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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

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1. Round 1

1.1. Reviewer 1

Reviewer:

The eligibility paragraph states that participants had “a primary diagnosis of social anxiety disorder according to DSM-5-TR criteria,” but it is unclear how diagnostic primacy and severity were established. The authors should specify whether the SCID-5 was used specifically for the DSM-5-TR diagnosis, whether additional validated measures of social anxiety severity were administered, and how competing primary diagnoses were ruled out. Since social anxiety disorder is the defining condition of the sample, the absence of a disorder-specific measure such as the Liebowitz Social Anxiety Scale, Social Phobia Inventory, or another validated instrument represents an important methodological weakness. At minimum, the authors should justify why the severity of the primary disorder was not directly quantified as an outcome or baseline clinical characteristic.

The CBT intervention paragraph likewise requires treatment-fidelity information. The statement that treatment “was based on established cognitive-behavioral models of social anxiety disorder” is insufficiently precise for replication. The authors should identify the specific manual or model used, for example, whether the intervention primarily followed the Clark and Wells model, Heimberg’s model, or an adapted protocol. Session-by-session treatment content should be summarized more systematically, and the authors should clarify whether exposure exercises were conducted in vivo, imaginally, or through behavioral experiments. It is also important to indicate whether the CBT and ISTDP interventions were matched in therapist contact time and therapist expertise.

The manuscript states that “The control group received no structured psychotherapy during the study period and continued routine clinical care when applicable.” This formulation creates ambiguity regarding the control condition. The authors should explicitly state whether the control group was a wait-list control, treatment-as-usual condition, or no-treatment control. “Routine clinical care when applicable” could include medication, counseling, or other therapeutic contacts and should therefore be operationally defined. Any psychological or pharmacological care received by control participants during the study must be documented because uncontrolled co-interventions may influence between-group comparisons.

Response: Revised and uploaded the manuscript.

1.2. Reviewer 2

Reviewer:

The paragraph describing participants states that individuals receiving stable pharmacological treatment were eligible if their medication regimen had remained unchanged for at least four weeks before study entry. This criterion requires more detailed reporting. The authors should indicate how many participants in each group were receiving psychotropic medication, what classes of medication were used, whether medication status differed between groups, and whether medication use was controlled statistically. Because antidepressants and anxiolytics may affect both social anxiety and somatic symptoms, unequal distribution of medication exposure could confound the apparent treatment effects. Medication stability should therefore be reported as a baseline clinical characteristic and considered in sensitivity analyses if the sample size permits.

The description of the “Structured Clinical Interview for DSM-5 Disorders” is too general and should be revised to identify the exact version used, such as SCID-5-CV or SCID-5-RV, and the language/version administered to the Iranian sample. The sentence “Previous psychometric investigations of structured DSM-based clinical interviews have demonstrated acceptable to strong inter-rater reliability and diagnostic validity across different clinical populations” is insufficiently specific. The authors should report reliability or validity evidence relevant to the exact instrument and, ideally, to the Persian version. They should also state whether interviewers were trained and supervised and whether inter-rater reliability was assessed in the present study.

The paragraph describing the PHQ-15 should provide psychometric information from the current sample rather than relying only on previous studies. The manuscript currently states that “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.” This should be supplemented with the Cronbach’s alpha or preferably McDonald’s omega obtained in the present sample at baseline. The authors should also clarify which validated Persian version was used. Because the PHQ-15 includes symptoms that may have medical causes, the manuscript should explain how known medical conditions were considered when interpreting somatization scores.

The description of the Dissociative Experiences Scale-II requires similar strengthening. The sentence “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” is appropriate, but the manuscript subsequently interprets changes in DES-II scores rather strongly as changes in dissociation. The authors should specify whether the validated Persian version was employed, report internal consistency in the current sample, and avoid implying that DES-II scores establish a dissociative disorder diagnosis. It would also be helpful to state whether the total DES-II score or subscale scores were analyzed and to explain why the total score was selected as the principal outcome.

The ISTDP intervention paragraph states that participants 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 authors should provide considerably more detail about therapist qualifications, training level, years of clinical experience, supervision, and adherence monitoring. ISTDP is technically demanding, and treatment effects may depend heavily on therapist competence. The manuscript should report whether sessions were audio- or video-recorded, whether an established fidelity or adherence scale was used, and whether independent assessors evaluated treatment integrity. Without such information, it is difficult to determine whether the intervention can legitimately be characterized as protocol-consistent ISTDP.

Response: Revised and uploaded the manuscript.

2. Revised

Editor’s decision after revisions: Accepted.

Editor in Chief’s decision: Accepted.