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Development of a Psychodynamic–Emotion-Focused Therapeutic Package and Comparison of Its Effectiveness with Dialectical Behavior Therapy on Emotional Capital and Sensation Seeking among Women with Comorbid Depression and Social Anxiety

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ABSTRACT

This study aimed to develop a psychodynamic–emotion-focused therapeutic package and compare its effectiveness with dialectical behavior therapy in improving emotional capital and modifying sensation seeking among women with comorbid depression and social anxiety. This exploratory sequential mixed-methods study was conducted in qualitative and quantitative phases. In the qualitative phase, relevant scientific texts were analyzed using theory-driven deductive thematic analysis, and the extracted components were organized into a ten-session psychodynamic–emotion-focused therapeutic package whose content validity was evaluated by experts. The quantitative phase employed a quasi-experimental three-group pretest–posttest design with a two-month follow-up. Forty-five unmarried women aged 20–40 years attending counseling centers in Isfahan were randomly assigned to psychodynamic–emotion-focused therapy, dialectical behavior therapy, and control groups, with 15 participants in each group. The experimental groups received ten one-hour sessions, whereas the control group received no intervention. Data were collected using the Beck Depression Inventory, Connor Social Phobia Inventory, Golparvar Emotional Capital Questionnaire, and Zuckerman Sensation-Seeking Questionnaire. Data were analyzed using mixed-design repeated-measures analysis of variance and Bonferroni post-hoc comparisons. The main effect of time on emotional capital was significant, $F(2, 84) = 552.183$, $p < .001$, partial $\eta^2 = .929$. The time-by-group interaction was also significant, $F(4, 84) = 413.550$, $p < .001$, partial $\eta^2 = .952$. Bonferroni comparisons showed significant increases in emotional capital from pretest to posttest and follow-up in both experimental groups, with substantially greater improvement in the psychodynamic–emotion-focused group. For sensation seeking, neither the main effect of time, $F(1.644, 69.066) = 0.234$, $p = .748$, nor the time-by-group interaction, $F(3.289, 69.066) = 0.654$, $p = .597$, was significant. Both interventions improved emotional capital, although the psychodynamic–emotion-focused package produced markedly stronger and sustained effects, while neither intervention significantly changed sensation seeking.

Key words: Psychodynamic psychotherapy; emotion-focused therapy; dialectical behavior therapy; emotional capital; sensation seeking; depression; social anxiety

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Introduction

Depression and social anxiety disorder are among the most prevalent and disabling psychological disorders in women, and their co-occurrence creates a particularly complex clinical condition characterized by persistent negative affect, interpersonal withdrawal, self-criticism, avoidance, diminished pleasure, and impaired social functioning. Depression typically involves sadness, hopelessness, reduced motivation, anhedonia, fatigue, and negative beliefs about the self and the future, whereas social anxiety is marked by an intense fear of evaluation, embarrassment, rejection, or humiliation in interpersonal and performance situations. When these disorders occur simultaneously, their symptoms may mutually reinforce one another: social avoidance reduces access to rewarding and supportive experiences, while depressive withdrawal and low self-worth intensify fears of negative evaluation and further restrict interpersonal engagement. Network-based research suggests that comorbidity may be maintained by bridge symptoms and mental states connecting anxiety and depressive symptom systems, rather than by the simple coexistence of two independent disorders (1). Longitudinal and epidemiological findings similarly indicate that depressive and anxiety disorders frequently operate "in concert," sharing vulnerabilities, clinical manifestations, and unfavorable consequences (2). Recent person-oriented evidence has further identified distinct profiles of combined social anxiety and depression associated with specific patterns of emotional dysfunction, highlighting the heterogeneity of adults experiencing these symptoms (3).

The clinical importance of this comorbidity extends beyond symptom severity. Social anxiety occurring alongside major depressive disorder has been associated with a more complicated course, poorer prognosis, and increased therapeutic difficulty, particularly when symptoms become chronic or are accompanied by functional impairment (4). Social anxiety disorder is itself characterized by high rates of psychiatric comorbidity, and the presence of depressive symptoms may complicate diagnosis, reduce treatment responsiveness, and increase the likelihood of recurrence (5). Population-based evidence also indicates that comorbid social anxiety is related to poorer quality of life than social anxiety alone, underscoring the cumulative burden created by overlapping disorders (6). Social anxiety symptoms have additionally been linked to elevated suicidal risk, especially when accompanied by depressive states, hopelessness, and social disconnection (7). More broadly, mood and anxiety disorders share several social, psychological, and demographic risk factors, while comorbid presentations may also be influenced by additional vulnerabilities that distinguish them from single-disorder conditions (8). Among women, biological sensitivity to stress, sex-specific neuroinflammatory pathways, hormonal mechanisms, and psychosocial pressures may further increase vulnerability to mood disturbance and stress-related emotional dysregulation (9).

The coexistence of depression and social anxiety can also be understood in relation to deficits in social and psychological resources. Young individuals living in deprived or stressful environments may experience higher rates of depression, anxiety, and comorbid anxiety–depression when social capital and resilience are limited (10). Reduced access to supportive relationships, trust, reciprocity, and emotionally sustaining social networks can intensify isolation and undermine effective coping. In this context, emotional capital represents an important but comparatively underexamined psychological resource. Emotional capital refers to a set of acquired emotional competencies and positive affective assets that facilitate adaptation, effective interaction, persistence, coping, and psychological growth. It includes capacities such as emotional vitality, positive affect, happiness, confidence, emotional awareness, constructive emotional expression, and the

ability to use emotional resources in challenging situations. Emotional capital has been conceptualized as a resource that develops within social and relational environments and supports individual functioning in educational, occupational, and interpersonal contexts (11). It has also been associated with innovativeness, adaptive engagement, and the willingness to approach new experiences constructively (12).

Affective or emotional capital may operate as a protective mechanism linking earlier emotional experiences to later socioeconomic and psychosocial functioning. Evidence suggests that socio-emotional capital can partly explain how depressive symptoms influence later life outcomes, indicating that reduced emotional resources may have consequences extending beyond immediate psychological distress (13). Affective capital has also been discussed as a relational and culturally situated resource that can support resistance, resilience, and adaptation in populations exposed to adversity and intergenerational trauma (14). In women with depression and social anxiety, low emotional capital may manifest as depleted energy, limited access to positive feelings, difficulty maintaining hope and pleasure, reduced emotional flexibility, and diminished confidence in interpersonal situations. These deficiencies may increase reliance on avoidance, emotional suppression, reassurance seeking, or withdrawal, thereby maintaining both depressive and socially anxious symptoms.

Empirical studies support the modifiability of emotional capital through psychological intervention. Positive psychotherapy and acceptance and commitment therapy have both been found to improve emotional capital among women experiencing depression, suggesting that interventions targeting psychological strengths, acceptance, and adaptive emotional processes can restore positive affective resources (15). Mindful self-acceptance therapy and positive psychotherapy have likewise produced improvements in the emotional capital of depressed female students (16). Positive mindfulness therapy has been associated with increased affective capital and improved meta-emotional processes among women with generalized anxiety disorder (17). In addition, parent–child relationship-based play therapy and cognitive-behavioral art play therapy have been shown to enhance emotional capital among mothers of children in single-parent families (18). These findings indicate that emotional capital is not a fixed trait; rather, it can be strengthened when treatment increases emotional awareness, positive affect, self-acceptance, relational security, and the ability to regulate distress.

Another variable that may be relevant to women with comorbid depression and social anxiety is sensation seeking. Sensation seeking refers to the tendency to pursue novel, varied, intense, complex, or stimulating experiences and to tolerate certain risks in order to obtain such experiences. Although sensation seeking is often studied in adolescence and in relation to externalizing behaviors, it also has implications for affect regulation, impulsive coping, interpersonal decisions, and attempts to escape low arousal or negative mood. High sensation seeking has been associated with risk-taking behavior and susceptibility to peer influence (19), problematic internet use (20), and participation in extreme or high-intensity behavior (21). The interaction between cognition, emotion, and individual differences in motivational intensity may contribute to the emergence of extreme behavioral responses under conditions of emotional strain (22). Sensation seeking may therefore represent not only a general personality tendency but also a possible regulatory strategy through which some individuals attempt to counter emotional numbness, boredom, emptiness, or low positive affect.

The relationship between sensation seeking and depression appears complex rather than linear. Sensation seeking may increase as an attempt to compensate for anhedonia or reduced emotional stimulation, yet depressive symptoms may also inhibit exploration and behavioral activation. In adolescents, sensation seeking has been identified as a mechanism linking chronotype and sleep-related factors to depression (23). Among women with depression, cognitive-behavioral hypnotherapy has produced changes in self-esteem and sensation seeking, suggesting that this construct may be responsive to psychological intervention (24). Intensive short-term dynamic psychotherapy has also been investigated in relation to sensation seeking and the tendency toward marital infidelity, supporting the relevance of unconscious conflict, affect regulation, and impulse-related processes in understanding this variable (25). Accordingly, examining sensation seeking in women with comorbid depression and social anxiety may clarify whether treatments that modify emotional processing, behavioral control, and tolerance of internal states can influence the need for stimulation or emotionally intense experiences.

Emotion regulation is a central mechanism connecting depression, anxiety, emotional capital, and sensation seeking. Individuals with comorbid depression and anxiety commonly experience difficulty identifying emotions, tolerating affective arousal, using flexible regulation strategies, and expressing emotional needs effectively. Research involving depressed adolescents has shown that anxiety comorbidity is associated with distinctive patterns of emotion-regulation difficulty, indicating that co-occurring anxiety may alter the emotional functioning of depressed individuals (26). Avoidance, rumination, suppression, self-criticism, and interpersonal withdrawal may provide temporary relief but ultimately intensify emotional distress and restrict opportunities for corrective emotional experiences. Therefore, interventions that directly address emotional processing and regulation may be especially suitable for this population.

Emotion-focused therapy views psychological symptoms as emerging partly from maladaptive emotional schemes and from difficulties in accessing, symbolizing, regulating, and transforming emotional experience. Treatment helps clients become aware of primary and secondary emotions, distinguish adaptive from maladaptive emotional responses, access unmet emotional needs, and transform painful emotional states through new emotional experiences. Emotion-focused interventions have shown effectiveness in reducing depression among women (27) and in decreasing social anxiety and interpersonal dependency among women receiving community-based services (28). Developments in emotion-focused therapy for social anxiety emphasize work with shame, self-criticism, fear, vulnerability, and maladaptive self-evaluative processes (29). Emotion-focused therapy has also been applied successfully to anxiety and depression in women coping with breast cancer, demonstrating its relevance to emotionally complex female populations facing multiple forms of distress (30). Related interventions have improved positive feelings in marital relationships (31) and strengthened positive meta-emotion, intimacy, and character strengths among older women (32).

Psychodynamic psychotherapy offers a complementary framework by focusing on unconscious emotional conflicts, defensive processes, recurring interpersonal patterns, and the ways in which anxiety interferes with the direct experience of emotion. Intensive short-term dynamic psychotherapy seeks to identify the sequence through which emotions activate anxiety and defenses, thereby preventing adaptive affective processing. Clarification, pressure, confrontation, and the regulation of anxiety are used to help clients experience previously avoided emotions and understand recurring patterns. Reviews indicate that intensive short-term dynamic psychotherapy can reduce symptoms in mood disorders (33), while short-term

psychodynamic psychotherapy has demonstrated efficacy for depressive disorders in systematic review and meta-analytic evidence (34). Positive outcomes have also been reported for treatment-resistant depression, with benefits maintained over extended follow-up periods and accompanied by favorable cost-effectiveness findings (35). Preliminary research has supported the effectiveness of intensive short-term dynamic psychotherapy for depression when used alone or in combination with complementary procedures (36).

Psychodynamic treatment may be particularly relevant to anxiety disorders because it addresses the affective and relational mechanisms underlying avoidance rather than focusing exclusively on overt symptoms. Intensive short-term dynamic psychotherapy delivered by relatively novice therapists has produced improvements in symptom severity and psychological structure among patients with anxiety disorders (37). Internet-based psychodynamic therapy has also demonstrated utility for social anxiety and has been compared with cognitive-behavioral treatment in preference-based designs (38). Research on mechanisms of change in intensive short-term dynamic psychotherapy emphasizes the therapeutic importance of recognizing defenses, regulating anxiety, facilitating emotional experiencing, and restructuring maladaptive relational patterns (39). These findings align with calls for a broader paradigm in mental-disorder treatment that moves beyond narrowly disorder-specific protocols and gives greater attention to transdiagnostic mechanisms, patient heterogeneity, and the limitations of existing evidence hierarchies (40).

Integrating psychodynamic and emotion-focused principles may therefore provide a theoretically coherent approach for women with comorbid depression and social anxiety. Both approaches emphasize emotional experience, but they contribute different therapeutic strengths. The psychodynamic component identifies unconscious conflict, anxiety, resistance, defenses, and recurring interpersonal patterns, whereas the emotion-focused component facilitates emotional awareness, acceptance, expression, transformation, and the construction of new emotional meaning. Such integration may be especially useful for increasing emotional capital because it not only reduces distress but also expands access to vitality, positive affect, emotional agency, and adaptive connection. It may also affect sensation seeking by helping clients tolerate internal states, recognize the emotional functions of high-intensity behavior, and replace impulsive or compensatory stimulation with more reflective and adaptive responses.

Dialectical behavior therapy provides an important comparison intervention because it directly targets emotion dysregulation through structured skills training in mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (41). Although originally developed for severe emotional and behavioral dysregulation, dialectical behavior therapy has been applied to a broad range of clinical problems. Meta-analytic evidence supports its effectiveness for suicidal behavior (42), and DBT-based treatment has reduced depressive symptoms among adolescents in acute psychiatric care (43). It has also improved emotional self-regulation and reduced aggression and self-harm in high-risk populations (44), as well as reducing emotion-regulation difficulties and aggression among adolescent girls with depressive symptoms (45). These outcomes indicate that DBT may strengthen behavioral control and emotional management, making it a clinically credible intervention against which to compare a newly developed psychodynamic–emotion-focused package.

Despite the growing evidence supporting psychodynamic therapy, emotion-focused therapy, and dialectical behavior therapy, several gaps remain. Few studies have developed a structured intervention that

explicitly integrates psychodynamic and emotion-focused techniques for women with simultaneous depression and social anxiety. Existing research has more often examined symptom reduction than the development of positive emotional resources such as emotional capital. Moreover, sensation seeking has rarely been studied as an outcome of psychotherapy in women with internalizing comorbidity, despite its potential role in compensatory emotional behavior and maladaptive stimulation seeking. Comparative studies are also needed to determine whether an intervention emphasizing emotional conflict, defenses, and transformation produces outcomes different from those of a skills-based intervention such as DBT. Addressing these gaps may contribute to the development of more mechanism-focused and population-sensitive treatments for women experiencing complex emotional and interpersonal difficulties.

Accordingly, the present study aimed to develop a psychodynamic–emotion-focused therapeutic package and compare its effectiveness with dialectical behavior therapy in improving emotional capital and modifying sensation seeking among women with comorbid depression and social anxiety.

Methods and Materials

Study Design and Participants

This study employed an exploratory sequential mixed-methods design and was conducted in two consecutive qualitative and quantitative phases. The qualitative phase was undertaken to develop an integrated psychodynamic–emotion-focused therapeutic package specifically adapted to the psychological characteristics and therapeutic needs of women with comorbid depression and social anxiety. During the first stage of this phase, relevant scientific literature concerning short-term psychodynamic psychotherapy, emotion-focused therapy, depression, social anxiety, emotional processes, and the clinical experiences of women with comorbid depressive and social anxiety symptoms was systematically reviewed. The sources examined included research articles, dissertations, theses, therapeutic manuals, and other relevant academic materials. In the second stage, the extracted texts were analyzed through a theory-driven deductive thematic analysis. The concepts and therapeutic components identified in the literature were coded, classified, and organized into a thematic network consisting of basic, organizing, and overarching themes. In the third stage, a comprehensive list of therapeutic techniques was prepared based on the principal categories and themes emerging from the analysis. The techniques were then integrated according to their theoretical compatibility, clinical relevance, and applicability to women experiencing simultaneous symptoms of depression and social anxiety. In the fourth stage, the preliminary version of the psychodynamic–emotion-focused therapeutic package was developed. The content validity and clinical appropriateness of the preliminary package were subsequently evaluated through expert judgment. Specialists with relevant academic and clinical experience reviewed the objectives, content, therapeutic sequence, techniques, session structure, and suitability of the package for the target population. The proposed revisions were incorporated, and the final version of the intervention package was prepared for implementation in the quantitative phase.

The quantitative phase used a quasi-experimental design involving three parallel groups, including two experimental groups and one control group, and three measurement occasions consisting of a pretest, a posttest, and a two-month follow-up assessment. The statistical population consisted of unmarried women aged 20 to 40 years who had attended counseling centers in Isfahan, Iran, and presented with comorbid symptoms of depression and social anxiety. Following initial screening and clinical assessment, 45 eligible

participants were selected and randomly assigned to three groups of 15 participants. The first experimental group received the developed psychodynamic–emotion-focused therapeutic package, the second experimental group received dialectical behavior therapy, and the control group did not receive a psychological intervention during the study period. Before the interventions commenced, all three groups completed the study measures as a pretest. The participants in the experimental groups subsequently attended their respective therapeutic programs. The interventions were delivered in ten one-hour sessions, whereas the control group remained on a waiting list and continued its usual activities without receiving either of the study interventions. Immediately after the completion of the therapeutic sessions, the posttest assessments were administered to all groups under comparable conditions. Two months later, the participants completed the same instruments during the follow-up stage to determine whether the effects of the interventions had been maintained over time.

The inclusion criteria were willingness to participate voluntarily in the study, provision of informed consent, acceptance of the rules and requirements of the therapeutic sessions, being an unmarried woman between 20 and 40 years of age, and receiving a diagnosis of comorbid depression and social anxiety based on scores obtained from the Beck Depression Inventory and the Connor Social Phobia Inventory as well as confirmation through a clinical evaluation conducted by a qualified mental health professional. Participants were also required not to receive another concurrent psychological or psychiatric treatment that could substantially interfere with the effects of the interventions. The exclusion criteria included withdrawal of consent, unwillingness to continue participating in the study, initiation of another psychological treatment during the intervention period, failure to complete the required assessments, and absence from more than two therapeutic sessions. Participants were informed about the objectives and procedures of the research, the voluntary nature of their participation, their right to withdraw from the study without adverse consequences, and the confidentiality of their personal information and questionnaire responses.

Data Collection Tools

Beck Depression Inventory. The Beck Depression Inventory is a 21-item self-report instrument developed to assess the presence and severity of depressive symptoms in individuals aged 13 years and older. The inventory evaluates a broad range of cognitive, affective, motivational, behavioral, and somatic manifestations of depression. Its items address symptoms such as sadness, pessimism, feelings of failure, loss of pleasure, guilt, self-dislike, self-criticism, suicidal thoughts, crying, agitation, loss of interest, indecisiveness, worthlessness, loss of energy, changes in sleep and appetite, irritability, concentration difficulties, fatigue, and reduced sexual interest. Each item consists of a series of statements representing increasing levels of symptom severity, and respondents select the statement that best describes their experience during the relevant time period. Higher total scores indicate more severe depressive symptomatology. The content and scoring framework of the instrument are broadly consistent with the diagnostic characteristics of depressive disorders described in psychiatric classification systems. In the present study, the inventory was primarily employed as a screening measure to identify women with clinically meaningful depressive symptoms and to support the determination of comorbidity with social anxiety. The Persian version of the instrument has demonstrated acceptable psychometric properties, with a Cronbach's alpha coefficient of .87 and a test–retest reliability coefficient of .73. Evidence obtained through

concurrent validation has also indicated that the instrument possesses satisfactory concurrent validity for assessing depressive symptoms in Iranian populations (Rahimi, 2014).

Connor Social Phobia Inventory. The Connor Social Phobia Inventory is a 17-item self-report measure designed to assess the severity of social anxiety symptoms. The instrument evaluates three principal dimensions of social anxiety, including fear in social situations, avoidance of anxiety-provoking interpersonal or performance situations, and physiological discomfort experienced in social contexts. The items cover common manifestations of social anxiety, such as fear of authority figures, anxiety when speaking with unfamiliar individuals, discomfort during social gatherings, avoidance of being the center of attention, concern about embarrassment or criticism, and physical symptoms such as sweating, trembling, palpitations, or blushing. Responses are recorded on a five-point Likert-type scale ranging from the lowest degree of symptom experience to the highest degree, with higher total scores indicating more severe social anxiety. In the present study, the inventory was used during the screening process to identify participants with clinically significant symptoms of social anxiety and to assist in confirming the coexistence of social anxiety and depression. Previous psychometric investigations have reported test–retest reliability coefficients ranging from .78 to .89 and a Cronbach's alpha coefficient of .94 for the total scale. Its convergent validity has also been supported through correlations ranging from .57 to .80 with a short-form social anxiety questionnaire, indicating that the instrument is a reliable and valid measure of social anxiety symptoms.

Golparvar Emotional Capital Questionnaire. The Emotional Capital Questionnaire developed by Golparvar in 2016 consists of 20 items and was designed to evaluate individuals' positive emotional resources. Emotional capital refers to the reservoir of adaptive emotional capacities that enables individuals to experience, preserve, and use positive affective states in coping with personal, interpersonal, and environmental demands. The questionnaire comprises three subscales: feelings of energy, positive affect, and happiness. The feeling-of-energy dimension evaluates the extent to which individuals experience emotional vitality, enthusiasm, and psychological activation. The positive-affect dimension assesses the frequency and intensity of constructive emotional experiences, whereas the happiness dimension examines general feelings of joy, contentment, and emotional well-being. The items are scored using a Likert-type response format, and higher scores represent greater emotional capital and stronger positive emotional resources. In the present study, the questionnaire was administered at the pretest, posttest, and two-month follow-up stages to evaluate changes in emotional capital following the psychodynamic–emotion-focused intervention and dialectical behavior therapy. The reliability coefficients reported for this instrument using Cronbach's alpha have ranged from .80 to .96. In the original validation study, the total Cronbach's alpha coefficient was .94, and its construct validity was supported through exploratory factor analysis. Another Iranian investigation reported a Cronbach's alpha coefficient of .97, further supporting the high internal consistency of the measure.

Zuckerman Sensation-Seeking Questionnaire. The Zuckerman Sensation-Seeking Questionnaire, developed in 1979, is a 14-item self-report instrument used to assess individual differences in sensation seeking. Sensation seeking is generally conceptualized as a tendency to pursue novel, varied, complex, intense, and emotionally stimulating experiences, sometimes accompanied by a willingness to accept interpersonal, emotional, or behavioral risks to obtain such experiences. The questionnaire evaluates the

degree to which respondents are attracted to novelty, excitement, stimulation, change, and potentially risky experiences. The items are scored according to the response format specified for the instrument, and higher total scores indicate a greater tendency toward sensation-seeking behavior and a stronger need for emotional and environmental stimulation. In the current study, this questionnaire was administered during the pretest, posttest, and follow-up assessments to examine whether the therapeutic interventions produced changes in maladaptive or excessive sensation-seeking tendencies among women with comorbid depression and social anxiety. Zuckerman reported reliability coefficients ranging from .83 to .86 and a test–retest reliability coefficient of .94 for the questionnaire. Evidence regarding criterion-related validity has also been obtained through its association with measures of psychological hardiness. In an Iranian study, the internal consistency of the questionnaire was supported by a Cronbach's alpha coefficient of .85.

Interventions

Psychodynamic–Emotion-Focused Therapeutic Package. The integrated psychodynamic–emotion-focused intervention was developed during the qualitative phase of the study and was administered to the first experimental group in ten one-hour sessions. The intervention combined the principles of short-term psychodynamic psychotherapy with emotion-focused therapeutic techniques and was organized around eight core therapeutic phases that were introduced, practiced, consolidated, and reviewed across the ten sessions. The initial phase focused on establishing a safe therapeutic alliance, explaining the treatment framework, and identifying the participant's principal problems through focused psychodynamic questioning. Particular attention was given to recurrent interpersonal difficulties, depressive experiences, social fears, and situations associated with shame, rejection sensitivity, withdrawal, avoidance, or self-criticism. The following phase involved exploring the feelings and emotions connected to the identified problems, helping participants differentiate primary emotions from secondary emotional reactions and recognize emotions that had previously remained suppressed, avoided, or insufficiently processed. The intervention then addressed anxiety and tension associated with the activation of difficult emotions. Participants were guided to identify both psychological signs of anxiety, such as confusion, rumination, fear, or emotional inhibition, and physiological manifestations, including muscular tension, changes in breathing, autonomic arousal, and bodily discomfort. Subsequent therapeutic work concentrated on identifying unconscious or habitual defensive strategies used to avoid painful emotions, including denial, intellectualization, emotional detachment, projection, self-criticism, minimization, avoidance, passivity, and withdrawal from interpersonal encounters. As treatment progressed, the therapist clarified and gently confronted maladaptive defensive patterns while maintaining emotional safety and sensitivity to each participant's capacity for affect tolerance. Participants were encouraged to observe the immediate consequences of their defenses and to understand how these patterns contributed to the continuation of depressive symptoms, social anxiety, emotional depletion, and maladaptive attempts to seek stimulation or escape emotional distress. The therapist and participant then examined the broader cycle through which emotions were activated, anxiety emerged, defenses were employed, and problematic behavioral or interpersonal outcomes were produced. This cyclical formulation enabled participants to develop a coherent understanding of the relationships among their underlying feelings, anxiety responses, defensive processes, and recurring difficulties. Alternative ways of experiencing, regulating, expressing, and communicating

emotions were subsequently explored and practiced. The intervention emphasized emotional awareness, differentiation of feelings, acceptance of primary adaptive emotions, transformation of maladaptive emotional responses, and the development of more direct and constructive interpersonal behavior. During the final phases, the therapist consolidated participants' awareness and insight regarding their emotional patterns, reviewed alternative coping responses, strengthened their capacity to tolerate and process difficult feelings, and developed plans for applying therapeutic learning to future interpersonal and emotionally challenging situations. The concluding sessions were devoted to reviewing progress, reinforcing emotional and psychodynamic insight, anticipating possible setbacks, strengthening relapse-prevention strategies, and preparing participants for the termination of therapy.

Dialectical Behavior Therapy Protocol. Dialectical behavior therapy was administered to the second experimental group in ten one-hour sessions. The intervention was based on the principal DBT skill domains of mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The first two sessions focused on mindfulness skills. During the first session, participants were introduced to the treatment program, the therapeutic rules, the dialectical perspective, and the concept of mindfulness. They were trained in the fundamental mindfulness skills of observing internal and external experiences, describing thoughts and feelings without unnecessary interpretation, and participating fully in current activities. The second session introduced more advanced mindfulness strategies, including accessing and strengthening the "wise mind," practicing radical acceptance, acting effectively rather than impulsively, and recognizing and overcoming common barriers to mindful awareness. The third through fifth sessions concentrated on distress-tolerance skills. Participants first learned acceptance-based strategies, including radical acceptance, mindful observation of breathing, and the use of a gentle facial expression to reduce physiological tension. They were then taught change-oriented distress-tolerance strategies, such as distraction, self-soothing through sensory experiences, positive imagery, and temporary attention redirection. Additional instruction addressed relaxation, remaining in the present moment, and selecting adaptive coping strategies during periods of acute emotional distress. The sixth through eighth sessions focused on emotion-regulation skills. Participants learned about the dimensions, categories, and functions of emotions and were trained to conduct a structured analysis of emotional experiences. They practiced identifying emotions as they occurred, recognizing emotional triggers, differentiating emotions from interpretations, and understanding the relationships among thoughts, physiological reactions, action urges, and behavior. The intervention also emphasized reducing vulnerability to intense negative emotions through improved self-care and increasing positive emotional experiences through purposeful and meaningful activities. Advanced strategies included observing emotions without judgment, approaching rather than avoiding manageable emotional experiences, modifying maladaptive emotional responses, and applying problem-solving skills when emotional distress was related to changeable circumstances. The final two sessions addressed interpersonal-effectiveness skills. Participants examined passive, aggressive, and assertive behavioral styles, difficulties in recognizing and communicating personal needs, harmful relationship patterns, and dysfunctional beliefs about interpersonal interactions. They were then trained in identifying interpersonal events accurately, making clear and respectful requests, setting boundaries, listening actively, negotiating conflicting needs, preserving self-respect, and resolving disagreements. The final session also included an integration of the skills taught throughout the program, a review of individual

progress, discussion of anticipated high-risk situations, and the development of plans for continuing the use of mindfulness, distress tolerance, emotion regulation, and interpersonal-effectiveness skills after treatment.

Data Analysis

The qualitative data obtained during the package-development phase were analyzed using theory-driven deductive thematic analysis. Relevant statements, concepts, treatment principles, and therapeutic techniques were extracted from the reviewed scientific sources and coded according to the theoretical frameworks of short-term psychodynamic psychotherapy and emotion-focused therapy. Similar codes were grouped into basic themes, which were subsequently organized into higher-order categories and overarching therapeutic themes. Relationships among the themes were examined, and a thematic network was developed to represent the conceptual structure, therapeutic mechanisms, and procedural sequence of the proposed intervention. The preliminary intervention package derived from this analysis was evaluated by experts in psychology, counseling, psychotherapy, psychodynamic therapy, and emotion-focused treatment. Their comments concerning the relevance, clarity, comprehensiveness, sequencing, feasibility, and clinical suitability of the package components were reviewed, and the intervention was revised accordingly before being implemented in the quantitative phase.

In the quantitative phase, descriptive statistics, including means, standard deviations, frequencies, and percentages, were used to summarize the participants' demographic characteristics and scores for emotional capital and sensation seeking at the pretest, posttest, and follow-up stages. Before conducting inferential analyses, the data were screened for missing values, extreme observations, and potential data-entry errors. The statistical assumptions required for parametric repeated-measures analysis were also examined. The normality of score distributions was evaluated, the homogeneity of error variances across the three groups was assessed using Levene's test, and the sphericity assumption for within-subject measurements was examined using Mauchly's test. Where the assumption of sphericity was violated, an appropriate correction, such as the Greenhouse–Geisser adjustment, was applied. A mixed-design repeated-measures analysis of variance was then conducted separately for emotional capital and sensation seeking. Measurement time, consisting of the pretest, posttest, and two-month follow-up assessments, was treated as the within-subject factor, whereas treatment condition, consisting of the psychodynamic–emotion-focused group, dialectical behavior therapy group, and control group, was treated as the between-subject factor. The main effects of time and group and, most importantly, the time-by-group interaction were examined to determine whether the patterns of change differed significantly among the three study groups. When significant effects were observed, Bonferroni-adjusted pairwise comparisons were performed to identify differences between measurement occasions and treatment groups while controlling for the increased probability of Type I error. Effect-size indices were calculated to estimate the magnitude and practical importance of the intervention effects. All statistical tests were conducted at a significance level of .05.

Findings and Results

The findings were obtained in two phases. In the qualitative phase, the reviewed psychodynamic and emotion-focused sources were analyzed to identify the principal therapeutic mechanisms, components, and

techniques required for developing the integrated intervention. The initial coding process generated a set of conceptually related codes that were organized into basic themes, organizing themes, and overarching therapeutic domains. Table 1 presents the thematic structure derived from the qualitative analysis.

Table 1. Thematic Network Used to Develop the Psychodynamic–Emotion-Focused Therapeutic Package

Overarching theme	Organizing themes	Basic themes and therapeutic indicators
Focused assessment and therapeutic formulation	Identification of the central problem	Focused questioning, clarification of the presenting complaint, identification of recurrent interpersonal problems, recognition of depressive and socially anxious patterns, formulation of the central emotional conflict
Emotional awareness and differentiation	Identification and exploration of emotions	Recognition of primary and secondary emotions, differentiation between emotions and thoughts, identification of suppressed feelings, attention to sadness, fear, anger, shame, guilt, and loneliness
Recognition of anxiety associated with emotion	Psychological and physiological manifestations of anxiety	Identification of rumination, confusion, tension, avoidance, muscular tension, changes in breathing, autonomic arousal, bodily discomfort, and anxiety arising during emotional activation
Identification of defensive processes	Conscious and unconscious avoidance of painful affect	Emotional suppression, denial, intellectualization, projection, minimization, self-criticism, passivity, withdrawal, detachment, and avoidance of interpersonal situations
Clarification and confrontation of defenses	Increasing awareness of maladaptive coping mechanisms	Clarification of defensive responses, examination of their immediate consequences, confrontation of avoidance patterns, recognition of the relationship between defenses and symptom persistence
Analysis of the emotion–anxiety–defense cycle	Development of psychodynamic and emotional insight	Recognition of emotional triggers, anxiety activation, defensive responses, behavioral consequences, interpersonal repetition, and symptom-maintaining cycles
Emotional processing and development of alternative responses	Adaptive experience, expression, and regulation of emotion	Acceptance of primary emotions, transformation of maladaptive emotional responses, emotional expression, affect tolerance, adaptive coping, assertive communication, and constructive interpersonal behavior
Consolidation and maintenance of therapeutic change	Strengthening insight and preventing relapse	Review of therapeutic progress, consolidation of emotional awareness, practice of alternative responses, preparation for difficult situations, relapse prevention, and treatment termination

The qualitative findings indicated that the developed package was organized around eight interrelated therapeutic domains. The first domains emphasized focused assessment, recognition of the central emotional conflict, and differentiation of emotions associated with depression and social anxiety. The middle domains concentrated on identifying anxiety and defensive mechanisms that prevented the direct experience and expression of painful emotions. Clarification and confrontation were subsequently used to help participants recognize the maladaptive consequences of these defensive patterns. The final domains emphasized the analysis of the emotion–anxiety–defense cycle, the processing and transformation of maladaptive emotions, the development of more adaptive emotional and interpersonal responses, and the consolidation of therapeutic changes. Accordingly, the thematic network provided a coherent theoretical and clinical basis for constructing the intervention package.

After the thematic network had been established, the extracted therapeutic components were arranged in a sequential intervention framework. The preliminary package was reviewed by experts with relevant clinical and academic backgrounds, and their recommendations were incorporated into its final structure. Table 2 presents the organization of the developed package and the principal therapeutic focus of each session.

Table 2. Final Structure of the Developed Psychodynamic–Emotion-Focused Therapeutic Package

Session	Main therapeutic focus	Principal content and techniques
First	Establishing the therapeutic framework and identifying the central problem	Establishing the therapeutic alliance, explaining treatment objectives and rules, focused psychodynamic questioning, identifying the principal complaint, and recognizing recurrent depressive, anxious, and interpersonal patterns
Second	Exploring emotions related to the identified problem	Identifying feelings associated with important situations, differentiating thoughts from emotions, distinguishing primary from secondary emotions, and facilitating emotional awareness
Third	Recognizing anxiety related to emotional activation	Identifying psychological and physiological manifestations of anxiety, examining bodily responses, recognizing emotional tension, and increasing tolerance of affective arousal
Fourth	Identifying unconscious and habitual defenses	Recognizing emotional suppression, avoidance, withdrawal, intellectualization, projection, denial, self-criticism, and other defensive strategies
Fifth	Clarifying and confronting maladaptive defenses	Examining the short- and long-term consequences of defenses, clarifying avoidance patterns, confronting resistance, and linking defensive processes to depression and social anxiety
Sixth	Analyzing the emotion–anxiety–defense cycle	Reviewing the sequence of emotional activation, anxiety, defense, behavior, and interpersonal consequences and developing an integrated formulation of recurring patterns
Seventh	Developing alternative emotional and coping responses	Exploring adaptive alternatives, increasing emotional acceptance, practicing emotional expression, strengthening affect regulation, and developing more constructive interpersonal responses
Eighth	Deepening emotional processing and insight	Processing unresolved emotions, transforming maladaptive emotional experiences, strengthening awareness of emotional needs, and practicing direct communication
Ninth	Consolidating therapeutic awareness and behavioral change	Reviewing changes, practicing alternative coping responses, applying therapeutic learning to socially stressful situations, and strengthening emotional and interpersonal competence
Tenth	Maintenance, relapse prevention, and termination	Summarizing therapeutic achievements, anticipating future difficulties, developing relapse-prevention strategies, consolidating insight, and preparing for treatment termination

The final package retained the eight major therapeutic domains identified in the thematic analysis but distributed them across ten sessions to allow sufficient time for practice, repetition, emotional processing, consolidation, and termination. Expert review resulted in greater clarity in the wording of session objectives, improved sequencing of the therapeutic components, and stronger correspondence between the psychodynamic and emotion-focused techniques. The final intervention progressed from assessment and emotional identification to recognition of anxiety and defenses, clarification of maladaptive emotional cycles, development of adaptive emotional responses, consolidation of insight, and relapse prevention.

Descriptive statistics were calculated for emotional capital and sensation seeking across the three measurement occasions in the psychodynamic–emotion-focused therapy, dialectical behavior therapy, and control groups. Table 3 presents the means, standard deviations, minimum scores, and maximum scores for the study variables at the pretest, posttest, and two-month follow-up stages.

Table 3. Descriptive Statistics for Emotional Capital and Sensation Seeking by Group and Measurement Time

Variable	Group	Measurement time	Mean	Standard deviation	Minimum	Maximum
Emotional capital	Psychodynamic–emotion-focused therapy	Pretest	37.60	6.94	29	54
		Posttest	58.40	7.19	49	76
		Follow-up	57.80	6.54	50	74
	Dialectical behavior therapy	Pretest	39.66	10.87	28	65
		Posttest	41.53	10.96	31	66
		Follow-up	42.06	10.60	32	66
	Control	Pretest	42.53	8.67	30	53

		Posttest	42.60	8.19	31	55
		Follow-up	42.40	8.08	32	56
Sensation seeking	Psychodynamic–emotion-focused therapy	Pretest	21.00	8.57	8	35
		Posttest	21.33	8.19	9	34
		Follow-up	21.40	7.63	11	35
	Dialectical behavior therapy	Pretest	20.86	8.69	9	37
		Posttest	21.86	8.02	10	35
		Follow-up	20.80	7.53	11	35
	Control	Pretest	21.13	8.33	7	35
		Posttest	20.73	7.44	9	34
		Follow-up	21.33	7.55	8	36

As shown in Table 3, the mean emotional capital score in the psychodynamic–emotion-focused therapy group increased considerably from 37.60 at the pretest to 58.40 at the posttest and remained relatively stable at 57.80 during the follow-up. The dialectical behavior therapy group demonstrated a smaller increase, from 39.66 at the pretest to 41.53 at the posttest and 42.06 at the follow-up. In contrast, the control group showed almost no change across the three measurement occasions, with mean scores of 42.53, 42.60, and 42.40, respectively. The descriptive results therefore suggested that both interventions, particularly the psychodynamic–emotion-focused intervention, were associated with increased emotional capital. However, sensation-seeking scores remained relatively stable in all three groups. In the psychodynamic–emotion-focused group, the mean scores were 21.00, 21.33, and 21.40; in the dialectical behavior therapy group, they were 20.86, 21.86, and 20.80; and in the control group, they were 21.13, 20.73, and 21.33 at the pretest, posttest, and follow-up, respectively.

Before conducting the mixed-design repeated-measures analysis of variance, the relevant statistical assumptions were examined. Inspection of the distributions and the results of the normality tests indicated that the scores of emotional capital and sensation seeking were approximately normally distributed across the groups and measurement occasions. Levene's test was nonsignificant for emotional capital at the pretest, $F(2, 42) = 2.160$, $p = .128$; posttest, $F(2, 42) = 2.125$, $p = .132$; and follow-up, $F(2, 42) = 2.116$, $p = .133$. The test was also nonsignificant for sensation seeking at the pretest, $F(2, 42) = 0.051$, $p = .950$; posttest, $F(2, 42) = 0.131$, $p = .878$; and follow-up, $F(2, 42) = 0.041$, $p = .960$. Thus, the assumption of homogeneity of variances was satisfied for both dependent variables. The sphericity assumption was supported for emotional capital; therefore, the sphericity-assumed estimates were interpreted for this variable. In contrast, the sphericity assumption was not supported for sensation seeking, and the Greenhouse–Geisser corrected estimates were consequently used.

Table 4. Repeated-Measures Analysis of Variance for Changes in Emotional Capital and Sensation Seeking

Variable	Source	Estimate	Type III sum of squares	df	Mean square	F	p	Partial η^2
Emotional capital	Time	Sphericity assumed	1702.711	2.000	851.356	552.183	<.001	.929
		Greenhouse–Geisser	1702.711	1.987	856.780	552.183	<.001	.929
	Time × group	Sphericity assumed	2550.444	4.000	637.611	413.550	<.001	.952
		Greenhouse–Geisser	2550.444	3.975	641.673	413.550	<.001	.952
	Error	Sphericity assumed	129.511	84.000	1.542	—	—	—

		Greenhouse–Geisser	129.511	83.468	1.552	—	—	—
Sensation seeking	Time	Sphericity assumed	0.459	2.000	0.230	0.234	.792	.006
		Greenhouse–Geisser	0.459	1.644	0.279	0.234	.748	.006
	Time × group	Sphericity assumed	2.563	4.000	0.641	0.654	.626	.030
		Greenhouse–Geisser	2.563	3.289	0.779	0.654	.597	.030
	Error	Sphericity assumed	82.311	84.000	0.980	—	—	—
		Greenhouse–Geisser	82.311	69.066	1.192	—	—	—

The repeated-measures analysis revealed a statistically significant main effect of time on emotional capital, $F(2, 84) = 552.183$, $p < .001$, partial $\eta^2 = .929$. This result indicated that, irrespective of group membership, emotional capital scores differed significantly across the three measurement occasions, and approximately 92.9% of the variance in within-participant changes was associated with measurement time. More importantly, the time-by-group interaction was statistically significant, $F(4, 84) = 413.550$, $p < .001$, partial $\eta^2 = .952$. This finding demonstrated that changes in emotional capital over time differed substantially among the psychodynamic–emotion-focused therapy, dialectical behavior therapy, and control groups. The very large interaction effect indicated that 95.2% of the variance in the pattern of emotional capital change was attributable to the combined effect of time and intervention condition. In contrast, the Greenhouse–Geisser corrected results showed that the main effect of time on sensation seeking was not statistically significant, $F(1.644, 69.066) = 0.234$, $p = .748$, partial $\eta^2 = .006$. The time-by-group interaction was also nonsignificant, $F(3.289, 69.066) = 0.654$, $p = .597$, partial $\eta^2 = .030$. Therefore, neither intervention produced a statistically significant change in sensation seeking across the pretest, posttest, and follow-up assessments. Because the time-by-group interaction was significant for emotional capital, Bonferroni-adjusted pairwise comparisons were conducted separately within each group to determine which measurement occasions differed significantly. The results of these comparisons are presented in Table 5.

Table 5. Bonferroni Post-Hoc Comparisons of Emotional Capital Scores across Measurement Times by Group

Group	Time comparison	Mean difference	Standard error	p	95% CI lower bound	95% CI upper bound
Psychodynamic–emotion-focused therapy	Pretest vs. posttest	-20.800	0.416	<.001	-21.931	-19.669
	Pretest vs. follow-up	-20.200	0.480	<.001	-21.505	-18.895
	Posttest vs. follow-up	0.600	0.400	.467	-0.487	1.687
Dialectical behavior therapy	Pretest vs. posttest	-1.867	0.496	.006	-3.216	-0.518
	Pretest vs. follow-up	-2.400	0.321	<.001	-3.272	-1.528
	Posttest vs. follow-up	-0.533	0.424	.687	-1.685	0.619
Control	Pretest vs. posttest	-0.067	0.408	1.000	-1.175	1.042
	Pretest vs. follow-up	0.133	0.576	1.000	-1.433	1.699
	Posttest vs. follow-up	0.200	0.509	1.000	-1.183	1.583

The Bonferroni comparisons indicated that emotional capital in the psychodynamic–emotion-focused therapy group increased significantly from the pretest to the posttest, with a mean difference of 20.80 points, $p < .001$, and from the pretest to the follow-up, with a mean difference of 20.20 points, $p < .001$. The difference between the posttest and follow-up was not statistically significant, $p = .467$, indicating that the improvement achieved after treatment was maintained over the two-month follow-up period. In the dialectical behavior therapy group, emotional capital also increased significantly from the pretest to the posttest, with a mean difference of 1.87 points, $p = .006$, and from the pretest to the follow-up, with a mean difference of 2.40 points, $p < .001$. The posttest–follow-up difference was nonsignificant, $p = .687$, suggesting that the more modest improvement produced by dialectical behavior therapy was also maintained. No statistically significant differences were observed among the pretest, posttest, and follow-up scores in the control group. Taken together with the descriptive means, these findings showed that both interventions improved emotional capital, but the magnitude of improvement was substantially greater in the psychodynamic–emotion-focused therapy group. Because the omnibus analyses for sensation seeking were nonsignificant, no post-hoc comparisons were required for that variable.

Discussion and Conclusion

The present study was conducted to develop a psychodynamic–emotion-focused therapeutic package and compare its effectiveness with dialectical behavior therapy in improving emotional capital and modifying sensation seeking among women with comorbid depression and social anxiety. The findings showed that emotional capital changed significantly over time and that the pattern of change differed significantly among the psychodynamic–emotion-focused therapy, dialectical behavior therapy, and control groups. Both intervention groups demonstrated significant increases in emotional capital from the pretest to the posttest and from the pretest to the two-month follow-up, whereas no significant change occurred in the control group. However, the magnitude of improvement was substantially greater in the psychodynamic–emotion-focused therapy group than in the dialectical behavior therapy group. Moreover, the absence of a significant difference between posttest and follow-up scores in both intervention groups indicated that the treatment gains were maintained during the follow-up period. In contrast, neither the main effect of time nor the interaction between time and group was significant for sensation seeking. Therefore, the two therapeutic approaches were effective in increasing emotional capital, particularly the developed psychodynamic–emotion-focused package, but neither intervention produced a statistically significant change in sensation seeking.

The significant improvement in emotional capital following the psychodynamic–emotion-focused intervention is consistent with previous studies showing that emotional and affective resources can be strengthened through treatments that directly address emotional experience, self-awareness, positive affect, and adaptive coping. Positive psychotherapy and acceptance and commitment therapy have been shown to increase emotional capital in women with depression, indicating that psychological treatments can restore positive affective capacities that are weakened by depressive symptoms (15). Similarly, mindful self-acceptance therapy and positive psychotherapy improved emotional capital among depressed female students (16), while positive mindfulness therapy enhanced affective capital and meta-emotions in women with generalized anxiety disorder (17). Improvements in emotional capital have also been reported following

relational and expressive interventions among mothers experiencing psychosocial strain (18). Collectively, these studies support the present finding that emotional capital is a modifiable psychological resource rather than a fixed personal characteristic.

The effectiveness of the developed intervention may be explained by its emphasis on identifying, experiencing, regulating, and transforming emotions rather than merely suppressing symptoms. Women with comorbid depression and social anxiety frequently experience diminished positive affect, shame, fear of evaluation, withdrawal, self-criticism, and avoidance of interpersonal situations. These processes reduce opportunities for rewarding emotional experiences and gradually weaken feelings of energy, happiness, hope, and emotional competence. The emotion-focused component of the intervention encouraged participants to identify primary and secondary emotions, differentiate emotions from thoughts, recognize unmet emotional needs, and replace maladaptive emotional schemes with more adaptive emotional responses. Emotion-focused therapy has previously been found to reduce depression among women (27) and to improve social anxiety and interpersonal dependency in women attending health services (28). Its usefulness has also been demonstrated among women experiencing anxiety and depression in the context of breast cancer (30). These findings suggest that facilitating emotional awareness and emotional transformation can reduce negative affect while simultaneously increasing access to positive emotional resources.

The current findings are also consistent with developments in emotion-focused therapy for social anxiety, which emphasize shame, self-criticism, fear, vulnerability, and negative self-evaluation as central therapeutic targets (29). Social anxiety is not limited to fear of social situations; it often involves a broader emotional structure in which individuals perceive themselves as defective, unacceptable, or incapable of managing interpersonal exposure. When these internal emotional schemes remain unprocessed, social avoidance may become chronic and contribute to depressive withdrawal. By helping participants access painful emotions in a safe therapeutic context and develop more compassionate and adaptive responses, the intervention may have increased their emotional confidence, vitality, and capacity to remain engaged in interpersonal situations. Previous emotion-focused interventions have also increased positive feelings in women's close relationships (31) and strengthened positive meta-emotions and personal strengths among older women (32). These findings further support the role of emotional processing in developing positive affective capacities.

The psychodynamic component of the developed package may also explain its strong effect on emotional capital. Short-term psychodynamic approaches focus on unconscious emotional conflicts, anxiety, defensive processes, and recurring interpersonal patterns that maintain psychological distress. In the present intervention, participants were helped to recognize how painful emotions activated anxiety and how they relied on defenses such as suppression, withdrawal, intellectualization, denial, minimization, and self-criticism. These defenses may temporarily reduce emotional discomfort, but they also limit access to adaptive emotions and positive relational experiences. Intensive short-term dynamic psychotherapy has demonstrated effectiveness for mood disorders (33), and systematic review evidence supports short-term psychodynamic psychotherapy for depressive disorders (34). It has also produced sustained benefits in treatment-resistant depression (35) and has reduced depressive symptoms in preliminary clinical studies

(36). These findings align with the present results and suggest that emotional capital may improve when maladaptive defenses are identified and replaced with more direct emotional experiencing.

Psychodynamic treatment is also relevant to anxiety because it addresses the emotional and relational mechanisms underlying avoidance. Intensive short-term dynamic psychotherapy has improved symptomatology and psychological structure among patients with anxiety disorders (37), and psychodynamic therapy has shown beneficial effects for social anxiety in internet-based formats (38). Research on the mechanisms of change in intensive short-term dynamic psychotherapy indicates that recognizing defenses, regulating anxiety, deepening emotional experience, and restructuring interpersonal patterns are central to therapeutic improvement (39). In the present study, these mechanisms may have allowed participants to move from emotional inhibition and interpersonal avoidance toward greater emotional vitality and adaptive engagement. This interpretation is compatible with the view that emotional capital develops through the accumulation and effective use of emotional resources in social and relational contexts (11). Once participants became more capable of tolerating emotions and communicating their needs, they may have experienced greater positive affect, happiness, and psychological energy.

The particularly large improvement observed in the psychodynamic–emotion-focused group may be attributed to the complementary mechanisms of the integrated approach. The psychodynamic component helped participants understand unconscious conflicts, anxiety, defenses, and repetitive interpersonal patterns, while the emotion-focused component provided experiential techniques for accessing, expressing, and transforming emotions. This combination may have produced deeper changes than an intervention focused primarily on skills acquisition. Emotional capital includes not only the capacity to control distress but also the ability to experience positive affect, use emotional knowledge, preserve vitality, and engage meaningfully with others. Evidence indicates that emotional capital is associated with adaptive engagement and openness to innovation (12), while affective capital may function as a relational resource supporting adaptation under adversity (14). Socio-emotional capital may also influence long-term functioning and mediate the consequences of depressive symptoms across the life course (13). Therefore, a treatment that simultaneously addresses deep emotional conflicts and facilitates new emotional experiences may be especially effective in increasing this multidimensional resource.

The improvement observed in the dialectical behavior therapy group is also consistent with previous findings. DBT provides structured training in mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (41). These skills can help individuals observe emotions without immediate judgment, tolerate distress without avoidance, reduce emotional vulnerability, and communicate more effectively. DBT has reduced depressive symptoms in acute-care adolescents (43) and improved emotional self-regulation in high-risk populations (44). It has also reduced emotion-regulation difficulties and aggression among adolescent girls with depressive symptoms (45). These studies support the present finding that DBT can increase emotional capital by strengthening emotional competence and reducing dysregulated responses.

Nevertheless, the improvement in emotional capital was much smaller in the DBT group than in the psychodynamic–emotion-focused group. One possible explanation is that the ten-session DBT intervention emphasized the acquisition of general coping skills, whereas the integrated intervention directly examined the individualized emotional conflicts and defenses associated with each participant's depression and social

anxiety. DBT may improve the management of emotional reactions, but the developed intervention may have had a stronger influence on the sources, meanings, and relational patterns of emotional distress. Furthermore, emotional capital includes happiness, positive affect, and emotional energy, which may require more than behavioral control or distress tolerance. The developed package explicitly facilitated the experience of adaptive emotions and challenged processes that blocked positive affect, potentially producing a larger improvement in these dimensions.

The stability of emotional capital scores from posttest to follow-up in both intervention groups indicates that the gains were maintained for at least two months. This result suggests that participants did not merely experience a short-term emotional response to treatment but acquired insights and skills that remained available after the sessions ended. In the psychodynamic–emotion-focused group, the consolidation of insight, recognition of the emotion–anxiety–defense cycle, and practice of alternative responses may have helped participants continue applying therapeutic learning in daily life. In the DBT group, repeated practice of mindfulness, distress tolerance, emotion regulation, and interpersonal skills may similarly have supported maintenance. Sustained effects are consistent with evidence that psychodynamic interventions may produce enduring changes by modifying underlying psychological structures rather than only reducing immediate symptoms (35). They also align with the broader argument that effective treatment should address transdiagnostic mechanisms and individual patterns rather than focus narrowly on isolated diagnostic symptoms (40).

The absence of significant changes in sensation seeking requires careful interpretation. Although sensation seeking may be associated with emotional regulation, risk taking, and the pursuit of intense experiences, it is also commonly conceptualized as a relatively stable personality tendency. Sensation seeking has been linked to peer influence and risky behavior (19), internet addiction (20), political violence (21), and extreme forms of emotionally motivated behavior (22). These associations indicate that sensation seeking may influence behavior across multiple contexts, but they do not necessarily imply that it will change rapidly through a brief psychotherapy program. The ten-session interventions used in the present study may have been sufficient to improve emotional awareness and regulation but insufficient to alter a relatively enduring motivational disposition.

The nonsignificant finding is partly inconsistent with studies reporting changes in sensation seeking after psychological treatment. Cognitive-behavioral hypnotherapy has been found to influence sensation seeking among women with depression (24), and intensive short-term dynamic psychotherapy has been examined in relation to sensation seeking among married women (25). However, differences in participants, intervention duration, treatment content, measurement instruments, and the function of sensation seeking may account for the inconsistent findings. In the present sample, baseline sensation-seeking scores were highly similar across groups and remained close to their initial levels, possibly indicating that participants did not have clinically elevated or problematic sensation-seeking tendencies. When a variable is not substantially disturbed at baseline, meaningful statistical change is less likely to occur.

Another possible explanation is that sensation seeking may operate differently in women with comorbid depression and social anxiety than in externalizing or adolescent populations. Depression often reduces motivation, activity, and reward sensitivity, whereas social anxiety inhibits novelty seeking and exposure to socially uncertain situations. Consequently, the behavioral expression of sensation seeking may be restricted

even when the underlying need for stimulation remains present. Research has shown that sensation seeking may mediate relationships among sleep, chronotype, and depression in adolescents (23), suggesting that it interacts with developmental and behavioral variables. In adult women with internalizing disorders, sensation seeking may be less central to the maintenance of symptoms than emotional avoidance, shame, self-criticism, and interpersonal withdrawal. Therefore, treatments that primarily influence emotional processing may improve emotional capital without necessarily changing sensation -seeking tendencies.

The findings should also be understood in the context of depression –anxiety comorbidity. These disorders are connected by bridge symptoms and dynamic interactions (1), and their co-occurrence is associated with more severe emotional dysfunction (2). Different profiles of combined social anxiety and depression may also show distinct emotional patterns (3). The participants in the present study may therefore have benefited most in the domain directly targeted by both interventions—emotional functioning—while sensation seeking remained relatively independent of short-term therapeutic change. The prognostic burden associated with social anxiety in major depression (4), the reduced quality of life associated with psychiatric comorbidity (6), and the diagnostic complexity of social anxiety accompanied by other disorders (5) further emphasize the need for interventions that strengthen positive emotional resources in addition to reducing symptoms.

This study had several limitations. The sample consisted only of unmarried women aged 20 to 40 years who attended counseling centers in Isfahan, which limits the generalizability of the findings to men, married women, other age groups, individuals from different cultural or socioeconomic backgrounds, and patients receiving psychiatric services in other settings. The sample size was relatively small, and each group included only 15 participants, reducing statistical power and the precision of effect estimates. The outcomes were assessed using self-report questionnaires, which may be affected by social desirability, response bias, current mood, and participants' interpretations of the items. The follow-up period was limited to two months and therefore did not permit evaluation of the long-term stability of treatment effects. The control group did not receive an active comparison intervention, making it difficult to separate treatment-specific effects from attention, therapeutic alliance, expectancy, and group participation. In addition, therapist adherence, treatment fidelity, and therapist effects were not evaluated using independent ratings. Sensation seeking may also have been insufficiently sensitive to brief therapeutic change, especially because baseline scores did not indicate substantial group differences or clearly elevated levels.

Future studies should replicate the research with larger and more diverse samples, including married women, men, adolescents, older adults, and participants from different regions and cultural backgrounds. Randomized controlled trials with adequate statistical power and active comparison conditions would provide stronger evidence regarding the specific effects of the developed package. Follow-up assessments should be extended to six months, one year, or longer to determine whether improvements in emotional capital are maintained and whether delayed changes in sensation seeking emerge. Future research should include clinician-rated measures, behavioral tasks, physiological indicators of emotion regulation, and qualitative interviews alongside self-report questionnaires. It would also be useful to evaluate changes in depression, social anxiety, shame, self-criticism, emotional avoidance, defense mechanisms, interpersonal functioning, and quality of life as primary or secondary outcomes. Mediation analyses could determine whether changes in emotional awareness, anxiety tolerance, defense use, or emotion regulation explain improvements in emotional capital. Future studies may also examine whether sensation seeking responds

more effectively to longer interventions or to protocols specifically targeting reward sensitivity, impulsivity, behavioral activation, and risk-related decision-making.

Counseling centers and mental health clinics may use the developed psychodynamic–emotion-focused package as a structured intervention for women experiencing comorbid depression and social anxiety, particularly when low positive affect, emotional inhibition, shame, interpersonal avoidance, and defensive coping are prominent. Therapists should receive specialized training in both psychodynamic and emotion-focused methods and should carefully monitor clients' anxiety tolerance before encouraging deeper emotional experiencing. The intervention may be incorporated into individual or small-group services and adapted to clients' cultural, interpersonal, and clinical characteristics. DBT skills may also be used as a complementary component when clients require greater support in mindfulness, crisis management, distress tolerance, or interpersonal effectiveness. Because the intervention did not significantly change sensation seeking, clinicians should assess whether this tendency is actually problematic for a particular client and, where necessary, add targeted strategies focused on impulsivity, reward seeking, high-risk behavior, and behavioral decision-making rather than assuming that improvements in emotional processing will automatically modify sensation-seeking tendencies.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

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

Transparency of Data

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

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