

Article history:
Received 27 March 2026
Revised 22 September 2026
Accepted 29 September 2026
Initial Publication 02 October 2026
Final Publication 01 January 2027

Volume 5, pp 1-15

Comparison of the Effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Cognitive Behavioral Therapy (CBT) on Somatization Symptoms and Dissociative Experiences in Patients with Social Anxiety Disorder

Mahboobeh. Javanmard¹, Hadis. Khodashenas², Fateme. Hooshmand³, Mona. Soleiman Heshmat⁴, Arsalan. Barekat^{5*}

¹ Department of Psychology, Ka.C., Islamic Azad University, Karaj, Iran

² Department of Psychology, Ash.C., Islamic Azad University, Ashtian, Markazi, Iran

³ Department of Psychology, Il.C., Islamic Azad University, Ilam, Iran

⁴ Department of Counseling, Ka.C., Islamic Azad University, Karaj, Iran

⁵ Ph.D. Student, Department of Health Psychology, To.C., Islamic Azad University, Mazandaran, Iran

* Corresponding author email address: arsalan.br@gmail.com

Article Info

Article type:

Original Research

Section:

Health Psychology

How to cite this article:

Javanmard, M., Khodashenas, H., Hooshmand, F., Soleiman Heshmat, M., & Barekat, A. (2027). Comparison of the Effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Cognitive Behavioral Therapy (CBT) on Somatization Symptoms and Dissociative Experiences in Patients with Social Anxiety Disorder. *KMAN Counseling and Psychology Nexus*, 5, 1-15.

<http://doi.org/10.61838/kman.psynexus.6422>



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ABSTRACT

The present study aimed to compare the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Cognitive Behavioral Therapy (CBT) in reducing somatization symptoms and dissociative experiences in patients with social anxiety disorder. This randomized controlled study employed a pretest–posttest design with a three-month follow-up and three parallel groups. The statistical population consisted of adults with social anxiety disorder who attended psychological and psychiatric treatment centers in Tehran, Iran. A total of 45 eligible participants were selected through purposive sampling and randomly assigned to the ISTDP, CBT, or control group, with 15 participants in each group. The ISTDP and CBT groups each received 12 individual weekly sessions lasting approximately 60 minutes, whereas the control group received no structured psychotherapy during the study period. Somatization symptoms were assessed using the Patient Health Questionnaire-15, and dissociative experiences were measured using the Dissociative Experiences Scale-II. Data were analyzed using repeated-measures analysis of variance and Bonferroni-adjusted pairwise comparisons at a significance level of $p < .05$. Repeated-measures analysis showed significant time effects for somatization symptoms, $F(2, 84) = 118.64$, $p < .001$, partial $\eta^2 = .739$, and dissociative experiences, $F(2, 84) = 96.31$, $p < .001$, partial $\eta^2 = .696$. Significant group effects were also observed for somatization symptoms, $F(2, 42) = 31.82$, $p < .001$, partial $\eta^2 = .602$, and dissociative experiences, $F(2, 42) = 28.44$, $p < .001$, partial $\eta^2 = .575$. The time $\times$ group interactions were significant for both somatization symptoms, $F(4, 84) = 42.57$, $p < .001$, partial $\eta^2 = .670$, and dissociative experiences, $F(4, 84) = 36.18$, $p < .001$, partial $\eta^2 = .633$. Bonferroni comparisons indicated that both interventions were significantly more effective than the control condition, while ISTDP produced significantly greater reductions than CBT at both posttest and follow-up. Both ISTDP and CBT were effective in reducing somatization symptoms and dissociative experiences in patients with social anxiety disorder, with ISTDP demonstrating greater and sustained effects across both outcome domains.

Keywords: Intensive Short-Term Dynamic Psychotherapy; Cognitive Behavioral Therapy; Social Anxiety Disorder; Somatization; Dissociative Experiences

1. Introduction

Social anxiety disorder is a persistent and disabling psychological condition characterized by marked fear, anxiety, and avoidance in situations in which an individual may be observed, evaluated, criticized, or rejected by others. Although fear of negative evaluation and avoidance of social situations are generally regarded as the core manifestations of the disorder, its clinical presentation is often considerably broader than overt social fear. Individuals with social anxiety may experience persistent physiological arousal, heightened awareness of bodily sensations, difficulties in emotional processing, excessive self-monitoring, avoidance of distressing internal experiences, and disruptions in the integration of emotional and cognitive experiences. When these processes become chronic, psychological distress may increasingly be expressed through bodily complaints or through dissociative phenomena such as depersonalization, derealization, absorption, emotional detachment, and discontinuities in subjective experience (Li et al., 2025; Mohammadi Begi, 2023). Consequently, treatment of social anxiety disorder may require attention not only to overt anxiety and avoidance but also to the somatic and dissociative manifestations that may accompany or maintain the disorder.

Somatization refers broadly to the experience and reporting of bodily symptoms that are influenced, intensified, or maintained by psychological and emotional processes. Such symptoms may include pain, fatigue, gastrointestinal complaints, dizziness, cardiopulmonary sensations, headaches, sleep disturbances, and other physical experiences that can cause significant distress and functional impairment. Contemporary psychosomatic perspectives increasingly conceptualize bodily symptoms within an integrated framework in which emotional dysregulation, autonomic arousal, maladaptive beliefs, attentional processes, avoidance, and interpersonal stress interact with physiological functioning. Evidence from patients with chronic pain and other psychosomatic conditions suggests that psychological processes are closely related to the severity and persistence of bodily symptoms and that psychotherapeutic interventions targeting these processes can produce clinically meaningful improvements. For example, intensive short-term dynamic psychotherapy has been associated with reductions in somatization and health anxiety among patients with chronic pain, suggesting that direct therapeutic work with emotional and defensive processes may influence the experience and interpretation of

physical symptoms (Nakhaei Moghadam et al., 2024). Similarly, reductions in gastrointestinal symptoms following intensive dynamic psychotherapy in individuals with irritable bowel syndrome provide further support for the relevance of psychological interventions to conditions in which emotional and somatic functioning are closely intertwined (Hajrezaei et al., 2024).

The relationship between anxiety and somatic symptoms may be particularly important in social anxiety disorder. Socially threatening situations are commonly accompanied by intense physiological activation, including palpitations, trembling, sweating, gastrointestinal discomfort, muscular tension, shortness of breath, dizziness, blushing, and sensations of loss of bodily control. Individuals who are highly self-focused may interpret these sensations as evidence that their anxiety is visible to others, thereby increasing embarrassment, anticipatory fear, and avoidance. Repeated attention to bodily signs of anxiety can therefore create a reciprocal cycle in which fear increases physiological arousal, bodily sensations reinforce catastrophic social predictions, and avoidance prevents corrective learning. Studies of psychosomatic populations suggest that difficulties in regulating emotional activation and insecure or maladaptive relational patterns can contribute to the persistence of physical symptoms (Kelidari et al., 2024). Research has also shown that intensive short-term dynamic psychotherapy can reduce somatic symptoms in individuals experiencing psychological and physical consequences following illness, further indicating that bodily distress may respond to interventions directed toward underlying emotional mechanisms (Jafari et al., 2024). A recent scoping review of intensive short-term dynamic psychotherapy for functional somatic disorders similarly highlights growing evidence that psychodynamic interventions focused on emotion, anxiety, and defensive processes may have therapeutic value across a range of somatic presentations (Abbass & Haghir, 2025).

Dissociation represents another clinically important phenomenon that may complicate the presentation and treatment of anxiety disorders. Dissociative experiences encompass disturbances in the normal integration of consciousness, attention, memory, perception, identity, emotion, and bodily experience. They may range from relatively common experiences of absorption and emotional detachment to more clinically significant manifestations such as depersonalization, derealization, dissociative amnesia, and altered awareness of self or surroundings. From an emotion-regulation perspective, dissociation may

function as a defensive or avoidant response when emotional activation exceeds an individual's capacity for conscious processing. The relationship between cognitive emotion-regulation strategies and defensive functioning suggests that maladaptive mechanisms of managing affect may contribute to more severe psychopathological manifestations when distress cannot be adequately processed or symbolized (Nohi & Hasani, 2017). In patients with social anxiety, intense shame, fear of judgment, interpersonal vulnerability, and heightened autonomic activation may similarly create conditions in which distancing from emotional or bodily experience becomes an adaptive short-term strategy but a potentially maladaptive long-term pattern.

Dissociation may also have important implications for psychotherapy response. Research in other clinical populations has shown that trauma-related and dissociative symptoms can influence the course and outcome of cognitive-behavioral treatment, underscoring the importance of considering dissociation as a clinically relevant process rather than merely an accompanying symptom (Serra et al., 2020). Clinical evidence has further suggested that cognitive behavioral therapy can be applied to social anxiety presentations accompanied by dissociative and other complex behaviors, although such cases may require careful attention to the interaction between anxiety, avoidance, emotional dysregulation, and dissociative responses (Tarakçioğlu, 2024). At the same time, psychodynamic approaches have increasingly examined dissociation as an expression of affective overload, defensive functioning, and difficulty tolerating or integrating emotionally charged experiences. A pilot investigation of intensive short-term dynamic psychotherapy among patients with dissociative seizures demonstrated the potential of a focused dynamic approach for addressing symptoms in which emotional and dissociative processes are closely interconnected (Castillo et al., 2022). Likewise, intensive short-term psychodynamic psychotherapy has been reported to reduce depressive symptoms among individuals with dissociative disorders, providing additional preliminary evidence for the applicability of this model to clinical presentations involving disruptions in emotional integration (Donyavi & Mohtashami, 2024).

Intensive Short-Term Dynamic Psychotherapy is an affect-focused psychodynamic treatment originally developed to accelerate the identification and resolution of unconscious emotional conflicts while actively addressing maladaptive defenses and anxiety. A central assumption of ISTDP is that painful or conflictual emotions may activate

anxiety and defensive processes, particularly when emotional experiences have historically been associated with interpersonal threat, loss, guilt, shame, anger, or fear. When such emotions are repeatedly avoided or defended against, psychological symptoms may emerge or persist. In treatment, the therapist seeks to identify the patient's characteristic sequence of feelings, anxiety, and defenses and to facilitate a greater capacity to recognize, tolerate, experience, and integrate previously avoided affect. Unlike more traditional long-term psychodynamic approaches, ISTDP uses active clarification, pressure, and, where appropriate, challenge to address resistance and facilitate relatively rapid access to core emotional experiences.

Evidence supporting ISTDP has accumulated across mood, personality, and somatic disorders. Reviews of the literature have indicated that the treatment can produce meaningful improvements in mood-related psychopathology, although the strength of evidence varies across diagnoses and study designs (Caldirola et al., 2020). Earlier work also identified emerging evidence for ISTDP in personality and somatic disorders, emphasizing the potential relevance of intensive affect-focused treatment for patients whose psychological conflicts are expressed through complex symptom patterns (Town & Driessen, 2013). Beyond symptomatic improvement, economic analyses have suggested that ISTDP may also have favorable implications for healthcare utilization and treatment costs, particularly in populations characterized by recurrent service use and medically unexplained or psychosomatic complaints (Abbass et al., 2018). These findings are relevant to social anxiety disorder because patients with substantial somatization may seek repeated medical reassurance or treatment for bodily complaints while the emotional mechanisms underlying those symptoms remain insufficiently addressed.

The potential advantage of ISTDP for somatization and dissociation may derive from its direct focus on emotional experience and defensive avoidance. Rather than treating bodily symptoms solely as erroneous interpretations or physiological manifestations of anxiety, ISTDP examines whether somatic activation functions as a channel through which unconscious or poorly processed affect is expressed. The therapist monitors anxiety manifestations, identifies defenses that interrupt emotional experience, and works to increase the patient's capacity to experience emotions without excessive somatic discharge or dissociative detachment. Findings showing improvements in emotion regulation and attachment-related processes among

psychosomatic patients following intensive dynamic treatment are consistent with this conceptualization (Kelidari et al., 2024). Similarly, reductions in somatization among patients with chronic pain after intensive short-term dynamic psychotherapy suggest that modifying defensive and affective mechanisms may translate into measurable changes in bodily symptom burden (Nakhaei Moghadam et al., 2024). The broader literature on functional somatic disorders further supports examining ISTDP as a potentially valuable intervention where bodily distress and emotional processes are closely linked (Abbass & Haghiri, 2025).

Cognitive Behavioral Therapy, in contrast, conceptualizes social anxiety primarily in terms of maladaptive beliefs, attentional biases, avoidance behaviors, safety behaviors, and dysfunctional interpretations of social experiences. Individuals with social anxiety frequently overestimate the probability and consequences of negative evaluation, focus excessive attention on their internal sensations and perceived performance, interpret ambiguous interpersonal cues negatively, and avoid situations that could disconfirm their fears. CBT attempts to modify these maintaining mechanisms through psychoeducation, cognitive restructuring, behavioral experiments, exposure, reduction of safety behaviors, attentional retraining, and relapse-prevention strategies. By repeatedly confronting feared situations and evaluating catastrophic predictions against observable outcomes, patients are encouraged to develop more realistic beliefs regarding social evaluation and their ability to cope with anxiety.

The empirical basis for CBT extends across a wide range of emotional and psychosomatic problems. Research has demonstrated that cognitive-behavioral interventions can affect psychological variables closely associated with bodily distress, including concerns about body image and maladaptive interpretations of physical experience (Kiani Rad, 2024). Comparative research among women with migraine has also shown the relevance of CBT for anxiety sensitivity, a construct directly related to fear and catastrophic interpretation of anxiety-associated bodily sensations (Mehrmanesh et al., 2023). A systematic review of cognitive-behavioral interventions for gastroduodenal disorders of gut-brain interaction likewise provides evidence that CBT-based approaches may reduce psychological and symptom-related difficulties in disorders characterized by substantial interaction between cognitive, emotional, and bodily processes (Law et al., 2023). More recently, a network meta-analysis examining adults with bodily distress found evidence supporting psychological interventions

including CBT and acceptance- and mindfulness-based treatments, reinforcing the role of structured psychological approaches in the management of persistent bodily symptoms (Berpohl & Martin, 2025).

CBT may also affect dissociative experiences indirectly by reducing emotional arousal, catastrophic interpretations, avoidance, and dysfunctional coping. Cognitive and behavioral interventions can promote greater engagement with feared experiences while decreasing reliance on maladaptive avoidance strategies. Research examining personality beliefs, coping strategies, and quality of life during CBT has demonstrated that therapeutic change extends beyond surface symptom reduction and may involve broader modifications in cognitive and coping processes (Bourdon et al., 2019). However, dissociation can itself interfere with exposure, emotional engagement, and cognitive processing, making it important to determine whether standard cognitive-behavioral mechanisms adequately address dissociative symptoms when they coexist with severe anxiety. Evidence from populations in which dissociation is clinically prominent suggests that dissociative processes may influence treatment response and therefore warrant direct measurement when evaluating cognitive-behavioral interventions (Serra et al., 2020).

Recent research continues to demonstrate the versatility of CBT across disorders and delivery formats. A randomized controlled trial comparing group acceptance and commitment therapy with CBT/exposure and response prevention in obsessive-compulsive disorder highlights the continuing importance of cognitive-behavioral methods as an established active treatment against which other psychological interventions can be evaluated (Nielsen et al., 2025). Likewise, digital CBT has demonstrated measurable therapeutic effects in individuals with insomnia and chronic pain, indicating that cognitive-behavioral principles remain applicable even in clinically complex populations in which physical and psychological symptoms interact (Schuffelen et al., 2026). Such evidence strengthens the rationale for examining CBT in patients whose social anxiety co-occurs with bodily distress, while also raising the question of whether a treatment emphasizing cognition and behavior produces the same degree of change in somatic and dissociative symptoms as an intervention directly targeting affect, anxiety, and defensive mechanisms.

Despite evidence supporting both treatment models, relatively little comparative research has directly examined ISTDP and CBT with respect to somatization and dissociative experiences in individuals with social anxiety

disorder. Existing ISTDP studies have predominantly focused on somatic disorders, chronic pain, mood symptoms, health anxiety, gastrointestinal symptoms, or dissociative conditions (Castillo et al., 2022; Donyavi & Mohtashami, 2024; Hajrezaei et al., 2024; Jafari et al., 2024), whereas much of the CBT literature has investigated anxiety-related cognition, exposure-based change, bodily distress, trauma-related processes, or other psychiatric and psychosomatic conditions (Berpohl & Martin, 2025; Law et al., 2023; Tarakçioğlu, 2024). This gap is clinically meaningful because the two interventions may influence the same symptoms through substantially different mechanisms. CBT primarily seeks to modify dysfunctional thoughts, behavioral avoidance, safety behaviors, and attentional biases, whereas ISTDP emphasizes the experience of avoided emotions, regulation of anxiety, recognition of defenses, and resolution of internal emotional conflict. Comparing these approaches therefore offers an opportunity not only to determine whether both reduce symptoms, but also to clarify whether an affect-focused dynamic treatment is particularly beneficial for symptom domains such as somatization and dissociation that may be closely linked to emotional avoidance and defensive processing.

Accordingly, the aim of the present study was to compare the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Cognitive Behavioral Therapy (CBT) in reducing somatization symptoms and dissociative experiences in patients with social anxiety disorder.

2. Methods and Materials

2.1. Study Design and Participants

The present study was a randomized controlled clinical trial with a pretest–posttest design, a three-month follow-up, and three parallel groups, conducted to compare the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Cognitive Behavioral Therapy (CBT) in reducing somatization symptoms and dissociative experiences among patients with social anxiety disorder. The statistical population consisted of adults with social anxiety disorder who attended psychological and psychiatric counseling and treatment centers in Tehran, Iran. Following announcements at the participating centers and preliminary screening, individuals who expressed willingness to participate were evaluated through a clinical interview based on the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). A total of 45 eligible patients were selected

using purposive sampling and were subsequently randomly allocated, by means of a computer-generated randomization sequence, to the ISTDP group ($n = 15$), CBT group ($n = 15$), or control group ($n = 15$). The inclusion criteria were a primary diagnosis of social anxiety disorder according to DSM-5-TR criteria, age between 20 and 45 years, at least a secondary-school education, the ability to attend all treatment sessions, absence of concurrent participation in another structured psychological intervention, and provision of written informed consent. Exclusion criteria included the presence of psychotic disorders, bipolar disorder, severe substance use disorder, acute suicidal risk, severe neurological or medical conditions that could interfere with participation, initiation or substantial modification of psychotropic medication during the intervention period, absence from more than two treatment sessions, and unwillingness to continue participation. Participants who were receiving stable pharmacological treatment were required to have maintained an unchanged medication regimen for at least four weeks before study entry and throughout the intervention period. Assessments were conducted at three time points: before the intervention, immediately after completion of treatment, and three months after the posttest. The control group received no structured psychotherapy during the study period and continued routine clinical care when applicable; following completion of the follow-up assessment, participants in this group were offered access to psychological treatment. All participants were informed about the objectives and procedures of the study, the voluntary nature of participation, confidentiality of their information, their right to withdraw at any stage without adverse consequences, and the use of collected data exclusively for research purposes.

2.2. Instruments

Structured Clinical Interview for DSM-5 Disorders. A structured diagnostic interview based on the criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, was used to establish the diagnosis of social anxiety disorder and to screen for major psychiatric conditions that constituted exclusion criteria. The Structured Clinical Interview for DSM-5 Disorders (SCID-5) was developed as a clinician-administered diagnostic instrument for systematic assessment of major DSM-5 psychiatric disorders. The interview follows standardized diagnostic decision rules and evaluates the presence, duration, severity, and clinical significance of symptoms as well as their effects

on social, occupational, and other important areas of functioning. In the present study, the interview was administered individually by a trained clinical psychologist before random allocation. Particular attention was given to confirming social anxiety disorder as the primary clinical diagnosis and identifying psychiatric conditions that could substantially affect treatment participation or interpretation of the results. Previous psychometric investigations of structured DSM-based clinical interviews have demonstrated acceptable to strong inter-rater reliability and diagnostic validity across different clinical populations.

Patient Health Questionnaire-15. Somatization symptoms were assessed using the Patient Health Questionnaire-15 (PHQ-15), developed by Kroenke, Spitzer, and Williams in 2002 as a brief self-report measure of the severity of common somatic symptoms. The questionnaire consists of 15 items addressing physical symptoms frequently observed in primary care and psychological treatment settings, including stomach pain, back pain, pain in the arms or legs, headaches, chest pain, dizziness, fainting, heart palpitations, shortness of breath, bowel-related complaints, sleep problems, fatigue, and other bodily symptoms. Respondents indicate how much they have been bothered by each symptom during the specified period using a three-point Likert scale ranging from 0 (not bothered at all) to 2 (bothered a lot). Total scores range from 0 to 30, with higher scores indicating greater severity of somatization symptoms; scores of approximately 5, 10, and 15 have commonly been considered indicative of mild, moderate, and severe levels of somatic symptom burden, respectively. The PHQ-15 has been widely used in clinical and research populations and has demonstrated satisfactory internal consistency, construct validity, convergent validity, and sensitivity to changes in somatic symptom severity. The reliability and validity of the instrument have also been supported in studies conducted across different cultural and clinical contexts.

Dissociative Experiences Scale-II. Dissociative experiences were measured using the Dissociative Experiences Scale-II (DES-II), originally developed by Bernstein and Putnam in 1986 and subsequently revised for more convenient scoring. The DES-II is a 28-item self-report instrument designed to assess the frequency of dissociative phenomena in everyday life. Its items primarily reflect experiences related to dissociative amnesia, depersonalization and derealization, and absorption or imaginative involvement. Respondents indicate the percentage of time they experience each phenomenon on a continuum ranging from 0% to 100%, typically in 10-point

increments. The overall score is obtained by calculating the mean of the responses to all 28 items, resulting in a total score ranging from 0 to 100, with higher scores reflecting a greater frequency or intensity of dissociative experiences. Although the DES-II is primarily a dimensional screening instrument rather than a stand-alone diagnostic measure, elevated scores may indicate clinically meaningful dissociative symptoms that warrant further assessment. Studies of the DES-II have consistently demonstrated good to excellent internal consistency, satisfactory test-retest reliability, and acceptable convergent and discriminant validity. Its factorial structure and psychometric adequacy have also been supported in both clinical and nonclinical populations and in translated versions used across different cultural settings.

2.3. Interventions

Intensive Short-Term Dynamic Psychotherapy Intervention. Participants allocated to the ISTDP group received 12 individual psychotherapy sessions, each lasting approximately 60 minutes, conducted once weekly by a clinical psychologist trained in Intensive Short-Term Dynamic Psychotherapy. The intervention was based on the principles of Davanloo's ISTDP model and focused on identifying unconscious emotional conflicts, defensive processes, anxiety manifestations, and patterns of avoidance that contributed to the persistence of social anxiety, bodily symptoms, and dissociative experiences. During the initial sessions, the therapist established the therapeutic focus, clarified the participant's principal interpersonal and emotional difficulties, and assessed the patient's responses to emotional activation, including patterns of anxiety discharge and defensive functioning. Subsequent sessions emphasized clarification of defenses, systematic pressure toward direct experience and expression of avoided emotions, identification of resistance, and appropriate challenge of maladaptive defensive processes when the patient demonstrated sufficient capacity to tolerate emotional activation. Particular attention was paid to the relationship among anxiety, bodily sensations, inhibition of emotion, interpersonal fears, and dissociative reactions. The therapist continuously monitored the participant's anxiety tolerance and adjusted the intensity of therapeutic interventions accordingly to prevent excessive emotional dysregulation. As treatment progressed, recurrent patterns of feelings, anxiety, and defenses were explored both in current interpersonal relationships and within the therapeutic

relationship, facilitating greater recognition and processing of previously avoided emotions. Later sessions focused on consolidation of emotional insight, reduction of reliance on maladaptive defenses, improvement in the capacity to experience and regulate complex affect, and integration of newly recognized emotional and interpersonal patterns into everyday functioning. The final session included a review of therapeutic gains, identification of remaining vulnerabilities, consolidation of adaptive emotional processing strategies, and preparation for termination and maintenance of treatment effects.

Cognitive Behavioral Therapy Intervention. Participants assigned to the CBT group received 12 individual sessions of cognitive behavioral therapy, each lasting approximately 60 minutes and delivered once weekly by a clinical psychologist trained in CBT for anxiety disorders. The treatment protocol was based on established cognitive-behavioral models of social anxiety disorder and focused on the reciprocal relationships among maladaptive cognitions, self-focused attention, avoidance and safety behaviors, physiological arousal, and anxiety-provoking social situations. The initial sessions included psychoeducation about social anxiety disorder, presentation of the cognitive-behavioral model, identification of feared social situations, and formulation of individualized treatment goals. Participants were trained to recognize automatic negative thoughts, dysfunctional assumptions, catastrophic predictions, and distorted interpretations concerning social evaluation, rejection, embarrassment, and perceived inadequacy. Cognitive restructuring techniques were then used to examine the evidence supporting and contradicting maladaptive beliefs and to generate more balanced and realistic alternative interpretations. Behavioral components included gradual in-session and between-session exposure to feared social situations, systematic reduction of avoidance and safety behaviors, behavioral experiments designed to test negative predictions, and exercises aimed at shifting attention away from excessive internal self-monitoring toward external social information. Relaxation and emotion-regulation strategies were introduced when clinically appropriate, while participants were encouraged to develop greater tolerance of physiological sensations and bodily manifestations of anxiety rather than interpreting them catastrophically. Homework assignments were used throughout treatment to reinforce cognitive and behavioral skills in everyday situations. In the later sessions, treatment focused on modifying deeper assumptions related to social evaluation and self-worth, strengthening adaptive coping

responses, reviewing progress, identifying high-risk situations for symptom recurrence, and developing an individualized relapse-prevention plan to facilitate maintenance of therapeutic gains after treatment termination.

2.4. Data analysis

Data were analyzed using IBM SPSS Statistics. Initially, descriptive statistics, including frequency, percentage, mean, and standard deviation, were calculated to describe participants' demographic characteristics and study variables at the pretest, posttest, and three-month follow-up assessments. Baseline equivalence of the three groups with respect to demographic and clinical characteristics was examined using appropriate inferential tests. Prior to the primary analyses, the assumptions required for parametric statistical procedures were evaluated. Normality of score distributions was examined using the Shapiro–Wilk test together with skewness and kurtosis indices; homogeneity of variances was evaluated using Levene's test; homogeneity of covariance matrices was assessed using Box's M test; and the assumption of sphericity for the within-subject factor was examined using Mauchly's test. When the sphericity assumption was violated, the Greenhouse–Geisser correction was applied. To determine the effects of time, treatment group, and the interaction between time and treatment group on somatization symptoms and dissociative experiences, repeated-measures analysis of variance was performed with measurement time as the within-subject factor and group as the between-subject factor. Significant omnibus effects were followed by Bonferroni-adjusted pairwise comparisons to determine differences between the ISTDP, CBT, and control groups and to examine changes across the three assessment points. Effect sizes were reported using partial eta squared to indicate the magnitude of treatment effects. All statistical tests were two-tailed, and the level of statistical significance was set at $p < .05$.

3. Findings and Results

All 45 participants who entered the study completed the pretest, posttest, and three-month follow-up assessments and were therefore included in the final statistical analyses. The participants consisted of 27 women (60.0%) and 18 men (40.0%), with a mean age of 32.24 years ($SD = 5.88$; range = 21–44 years). The mean ages of participants in the ISTDP, CBT, and control groups were 32.27 ± 5.91 , 31.80 ± 5.67 , and 32.67 ± 6.20 years, respectively. In the ISTDP group, 10

participants (66.7%) were women and 5 (33.3%) were men; in the CBT group, 9 participants (60.0%) were women and 6 (40.0%) were men; and in the control group, 8 participants (53.3%) were women and 7 (46.7%) were men. Regarding marital status, 21 participants (46.7%) were single and 24 (53.3%) were married. In terms of educational attainment, 8 participants (17.8%) had a high-school diploma or associate degree, 26 (57.8%) held a bachelor's degree, and 11 (24.4%) held a master's degree or higher. The three study groups were

statistically comparable at baseline with respect to age ($F = 0.08$, $p = .925$), gender ($\chi^2 = 0.56$, $p = .757$), marital status ($\chi^2 = 0.37$, $p = .832$), and educational level ($\chi^2 = 0.81$, $p = .937$), indicating that random allocation resulted in groups that were generally homogeneous in their demographic characteristics. No participant discontinued treatment because of serious adverse events, and no substantial change in concurrent medication was reported during the intervention or follow-up periods.

Table 1

Descriptive Statistics for Somatization Symptoms and Dissociative Experiences by Group and Assessment Time

Variable	Group	Pretest M $\pm$ SD	Posttest M $\pm$ SD	3-Month Follow-up M $\pm$ SD
Somatization symptoms	ISTDP	18.33 $\pm$ 3.15	9.47 $\pm$ 2.90	8.87 $\pm$ 2.76
	CBT	18.00 $\pm$ 3.31	11.73 $\pm$ 3.06	11.27 $\pm$ 2.94
	Control	18.13 $\pm$ 3.20	17.67 $\pm$ 3.18	17.53 $\pm$ 3.12
Dissociative experiences	ISTDP	48.87 $\pm$ 8.64	27.40 $\pm$ 7.21	25.60 $\pm$ 6.91
	CBT	49.53 $\pm$ 8.31	33.13 $\pm$ 7.59	32.07 $\pm$ 7.36
	Control	48.60 $\pm$ 8.48	48.27 $\pm$ 8.22	47.80 $\pm$ 8.15

As shown in Table 1, the mean pretest scores for both dependent variables were highly similar across the three groups, providing descriptive evidence of baseline comparability before implementation of the interventions. For somatization symptoms, the ISTDP group decreased from a pretest mean of 18.33 ± 3.15 to 9.47 ± 2.90 at posttest and further to 8.87 ± 2.76 at the three-month follow-up. This pattern corresponded to a reduction of approximately 48.3% from pretest to posttest and 51.6% from pretest to follow-up. In the CBT group, the mean somatization score decreased from 18.00 ± 3.31 at pretest to 11.73 ± 3.06 at posttest and 11.27 ± 2.94 at follow-up, representing reductions of approximately 34.8% and 37.4%, respectively. In contrast, the control group demonstrated only a minimal decrease, from 18.13 ± 3.20 at pretest to 17.67 ± 3.18 at posttest and 17.53 ± 3.12 at follow-up. A similar pattern was observed for dissociative experiences. The mean DES-II score in the ISTDP group declined markedly from 48.87 ± 8.64 at pretest to 27.40 ± 7.21 at posttest and 25.60 ± 6.91 at follow-up. The corresponding scores in the CBT group were 49.53 ± 8.31 , 33.13 ± 7.59 , and 32.07 ± 7.36 , respectively. The control group showed virtually no meaningful change, with means of 48.60 ± 8.48 , 48.27 ± 8.22 , and 47.80 ± 8.15 across the three assessment occasions. Thus, descriptively, both active interventions were associated with substantial reductions in

somatization and dissociative experiences, while the magnitude of reduction appeared greater in the ISTDP group and was largely maintained through the three-month follow-up. Before performing the repeated-measures analyses, the statistical assumptions were examined. The Shapiro–Wilk test was nonsignificant for somatization symptoms and dissociative experiences within each group at all three measurement occasions (all $p > .05$), indicating no substantial deviation from normality. Examination of skewness and kurtosis coefficients further supported the approximate normality of the distributions, with all coefficients remaining within acceptable limits. Levene's test indicated homogeneity of error variances among the three groups for somatization symptoms at pretest ($F = 0.06$, $p = .943$), posttest ($F = 0.09$, $p = .914$), and follow-up ($F = 0.11$, $p = .895$), as well as for dissociative experiences at pretest ($F = 0.04$, $p = .958$), posttest ($F = 0.18$, $p = .837$), and follow-up ($F = 0.16$, $p = .853$). Box's M test was also nonsignificant (Box's M = 14.62, $F = 0.69$, $p = .812$), supporting equality of the covariance matrices across groups. Mauchly's test indicated that the assumption of sphericity was satisfied for somatization symptoms ($W = .94$, $\chi^2 = 2.43$, $p = .297$) and dissociative experiences ($W = .96$, $\chi^2 = 1.74$, $p = .419$). Accordingly, uncorrected degrees of freedom were used in the repeated-measures analyses.

Table 2

Repeated-Measures Analysis of Variance for Somatization Symptoms and Dissociative Experiences

Outcome	Effect	df	F	p	Partial η^2
Somatization symptoms	Time	2, 84	118.64	< .001	.739
	Group	2, 42	31.82	< .001	.602
	Time $\times$ Group	4, 84	42.57	< .001	.670
Dissociative experiences	Time	2, 84	96.31	< .001	.696
	Group	2, 42	28.44	< .001	.575
	Time $\times$ Group	4, 84	36.18	< .001	.633

The repeated-measures analysis presented in Table 2 demonstrated statistically significant changes in both study outcomes across time. For somatization symptoms, the main effect of time was significant, $F(2, 84) = 118.64$, $p < .001$, partial $\eta^2 = .739$, showing that somatization scores changed substantially across the pretest, posttest, and follow-up assessments. The effect size indicated that approximately 73.9% of the explainable within-subject variability associated with measurement occasion was attributable to time. The main effect of group was also statistically significant, $F(2, 42) = 31.82$, $p < .001$, partial $\eta^2 = .602$, indicating significant overall differences among the ISTDP, CBT, and control groups when scores were considered across assessment occasions. More importantly, the time $\times$ group interaction was statistically significant, $F(4, 84) = 42.57$, $p < .001$, partial $\eta^2 = .670$. This interaction demonstrates that the pattern of change in somatization symptoms over time differed significantly among the three

groups and therefore supports the presence of intervention-specific effects rather than a general reduction occurring equally across all participants. For dissociative experiences, the main effect of time was similarly significant, $F(2, 84) = 96.31$, $p < .001$, partial $\eta^2 = .696$, while the main effect of group was significant, $F(2, 42) = 28.44$, $p < .001$, partial $\eta^2 = .575$. The significant time $\times$ group interaction, $F(4, 84) = 36.18$, $p < .001$, partial $\eta^2 = .633$, indicated that changes in dissociative experiences were also dependent on treatment condition. The large partial eta-squared values observed for both interaction effects indicated substantial differentiation among the longitudinal trajectories of the two treatment groups and the control group. Examination of the means showed that these interactions were primarily attributable to pronounced reductions from pretest to posttest in both active treatment groups, persistence or slight additional improvement of these reductions at follow-up, and relative stability of symptom scores in the control group.

Table 3

Bonferroni-Adjusted Pairwise Comparisons Between Study Groups at Posttest and Three-Month Follow-up

Outcome	Assessment	Comparison	Mean Difference	SE	p	95% CI
Somatization symptoms	Posttest	ISTDP – CBT	-2.26	0.78	.018	-4.18 to -0.34
		ISTDP – Control	-8.20	0.79	< .001	-10.14 to -6.26
		CBT – Control	-5.94	0.81	< .001	-7.93 to -3.95
Somatization symptoms	Follow-up	ISTDP – CBT	-2.40	0.74	.007	-4.22 to -0.58
		ISTDP – Control	-8.66	0.76	< .001	-10.53 to -6.79
		CBT – Control	-6.26	0.78	< .001	-8.18 to -4.34
Dissociative experiences	Posttest	ISTDP – CBT	-5.73	1.91	.014	-10.43 to -1.03
		ISTDP – Control	-20.87	2.00	< .001	-25.79 to -15.95
		CBT – Control	-15.14	2.04	< .001	-20.16 to -10.12
Dissociative experiences	Follow-up	ISTDP – CBT	-6.47	1.85	.004	-11.02 to -1.92
		ISTDP – Control	-22.20	1.94	< .001	-26.97 to -17.43
		CBT – Control	-15.73	1.99	< .001	-20.62 to -10.84

The Bonferroni-adjusted pairwise comparisons shown in Table 3 clarified the direction of the significant interaction effects. At posttest, participants who received ISTDP had significantly lower somatization scores than those who received CBT, with a mean difference of -2.26 points ($SE = 0.78$, $p = .018$, 95% CI [-4.18, -0.34]). Both interventions were also significantly more effective than the control condition: the ISTDP group scored 8.20 points lower than the control group ($p < .001$), while the CBT group scored

5.94 points lower than the control group ($p < .001$). These differences remained significant at the three-month follow-up. At this stage, the mean somatization score in the ISTDP group was 2.40 points lower than in the CBT group ($p = .007$), 8.66 points lower than in the control group ($p < .001$), and the CBT group was 6.26 points lower than the control group ($p < .001$). Therefore, both interventions produced sustained improvements in somatization symptoms,

although the reduction associated with ISTDP was significantly greater than that associated with CBT.

For dissociative experiences, a comparable pattern emerged. At posttest, the mean dissociation score of the ISTDP group was 5.73 points lower than that of the CBT group ($SE = 1.91$, $p = .014$, 95% CI [-10.43, -1.03]). The difference between ISTDP and the control condition was particularly pronounced, with a mean difference of -20.87 points ($p < .001$), while CBT produced a 15.14-point lower mean compared with the control group ($p < .001$). At the three-month follow-up, the difference between ISTDP and CBT increased slightly to -6.47 points and remained statistically significant ($p = .004$). ISTDP participants scored 22.20 points lower than controls at follow-up ($p < .001$), whereas CBT participants scored 15.73 points lower than controls ($p < .001$). Accordingly, both active interventions were effective in reducing dissociative experiences relative to the control condition, but ISTDP demonstrated a significantly greater reduction than CBT at both posttest and follow-up. Moreover, the persistence of significant between-group differences at follow-up indicates that the therapeutic effects were maintained rather than being restricted to the immediate post-intervention period.

4. Discussion

The present study compared the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Cognitive Behavioral Therapy (CBT) in reducing somatization symptoms and dissociative experiences among patients with social anxiety disorder. The findings demonstrated that both interventions produced significant reductions in somatization symptoms and dissociative experiences compared with the control condition, and these therapeutic gains were maintained at the three-month follow-up. More specifically, the significant time $\times$ group interactions indicated that changes in both outcome variables were dependent on treatment condition rather than merely reflecting spontaneous improvement or the passage of time. The findings also showed that ISTDP produced significantly greater reductions than CBT in both somatization symptoms and dissociative experiences at posttest, and this advantage remained statistically significant at follow-up. The maintenance and slight continuation of improvement from posttest to follow-up, particularly in the ISTDP group, further suggest that the psychological changes initiated during treatment continued to exert beneficial effects after the formal intervention had ended. Taken together, the

findings support the effectiveness of both approaches for clinically relevant symptoms accompanying social anxiety disorder, while suggesting that an intensive affect-focused psychodynamic approach may have particular utility when somatic expression and dissociative processes are prominent.

The first major finding was that ISTDP significantly reduced somatization symptoms in patients with social anxiety disorder and produced a larger reduction than both CBT and the control condition. This result is consistent with the growing body of research indicating that intensive short-term psychodynamic approaches may be particularly useful for psychological difficulties expressed through bodily symptoms. In a recent scoping review of ISTDP for functional somatic disorders, evidence across different clinical populations suggested that treatment focused on affective processing, anxiety regulation, and maladaptive defenses can contribute to meaningful reductions in bodily symptom burden (Abbass & Haghiri, 2025). Likewise, research among patients with chronic pain has shown that ISTDP can reduce somatization and health anxiety, supporting the idea that bodily distress may decrease when underlying emotional conflicts and defensive processes are directly addressed (Nakhaei Moghadam et al., 2024). The present findings are also compatible with evidence that intensive dynamic psychotherapy reduces gastrointestinal symptom severity among patients with irritable bowel syndrome (Hajrezaei et al., 2024), as well as findings showing reductions in somatic symptoms among individuals who had recovered from COVID-19 following ISTDP (Jafari et al., 2024). Earlier evidence concerning the application of ISTDP to somatic disorders similarly suggested that the treatment can be useful in clinical presentations in which affective conflict, anxiety, defensive functioning, and physical symptom expression are strongly intertwined (Town & Driessen, 2013).

One explanation for the observed reduction in somatization can be derived from the theoretical mechanisms of ISTDP. Patients with social anxiety disorder often experience intense internal emotional activation in situations involving interpersonal evaluation, rejection, criticism, or possible humiliation. When emotions such as anger, sadness, shame, guilt, fear, and attachment-related distress cannot be consciously tolerated or appropriately expressed, anxiety may be activated and discharged through somatic pathways. Recurrent physiological activation can then become experienced as an independent source of threat, contributing to increased self-monitoring and further

anxiety. ISTDP systematically identifies the sequence linking emotion, anxiety, and defense and helps patients distinguish emotional experience from anxiety-based bodily activation. Through clarification of defenses, regulation of anxiety, and gradually increased tolerance of previously avoided affect, patients may become less dependent on somatic expression as a means of managing internal conflict. This interpretation is consistent with findings that ISTDP can improve difficulties in emotion regulation among psychosomatic patients (Kelidari et al., 2024). It is also compatible with the broader argument that intensive dynamic treatment can reduce psychological and healthcare burden by targeting processes that perpetuate recurrent symptom presentation rather than focusing exclusively on the symptoms themselves (Abbass et al., 2018).

The finding that CBT significantly reduced somatization symptoms compared with the control condition is also consistent with previous literature. Cognitive-behavioral interventions have been successfully applied to a range of conditions in which cognition, emotional arousal, and physical symptoms interact. A systematic review of CBT-based interventions for gastroduodenal disorders of gut-brain interaction demonstrated the clinical relevance of cognitive and behavioral mechanisms for conditions characterized by persistent bodily complaints (Law et al., 2023). More recent network meta-analytic evidence likewise supports the efficacy of CBT and related psychological treatments in adults experiencing bodily distress (Berpohl & Martin, 2025). Furthermore, CBT has demonstrated beneficial effects on body-related cognitive concerns (Kiani Rad, 2024), while studies involving patients with migraine have shown that cognitive-behavioral treatment can reduce anxiety sensitivity, which reflects fear of anxiety-related physical sensations and their perceived consequences (Mehrmanesh et al., 2023). These findings correspond with the present results by suggesting that modification of catastrophic interpretations, avoidance, attentional biases, and maladaptive beliefs about physical sensations can reduce bodily distress.

From a cognitive-behavioral perspective, the improvement in somatization symptoms can be explained through changes in the interpretation and behavioral management of physiological arousal. Individuals with social anxiety disorder frequently monitor internal sensations closely and interpret manifestations such as blushing, trembling, sweating, dizziness, gastrointestinal discomfort, or increased heart rate as signs that their anxiety is visible and will result in humiliation or negative

evaluation. Such interpretations amplify anxiety, which in turn intensifies bodily sensations and reinforces further monitoring. Cognitive restructuring can weaken catastrophic beliefs regarding the meaning and social consequences of bodily symptoms, while exposure and behavioral experiments can demonstrate that feared outcomes are less probable or less damaging than anticipated. Reduction of avoidance and safety behaviors can further prevent the maintenance of dysfunctional beliefs. Consequently, although CBT may not conceptualize somatization primarily as an expression of unconscious emotional conflict, it can reduce bodily distress by altering the cognitive-attentional and behavioral processes that magnify physiological sensations.

Nevertheless, the greater reduction in somatization observed following ISTDP may indicate that, for patients whose physical symptoms are closely connected to emotional inhibition and defensive avoidance, direct work with affective processes offers an additional therapeutic pathway. Whereas CBT mainly targets beliefs about symptoms and the avoidance patterns surrounding them, ISTDP seeks to alter the emotional processes that may contribute to the generation and persistence of somatic activation itself. The distinction is clinically relevant because social anxiety can involve not only distorted expectations of negative evaluation but also complex emotions regarding attachment, shame, anger, vulnerability, rejection, and self-assertion. When these experiences are repeatedly inhibited, distress may be redirected into bodily channels. The stronger reduction observed in the ISTDP group is therefore consistent with research suggesting that intensive psychodynamic treatment may have distinctive benefits for somatic disorders and medically unexplained symptoms (Abbass & Haghiri, 2025; Town & Driessen, 2013). However, this comparative advantage should be interpreted within the specific population, treatment duration, and follow-up period examined in the present study rather than as evidence that one treatment is universally superior across clinical populations.

The second principal finding was that both ISTDP and CBT significantly reduced dissociative experiences compared with the control condition. Again, ISTDP produced a significantly greater reduction than CBT, and the difference remained evident at the three-month follow-up. This result is consistent with emerging evidence concerning the applicability of intensive psychodynamic treatment to conditions characterized by dissociation. Castillo et al. reported promising results following brief ISTDP among

patients with dissociative seizures, indicating that interventions targeting affective activation, anxiety, and defensive processes may be relevant for dissociative symptom presentations (Castillo et al., 2022). Similarly, short-term intensive psychodynamic psychotherapy has demonstrated beneficial effects among individuals with dissociative disorders, suggesting that greater access to and integration of emotional experience may reduce psychopathological symptoms associated with dissociation (Donyavi & Mohtashami, 2024). Although those studies involved populations that differed diagnostically from patients with social anxiety disorder, they support the broader proposition that dissociative experiences may respond to interventions that improve the patient's capacity to experience and integrate emotionally threatening internal states.

The effect of ISTDP on dissociative experiences can be understood in terms of the defensive function of dissociation. Dissociation may emerge when emotional or physiological activation becomes difficult to tolerate within conscious awareness. In patients with social anxiety disorder, experiences involving perceived rejection, humiliation, criticism, or exposure may activate intense affect accompanied by overwhelming anxiety. Emotional detachment, depersonalization, derealization, absorption, or discontinuity of awareness may then function as mechanisms through which the person distances themselves from threatening internal experiences. In ISTDP, the therapist continuously monitors the patient's anxiety and defenses, regulates the intensity of affective work according to the patient's capacity, and attempts to replace automatic defensive responses with conscious recognition and toleration of emotion. As patients learn to experience feelings without becoming excessively overwhelmed by anxiety, reliance on dissociative mechanisms may diminish. The relationship between maladaptive emotion-regulation strategies and defensive functioning documented in clinical research supports the relevance of these mechanisms in understanding psychopathology (Nohi & Hasani, 2017). The present reduction in dissociative experiences may therefore reflect improved emotional integration and decreased dependence on defensive disengagement.

CBT also significantly decreased dissociative experiences, which is compatible with evidence that cognitive-behavioral approaches can remain effective even in clinically complex presentations involving dissociation. A clinical investigation of CBT for social anxiety accompanied by dissociative and self-harm behaviors illustrated the

potential usefulness of cognitive-behavioral strategies in addressing the interaction among social fear, avoidance, maladaptive cognition, and dissociative responding (Tarakçioğlu, 2024). CBT can potentially reduce dissociation by lowering overall anxiety, increasing exposure to avoided experiences, improving cognitive reappraisal, decreasing catastrophic interpretations, and promoting greater behavioral engagement with feared situations. Repeated exposure may also strengthen the patient's capacity to remain psychologically present during situations that previously produced emotional disengagement. Thus, dissociative symptoms may decrease indirectly as the individual becomes less threatened by internal arousal and more capable of confronting feared social experiences.

At the same time, previous evidence suggests that dissociation may influence treatment processes and treatment response within cognitive-behavioral interventions. Research examining trauma and dissociation in patients undergoing CBT has demonstrated that dissociative phenomena represent clinically relevant variables that should be considered when understanding therapeutic outcome (Serra et al., 2020). Dissociation may interfere with sustained attention, emotional engagement, memory integration, or full participation in exposure-based exercises. If patients psychologically detach when emotional activation becomes intense, they may have fewer opportunities for corrective learning. This possibility may partly explain why CBT, although clearly effective in the present study, produced smaller reductions in dissociative experiences than ISTDP. Because ISTDP treats defensive disengagement itself as a central therapeutic target and regulates the level of anxiety throughout emotional processing, it may exert a more direct influence on the mechanisms responsible for dissociative responses.

The broader psychotherapy literature also provides a basis for understanding the effectiveness of CBT observed in the present study. Cognitive-behavioral interventions have demonstrated benefits across a wide variety of disorders and clinical delivery formats. For example, CBT/exposure and response prevention continues to function as an established active treatment in controlled comparisons with other contemporary interventions (Nielsen et al., 2025). Digital CBT has also demonstrated effectiveness among patients with chronic pain and insomnia, illustrating the adaptability of cognitive-behavioral principles to populations characterized by interacting psychological and somatic difficulties

(Schuffelen et al., 2026). Moreover, therapeutic improvements during CBT can involve changes in maladaptive personality beliefs and coping strategies in addition to reductions in disorder-specific symptoms (Bourdon et al., 2019). Accordingly, the observed reductions in both somatization and dissociation may reflect broad improvements in cognitive appraisal, behavioral coping, emotional tolerance, and engagement with previously avoided experiences.

The maintenance of treatment effects at the three-month follow-up represents another important finding. Neither intervention showed a return toward baseline symptom levels after treatment; instead, mean scores remained substantially lower and showed modest additional reductions. The durability of these effects may suggest that both treatments generated skills or psychological changes that continued to operate beyond the formal therapy period. In CBT, patients may have continued to use cognitive restructuring, exposure, behavioral experiments, reduction of safety behaviors, and more adaptive interpretations of bodily and social experiences. In ISTDP, continued improvement may reflect sustained awareness of emotional processes, reduced reliance on maladaptive defenses, increased tolerance of anxiety, and greater capacity to identify and process affect before distress becomes somatized or dissociated. Reviews of ISTDP in mood and related disorders have previously indicated that clinically meaningful change can persist beyond the active treatment phase (Caldirola et al., 2020). The present findings therefore add to the evidence suggesting that relatively brief psychological interventions may have effects extending beyond immediate symptom reduction.

5. Conclusion

Overall, the study extends previous findings by examining somatization and dissociation simultaneously within social anxiety disorder and directly comparing two theoretically distinct interventions. Prior evidence has supported ISTDP in functional somatic, mood, dissociative, and psychosomatic conditions (Abbass & Haghiri, 2025; Caldirola et al., 2020; Castillo et al., 2022), while CBT has accumulated support across anxiety-related, somatic, trauma-related, and behavioral conditions (Bermphohl & Martin, 2025; Law et al., 2023; Serra et al., 2020). The current results suggest that both approaches can produce clinically meaningful change in symptom domains that extend beyond the defining social fears of social anxiety

disorder. At the same time, the larger reductions associated with ISTDP suggest that treatment mechanisms centered on emotional experience, anxiety regulation, and defensive restructuring may be especially relevant when social anxiety is accompanied by marked somatic expression and dissociative experiences. These findings emphasize the value of assessing such associated symptoms during treatment planning rather than viewing social anxiety solely through the dimensions of social fear and avoidance.

The present study has several limitations that should be considered when interpreting its findings. First, the sample consisted of only 45 patients recruited from clinical settings in Tehran, which limits the statistical power and restricts the generalizability of the findings to broader populations, other cultural settings, adolescents, older adults, or patients with different levels of disorder severity. Second, although random assignment strengthened internal validity, the use of purposive recruitment may have resulted in a sample that was more motivated for psychotherapy than the general population of individuals with social anxiety disorder. Third, somatization and dissociative experiences were primarily evaluated using self-report instruments, making the results potentially vulnerable to response biases, individual differences in symptom awareness, and expectations regarding treatment. Fourth, the follow-up period was limited to three months and therefore does not establish whether treatment gains persist over six months, one year, or longer periods. Fifth, therapist allegiance and differences in therapist competence or treatment fidelity could potentially have affected comparative outcomes if not independently monitored. Finally, the study focused specifically on somatization symptoms and dissociative experiences and did not simultaneously examine possible mediating mechanisms such as emotional regulation, defense mechanisms, experiential avoidance, anxiety sensitivity, self-focused attention, therapeutic alliance, or changes in core social anxiety symptoms.

Future studies should replicate these findings using larger multisite samples and more diverse clinical populations to increase the precision and external validity of the results. Longer follow-up periods of six months, one year, or longer would help determine the durability and temporal course of treatment effects. Future research should also incorporate clinician-rated assessments, behavioral indices, physiological measures, and structured diagnostic interviews alongside self-report questionnaires. Examining mechanisms of change would be particularly valuable; studies could test whether reductions in somatization

following ISTDP are mediated by improved emotion regulation, decreased defensive avoidance, or enhanced affect tolerance, and whether CBT effects are mediated by reductions in catastrophic interpretation, self-focused attention, safety behaviors, and experiential avoidance. Future research could also evaluate moderators such as baseline dissociation severity, attachment style, trauma history, personality organization, comorbidity, gender, medication status, and severity of social anxiety to identify which patients are most likely to benefit from each treatment. Direct comparisons incorporating treatment-fidelity assessment, blinded outcome evaluation, and larger samples would further clarify whether the observed difference between ISTDP and CBT remains robust under more rigorous experimental conditions.

In clinical practice, therapists working with patients with social anxiety disorder should routinely assess somatic complaints and dissociative experiences rather than limiting assessment to fear of negative evaluation and social avoidance. The present findings suggest that both ISTDP and CBT may be incorporated into treatment planning when these additional symptoms are clinically significant. CBT may be particularly useful when catastrophic beliefs, avoidance, safety behaviors, and excessive monitoring of bodily sensations are prominent, whereas intensive dynamic treatment may be considered when symptoms appear closely associated with emotional inhibition, defensive processes, interpersonal conflicts, and difficulty tolerating affect. Clinicians should monitor the patient's level of anxiety and dissociation throughout treatment because excessive emotional activation may interfere with therapeutic engagement. Training programs may also benefit from preparing psychotherapists to recognize the interaction among social anxiety, bodily distress, emotion regulation, and dissociative responding. Treatment selection should ultimately be individualized according to the patient's clinical presentation, preferences, psychological capacities, comorbidities, and response to intervention rather than relying exclusively on diagnostic labels.

Authors' Contributions

Authors equally contributed 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.

Acknowledgments

We would like to express our gratitude to all individuals helped us to do the project.

Declaration of Interest

The authors report no conflict of interest.

Funding

According to the authors, this article has no financial support.

Ethical Considerations

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

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