (n = 15), and control (n = 15). The data collection instruments used in this study were the Emotion Regulation Questionnaire by Garnefski and Kraaij (2006), as well as the therapeutic protocols for reality therapy by Glasser (2010) and compassion-focused therapy by Gilbert (2014). The reality therapy protocol lasted 8 sessions, with each session lasting 60 minutes, and the compassion-focused therapy protocol also lasted 8 sessions, with each session lasting 90 minutes. For statistical analysis of the data, a one-way analysis of covariance was employed. The findings indicated that both reality therapy and compassion-focused therapy had a significant effect on emotion regulation in the post-test phase. Additionally, there were differences in emotion regulation scores across the three phases (pre-test, post-test, and follow-up), regardless of the group. Among the therapeutic approaches, reality therapy was more effective in improving emotion regulation. Therefore, it can be concluded that using therapeutic approaches such as reality therapy and compassion-focused therapy, particularly reality therapy, can enhance the emotion regulation of gifted students.

Keywords: *Reality Therapy, Compassion-Focused Therapy, Emotion Regulation.*

1. Introduction

Success and progress in learning are the goals of all educational systems, and benefiting from educational environments requires students' sense of energy. One of the most important variables in the academic health of a country's educational system is avoiding any form of negative energy and embracing positive energy (AlHarbi, 2022). In students' daily academic lives, they face various challenges, obstacles, and pressures specific to their educational phase, which threaten their self-confidence, motivation, and consequently, their academic performance. Some students cope successfully with these challenges, while others do not achieve significant success. Thus, educational researchers must seriously consider understanding and adapting to academic challenges (Allsopp et al., 2019). One of the challenges students encounter is academic anxiety. Anxiety, as a negative feeling, affects an individual's perception and leads to decreased performance. Indeed, many students experience anxiety (APA, 2022).

Academic anxiety is a common issue faced by almost every student at some point. When the demands placed on a student exceed their perceived abilities, their stress level rises, and anxiety becomes inevitable (Amesberger et al., 2019). Symptoms of academic anxiety are individual-specific but are generally recognizable at three levels: cognitive symptoms related to thought processes, including fear, carelessness, poor concentration, loss of confidence, and self-defeating dialogue. Physical symptoms include muscle tension, clammy hands, and increased heart rate. Academic anxiety is often linked to a fear of failure, and a student's perception of their abilities may be based on academic performance, significantly impacting their academic outcomes (Amodeo et al., 2020). Due to family, environmental, cultural, and educational reasons, a student may develop psychological disorders, leading to psychological harm and emotional problems (Anton et al., 2021).

Emotion regulation levels and emotional problems are visible across different age groups in many societies. Emotion regulation refers to the stage at which individuals influence their emotions and how they express and experience those emotions (Apostolidis & Tsiatsos, 2021). Difficulty in emotion regulation results from a lack of emotional regulation abilities and skills. The concept of emotion regulation is broad and encompasses complex conscious and unconscious psychological, physiological, and behavioral processes (Ashraf et al., 2023). Emotion regulation through thoughts and cognition is associated with individuals' lives, helping them manage or regulate emotions during or after stressful or threatening events (Baartmans et al., 2020).

Considering the importance of students' health, many methods are used to address the psychological effects of academic pressure, such as compassion-focused therapy and reality therapy. Self-compassion is an essential psychological factor, especially among individuals with substance use disorders, as it involves a positive attitude toward oneself, promoting mental health (Bahrami et al., 2013). Individuals who treat themselves kindly are less likely to engage in self-blame and more likely to prioritize self-care and health improvement (Bailey et al., 2020). A key feature of self-compassion is directing kindness toward one's personal pain and suffering, making it a significant component of positive psychology. Self-compassion involves caring for oneself when facing difficulties or perceived shortcomings, addressing painful feelings with kindness, understanding, and a sense of shared humanity rather than avoiding them. In other words, self-compassion represents a healthy form of self-acceptance, acknowledging one's imperfections and including three main elements: first, loving and understanding oneself when experiencing pain from personal inadequacy; second, recognizing that pain and failure are unavoidable and common human experiences; and finally, maintaining a balanced awareness of one's emotions, facing distressing thoughts and feelings without over-identifying with them or feeling excessive self-pity (Barlow & Durand, 2014).

Self-compassion training is a novel therapeutic intervention that can enhance social support and social adjustment by fostering kindness toward oneself and others. Additionally, this approach positively influences individuals' stress tolerance and psychological well-being, potentially reducing psychological distress (Baum, 2018). Self-compassion comprises three components: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. The combination of these components characterizes individuals with high self-compassion (Beckwith & French, 2019).

Reality therapy is a strategic approach to behavior change. Explaining it requires a description of choice theory. Various psychological approaches, such as behavior therapy, cognitive therapy, and psychoanalysis, address behavior change. Behavior therapy focuses on changing behavior through learning principles, while cognitive therapy aims to transform negative behavior and improve

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mental health by applying cognitive theories and principles (Belin-Rauscent et al., 2016). Similarly, reality therapy assists individuals in shifting from ineffective to effective behaviors, from destructive to constructive choices, and from an unhappy to a happy lifestyle. William Glasser believed that humans must confront reality (Biwer et al., 2023).

Reality therapy is founded on the principle that humans always choose their behavior. Each behavior is chosen to reduce frustration or satisfy a specific need. Although the behavior may be ineffective, the individual continues it because they lack a better option to reduce their frustration at that moment (Biwer et al., 2023).

Therefore, using therapeutic methods to improve self-concept, academic anxiety, and emotion regulation among students is crucial. Considering the aforementioned points and the importance of the topic, this study aims to compare the effectiveness of reality therapy and compassion-focused therapy on emotion regulation among gifted high school girls. The primary research question is: Is there a significant difference in the effectiveness of reality therapy and compassion-focused therapy on emotion regulation in gifted high school girls?

2. Methods and Materials

2.1. Study Design and Participants

The present study employed a quasi-experimental design using a pre-test, post-test approach with a control group and a follow-up phase. The ethical code for the study, IR.IAU.SARI.REC.1403.103, was approved by the ethics committee of Islamic Azad University, Sari Branch.

The statistical population of this research included all gifted high school girls in Behshahr who were studying at Farzanegan School of Exceptional Talents during the 2023-2024 academic year. The research sample consisted of 45 students (15 in each group: 15 in Experimental Group 1, 15 in Experimental Group 2, and 15 in the control group). This study utilized purposive random sampling, selecting 45 female students from the high school who had unsatisfactory levels of self-concept, academic anxiety, and emotion regulation. The selected students were screened and then randomly assigned to three groups (two experimental groups and a waiting list control group), each comprising 15 students.

The inclusion criteria were being a high school student at a gifted school, having no history of psychological or psychiatric intervention in the past year, and having unsatisfactory levels of self-concept, academic anxiety, and emotion regulation. The exclusion criteria included missing more than two therapy sessions, being under psychiatric treatment, suffering from psychosomatic disorders, or withdrawing consent during the study.

Data collection involved obtaining the necessary research permits and explaining the study's objectives to the participants. After selecting the sample, the intervention was introduced to the experimental groups, and participants were asked to attend all sessions actively. Informed consent was obtained, and the participants were matched and randomly assigned to three groups, each consisting of 15 members: Experimental Group 1, Experimental Group 2, and the control group. The Garnefski and Kraaij (2006) Emotion Regulation Questionnaire was administered to both experimental and control groups, and participants were instructed to complete it. The intervention sessions were conducted at Hekmat Clinic in Behshahr, with semi-circular seating arrangements to facilitate group participation.

Before starting the therapy sessions, a 30-minute introductory session was held separately for the experimental and control groups to discuss the overall principles, rules, and goals of the group. After conducting the pre-test, the therapy sessions were carried out over two months. Reality therapy was conducted in eight group sessions, each lasting 60 minutes, once a week over eight weeks. Compassion-focused therapy was also conducted in eight group sessions, each lasting 90 minutes, once a week over eight consecutive weeks. A research assistant was present during the sessions to distribute necessary forms and assist participants. After completing the intervention sessions, the questionnaires were re-administered, and the control group members were contacted and invited to complete the questionnaires at the clinic. Finally, two months after the post-test, a follow-up phase was conducted with participants completing the questionnaire once again.

2.2. Measure

2.2.1. Emotion Regulation

This research utilized one standardized instrument and two intervention packages. The Emotion Regulation Questionnaire, developed by Garnefski and Kraaij (2006), is an 18-item self-report tool used to identify individuals' cognitive coping strategies. It is suitable for individuals aged 12 and older, both in normal and clinical populations, and includes nine subscales: self-blame, acceptance, rumination, positive refocusing, refocus on planning, positive

reappraisal, perspective-taking, catastrophizing, and other-blame. Each item is rated on a 5-point Likert scale from 1 (never) to 5 (always), with each subscale consisting of two items. The total score for each subscale is calculated by summing the item scores, with a range of 4 to 20, where higher scores indicate greater use of the strategy to cope with stressful or negative events (Vardikhan, 2024).

2.3. Interventions

2.3.1. Reality Therapy

Reality therapy sessions were conducted in eight 60-minute sessions, held once a week, with the control group placed on a waiting list for training. This intervention was based on Glasser's (2010) book (Behzadi et al., 2021; Eslami Hasanabadi et al., 2023; Taghizadeh et al., 2024).

Session 1: The session begins with introducing the group members and explaining the number and structure of the sessions. Participants sign a written confidentiality agreement, and a safe, trustworthy space is established. Each member articulates their goals for attending the sessions.

Session 2: The therapist expresses happiness to establish rapport. Differences and similarities among people are discussed, and Glasser's theory of basic human needs is explained. Participants are tasked with listing their primary needs and selecting ways to fulfill them.

Session 3: Previous homework is reviewed. Responsibility, adequacy, and self-worth are discussed, and members are encouraged to develop a sense of commitment to achieve self-worth and genuine affection. Participants are asked to list behaviors that help satisfy their core needs and increase their sense of adequacy and self-worth.

Session 4: The session reviews previous discussions and addresses questions. Open-ended questions are posed to connect meaningful past activities to current behaviors. Participants recall past achievements that made them feel valuable. They are assigned to identify a behavior they want to change and outline its components.

Session 5: Homework is reviewed, and participants are asked if they believe their behaviors are controlled externally or internally. Explanations on behavior control are provided, and participants are tasked with listing behaviors that are externally and internally controlled, along with strategies for better control.

Session 6: Homework is reviewed, focusing on participants' awareness of their abilities and realism about the world. The concept of the quality world is introduced, and members evaluate their current behaviors from a value-based perspective.

Session 7: Homework is reviewed, emphasizing goal setting and responsibility without causing frustration for others. Participants are asked to define their goals and specify the one they wish to achieve first.

Session 8: A comprehensive review of all sessions is conducted, and a final summary is provided. A post-test is administered to measure outcomes.

2.3.2. Compassion-Focused Therapy

The experimental group receiving compassion-focused therapy participated in eight 90-minute weekly sessions, also with the control group on a waiting list. The compassion-focused therapy intervention (Gilbert, 2014; Karami, 2024).

Session 1: The session starts with initial introductions and group formation. The structure and principles of the sessions are explained, distinguishing compassion from self-pity. Emotional distress is assessed, and the concept of compassion-focused therapy is described, including related emotional distress factors and self-compassion training.

Session 2: Mindfulness is introduced, accompanied by body scan and breathing exercises. Participants learn about the brain's systems related to compassion, and empathy training is provided to help them approach issues with an empathic mindset. Homework assignments are given.

Session 3: Participants learn the characteristics of compassionate individuals, developing warmth and kindness toward themselves and understanding that everyone has flaws and problems. The concept of shared humanity is emphasized to counter self-critical and shameful feelings. Empathy training continues, and homework is assigned.

Session 4: The previous session's exercises are reviewed, and participants are encouraged to reflect on their personalities as compassionate versus non-compassionate individuals. The value of self-compassion and empathetic thinking is discussed, and forgiveness practices are introduced. Participants apply exercises to themselves and others, with homework assignments.

Session 5: Compassionate mind training continues, and the session reviews previous exercises. Topics include forgiveness, non-judgmental acceptance, and dealing with life's changes and challenges. Participants learn to accept and tolerate difficult circumstances, acknowledging life's variability, and complete related homework.

Session 6: The session reviews previous exercises and introduces compassionate imagery techniques. Participants

learn various expressions of compassion (verbal, practical, situational, and continuous) and practice these methods in everyday life with loved ones, such as family and friends. They also work on developing higher, meaningful feelings, with assigned homework.

Session 7: Participants review previous exercises and learn to write compassionate letters to themselves and others. They practice daily journaling of real-life compassionate situations and reflect on their behavior in those moments.

Session 8: The session focuses on revising and practicing all the skills learned, helping participants develop strategies for dealing with different life situations using compassionate methods. The session concludes with a summary and guidance on how to maintain and apply the therapy in daily life.

2.4. Data analysis

For data analysis, a one-way repeated measures analysis of variance (ANOVA) and an ANOVA test were used. All data analyses were conducted using SPSS software, version 23.

3. Findings and Results

Table 1 presents the means of the three groups in the pre-test and post-test. These means indicate that the experimental groups (educational interventions) performed better compared to the control group. The lowest mean was observed in the reality therapy intervention group.

Table 1

Mean and Standard Deviation of the Emotion Regulation Variable Across Groups in Pre-test, Post-test, and Follow-up

Group	Pre-test Mean	Std. Deviation	Post-test Mean	Std. Deviation	Follow-up Mean	Std. Deviation	N
Reality Therapy Group (1)	1.9630	0.15667	4.2000	0.18039	4.0704	0.19412	15
Compassion-Focused Therapy Group (2)	1.9704	0.17298	4.1630	0.15918	3.9963	0.15638	15
Control Group (3)	1.9704	0.17171	2.1037	0.16516	2.0593	0.13684	15
Total	1.9679	0.16347	3.4889	1.00424	3.3753	0.95516	45

The Box's M test assesses the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups. Since the F-value (2.736) at the given error level (p = .001) is not significant, the observed covariance matrices are not equal across the three groups in the present study.

Table 2 shows the results of multivariate tests (Pillai's Trace, Wilks' Lambda, Hotelling's Trace, and Roy's Largest Root). The significance of each test can be determined by examining the Sig value, which is significant at $p < .05$. The partial eta-squared values for the dependent variable (emotion regulation) across the three groups are .347, indicating a large effect size, as values above .14 are considered large. The Wilks' Lambda test results for the mentioned variable are significant, showing differences among the groups, and the group means were significantly affected by the independent variable (p = .0001, F = 15.303).

Table 2

Results of Multivariate Tests for Emotion Regulation Variable in Pre-test and Post-test

Test	Value	F	Hypothesis df	Error df	Sig	Partial Eta Squared
Pillai's Trace	.817	85.013b	2.000	38.000	.000	.817
Wilks' Lambda	.183	85.013b	2.000	38.000	.000	.817
Hotelling's Trace	4.474	85.013b	2.000	38.000	.000	.817
Roy's Largest Root	4.474	85.013b	2.000	38.000	.000	.817
Pillai's Trace (Interaction)	.693	10.348	4.000	78.000	.000	.347
Wilks' Lambda (Interaction)	.307	15.303b	4.000	76.000	.000	.446
Hotelling's Trace (Interaction)	2.259	20.896	4.000	74.000	.000	.530
Roy's Largest Root (Interaction)	2.259	44.045c	2.000	39.000	.000	.693

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The results in Table 3 indicate differences in the emotion regulation variable among the three groups in pre-test, post-test, and follow-up phases. The Eta squared value shows that approximately 85% of the variance in the dependent variable (emotion regulation) is explained by the group variable.

Table 3

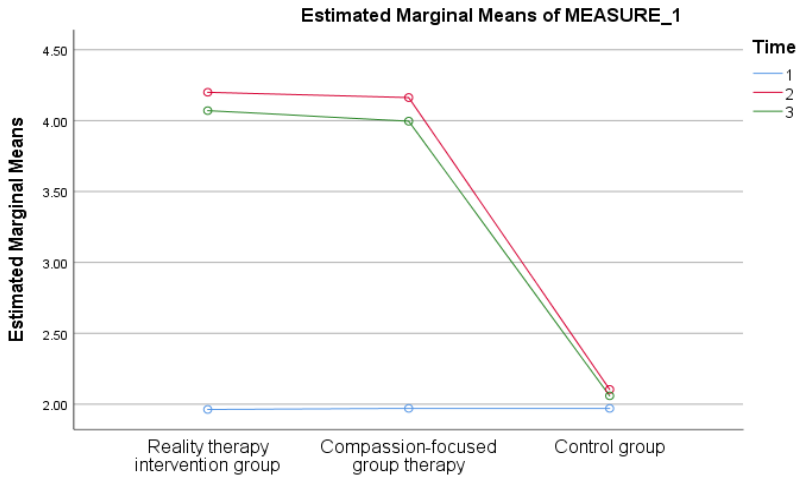
Results of Between-Subject Effects for Emotion Regulation Variable

Source	Type III Sum of Squares	df	Mean Square	F	Sig	Partial Eta Squared
Intercept	166.595	1	166.595	4777.318	.000	.992
Group	7.690	2	3.845	110.256	.000	.850
Error	1.360	39	.035	-	-	-

Figure 1 illustrates the changes in the emotion regulation variable separately in the pre-test, post-test, and follow-up phases. The colored lines represent emotion regulation in the pre-test (blue), post-test (red), and follow-up (green) phases across the three research groups. This chart shows that, on average, emotion regulation increased in the two intervention groups (reality therapy and compassion-focused therapy) from pre-test to post-test, while it slightly decreased in the control group. The follow-up phase also showed a slight increase in the two intervention groups compared to the post-test phase.

Figure 1

Changes in the Emotion Regulation Variable Across Pre-test, Post-test, and Follow-up Phases for the Three Research Groups



4. Discussion and Conclusion

The results indicated that both therapeutic approaches, compared to the control group, improved participants' emotion regulation, with reality therapy being more effective than compassion-focused therapy. Although a direct finding that specifically compared the effectiveness of these two treatments considering the interaction of group and time was not found, the results of this study align with findings reported in similar research.

To explain the findings, Glasser's perspective can be cited, which suggests that maladaptive behaviors are efforts by individuals to manage their perceptions and lives. This means that anxiety, depression, and feelings of guilt are personally created and chosen by the individual as a way to control their anger and gain support and help from others (Baartmans et al., 2020). Anxious individuals tend to lack flexibility in their behavior, do not take responsibility, and feel discomfort, anxiety, and sadness when facing life's realities (Belin-Rauscent et al., 2016).

Additionally, Glasser posits that a person can feel empowered, confident, and ultimately tolerate distress when they effectively meet their basic needs and believe they are in control of their life, capable of creating better conditions for themselves (Glasser, 2010). Reality therapy focuses on

what individuals can control in their relationships, viewing psychological problems as stemming from the belief that one is controlled by external forces. Depressed or hopeless individuals often blame others, society, or their unfavorable past, avoiding personal responsibility (Gilbert, 2014). Reality therapy teaches individuals not to escape from difficulties or blame others but to take responsibility for their problems and use all their capabilities to solve them. This process encourages problem-solving instead of conflict, thereby increasing positive emotions.

A key emphasis in reality therapy is on making moral judgments about the appropriateness of one's actions, with the criterion being the utility of these actions in fulfilling needs. If current actions are ineffective, individuals are encouraged to design a detailed, step-by-step plan for new behaviors that will help achieve their goals and to adhere to that plan (Beckwith & French, 2019). Reality therapy fosters a sense of responsibility to meet fundamental needs, freeing individuals from external control, and introduces them to their quality world through techniques like exploratory questioning. This responsibility and transition from external to internal control, combined with greater self-awareness, enhance cognitive emotion regulation in life. Reality therapy, in essence, fosters a sense of personal accountability.

Through this approach, individuals learn that their thoughts, behaviors, and emotions are under their control. In training sessions, participants are prompted with questions to consider a simple, precise action plan, which helps them improve their life situation and feel better as a result (Bailey, Brady, Ebner, & Ruffman, 2020). The emphasis of reality therapy on changing actions and thoughts before emotions suggests that the sessions effectively addressed participants' logical and mental concerns, leading to improved emotion regulation.

Overall, it can be concluded that using therapeutic approaches like reality therapy and compassion-focused therapy, particularly reality therapy, can enhance emotion regulation in gifted students.

One limitation of this study is the relatively small sample size, which may limit the generalizability of the findings to a broader population. Additionally, the study only included gifted high school girls, which may restrict the applicability of the results to other demographic groups. The reliance on self-reported measures may also introduce bias, as participants' responses may not fully reflect their true emotions and behaviors. Furthermore, the quasi-experimental design, though effective for intervention studies, cannot completely rule out potential confounding variables.

Future research should consider replicating this study with a larger and more diverse sample, including different age groups, genders, and cultural backgrounds, to enhance the generalizability of the findings. Longitudinal studies would be valuable to examine the long-term effects of reality therapy and compassion-focused therapy on emotion regulation. Additionally, incorporating qualitative methods, such as in-depth interviews, could provide richer insights into participants' experiences and the mechanisms underlying the observed changes.

The findings of this study have important implications for educational and psychological practitioners. Schools could implement reality therapy and compassion-focused therapy programs to support students' emotional well-being and improve their academic performance. Educators and school counselors should focus on developing students' self-regulation and responsibility-taking skills, as these are critical for managing academic and personal challenges. Policymakers could also consider incorporating these therapeutic approaches into school mental health initiatives to foster a more supportive and effective learning environment.

Authors' Contributions

Authors contributed equally to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

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

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants (Ethics code: IR.IAU.SARI.REC.1403.103).

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