

Comparison of the Effectiveness of Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT) on Experiential Avoidance and Social Anxiety in Individuals with Social Phobia

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ABSTRACT

This study aimed to compare the effectiveness of Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT) in reducing experiential avoidance and social anxiety among individuals with social phobia. The study employed a quasi-experimental pretest–posttest control-group design with a three-month follow-up. The statistical population consisted of adults with social anxiety disorder who attended psychological counseling and psychotherapy centers in Tehran, Iran, in 2026. Forty-five eligible participants were selected through purposive sampling and randomly assigned to ACT, DBT, and control groups, with 15 participants in each group. The ACT and DBT groups each received eight weekly 90-minute group sessions, while the control group received no structured intervention during the study period. Experiential avoidance was assessed using the Acceptance and Action Questionnaire-II, and social anxiety was measured using the Social Interaction Anxiety Scale. Data were analyzed using mixed repeated-measures analysis of variance and Bonferroni-adjusted pairwise comparisons. The time-by-group interaction was statistically significant for experiential avoidance, $F(3.23, 67.73) = 31.84$, $p < .001$, partial $\eta^2 = .603$, and for social anxiety, $F(3.36, 70.47) = 29.63$, $p < .001$, partial $\eta^2 = .585$. At posttest, the ACT group showed significantly lower experiential avoidance than the DBT group (mean difference = -3.87 , $p = .034$) and the control group (mean difference = -12.20 , $p < .001$). The DBT group also differed significantly from the control group (mean difference = -8.33 , $p < .001$). For social anxiety, ACT was significantly more effective than DBT at posttest (mean difference = -4.26 , $p = .048$), while both ACT and DBT were significantly superior to the control condition ($p < .001$). These differences remained significant at follow-up. Both ACT and DBT were effective in reducing experiential avoidance and social anxiety in individuals with social phobia, but ACT produced greater improvements and maintained a modest advantage over DBT at follow-up.

Keywords: Acceptance and Commitment Therapy; Dialectical Behavior Therapy; Experiential Avoidance; Social Anxiety; Social Phobia

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Introduction

Social anxiety disorder, traditionally referred to as social phobia, is a prevalent and potentially disabling psychological disorder characterized by marked fear, anxiety, and apprehension in social or performance situations in which the individual anticipates scrutiny, negative evaluation, embarrassment, humiliation, or rejection by others. Individuals with social anxiety frequently experience intense anticipatory anxiety before entering interpersonal situations and may engage in extensive avoidance of public speaking, meeting unfamiliar people, initiating conversations, eating or writing in front of others, participating in group activities, or expressing opinions in situations involving perceived evaluation. Although social apprehension can occur on a continuum in the general population, social anxiety disorder becomes clinically significant when fear and avoidance are persistent, disproportionate to the actual threat, and associated with substantial impairment in educational, occupational, interpersonal, and social functioning. The disorder may consequently restrict opportunities for social participation, intimate relationships, employment advancement, academic achievement, and broader psychological development. In addition to subjective anxiety, affected individuals often report heightened self-focused attention, negative self-appraisals, physiological arousal, fear of visible anxiety symptoms, repetitive negative thinking, and maladaptive efforts to control or escape unpleasant internal experiences. These mechanisms can reinforce avoidance and contribute to the persistence of the disorder over time (1-3).

A central behavioral feature of social anxiety is avoidance. At the overt level, individuals may avoid feared social circumstances entirely or remain in them while relying on safety behaviors, such as avoiding eye contact, speaking minimally, rehearsing sentences excessively, remaining silent during group discussions, or seeking reassurance. At a more internal and psychological level, individuals may also attempt to suppress, control, escape, or eliminate distressing thoughts, emotions, bodily sensations, and memories. This latter process is commonly conceptualized as experiential avoidance. Experiential avoidance refers to an unwillingness to remain in contact with unwanted private events and attempts to alter their form, frequency, intensity, or situational occurrence even when doing so produces behavioral restriction or long-term psychological costs. In social anxiety disorder, experiential avoidance may include attempts to suppress thoughts about being judged, avoid sensations of blushing or trembling, prevent feelings of shame, distract from self-critical cognitions, or withdraw from situations likely to activate interpersonal vulnerability. While such strategies may temporarily reduce distress, they can paradoxically strengthen the perceived threat associated with anxiety and prevent corrective learning, thereby maintaining psychological inflexibility and social impairment. Contemporary research increasingly identifies experiential avoidance as a transdiagnostic mechanism relevant to anxiety, depression, stress, and other forms of emotional distress (4, 5).

The significance of experiential avoidance is particularly evident in psychological models emphasizing the functional relationship between internal experiences and behavior. From this perspective, psychopathology is not determined solely by the presence of unpleasant thoughts or emotions but also by the manner in which individuals respond to those experiences. Persistent efforts to control naturally occurring psychological discomfort may narrow behavioral repertoires and reduce engagement in personally meaningful activities. Research in different clinical populations has demonstrated that interventions targeting experiential avoidance can improve psychological functioning and promote more adaptive patterns of behavior. For

example, Acceptance and Commitment Therapy has been associated with reductions in experiential avoidance among individuals coping with chronic medical and psychological difficulties, suggesting that increased willingness to experience distress may constitute an important mechanism of therapeutic improvement (6-8). These findings are particularly relevant to social anxiety, where attempts to escape or suppress anxiety often become intertwined with avoidance of valued interpersonal activities.

Acceptance and Commitment Therapy (ACT) is a contextual behavioral intervention developed to enhance psychological flexibility rather than directly eliminate unwanted symptoms. Psychological flexibility refers to the capacity to remain in contact with present-moment experiences while selecting and maintaining behaviors that are consistent with personally meaningful values. ACT conceptualizes many forms of psychological suffering as resulting from rigid attempts to avoid or control private experiences, cognitive fusion with distressing thoughts, disconnection from the present moment, overidentification with conceptualized self-narratives, lack of clarity regarding values, and behavioral inaction. Accordingly, ACT uses six interrelated therapeutic processes: acceptance, cognitive defusion, present-moment awareness, self-as-context, values clarification, and committed action. Instead of disputing the literal accuracy of anxiety-provoking thoughts, ACT seeks to alter the individual's relationship with those thoughts, thereby reducing their behavioral dominance. Rather than making symptom reduction the primary objective, individuals are encouraged to accept the presence of anxiety when necessary and continue engaging in value-consistent behavior (5, 9).

The ACT model appears particularly compatible with the treatment needs of individuals with social anxiety because social anxiety is often maintained by persistent attempts to avoid internal discomfort and external situations associated with evaluation. Through acceptance-based exposure to distressing private events and values-guided engagement with social situations, ACT can potentially reduce the functional impact of fear even when anxiety is still present. Cognitive defusion may help individuals distance themselves from self-critical thoughts such as beliefs that others are constantly evaluating them negatively, while present-focused awareness can reduce absorption in anticipatory worry and post-event rumination. Values clarification may further strengthen motivation for approaching social relationships, education, work, intimacy, and community participation despite psychological discomfort. Evidence suggests that ACT may be useful across diverse formats, including conventional face-to-face interventions, telehealth, and self-help programs. Spencer et al. reported beneficial applications of ACT for experiential avoidance-related anxiety and depressive difficulties in a telehealth context, while Sierra and Ortiz demonstrated the feasibility and potential effectiveness of an online ACT-based intervention targeting repetitive negative thinking (4, 10). Such findings reinforce the adaptability of ACT across settings and symptom presentations.

Research specifically involving social anxiety also provides support for acceptance-based interventions. Sahragard reported therapeutic benefits of ACT for social anxiety among adolescent girls, while Salehi and colleagues examined ACT in individuals with social anxiety disorder and found it useful in reducing maladaptive worry processes (1-3). Shahrouei et al. compared ACT with compassion-focused therapy and cognitive behavioral therapy among students with social anxiety and reported meaningful therapeutic effects on psychological processes such as mindfulness and emotion regulation (11). These findings suggest that ACT may affect social anxiety not only through reductions in overt symptoms but also through broader changes in emotional and cognitive functioning. Furthermore, research in other clinical populations

demonstrates that acceptance-based treatments may reduce experiential avoidance, strengthen self-care, and improve psychological adaptation, supporting the relevance of this approach for conditions in which attempts to control distress become themselves a source of dysfunction (6, 7).

Dialectical Behavior Therapy (DBT) represents another important behavioral treatment that may be relevant to social anxiety and experiential avoidance. Originally developed for individuals with severe emotion dysregulation, DBT integrates behavioral change procedures with acceptance-oriented strategies within a dialectical framework. Its core principle involves balancing acceptance of one's present experience with active efforts to change dysfunctional patterns of behavior. Standard DBT encompasses mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. Although DBT was initially designed for populations characterized by chronic self-harm and borderline personality disorder, its principles have increasingly been adapted to a wider range of psychological conditions involving emotional dysregulation, interpersonal problems, impulsive coping, and avoidance. Emotion-regulation processes occupy a central position within DBT, and the treatment provides structured behavioral skills for identifying emotions, understanding their functions, tolerating distress, modifying maladaptive emotional responses, and acting effectively in interpersonal contexts (12).

Several mechanisms of DBT may be especially relevant to social anxiety. Mindfulness can help socially anxious individuals observe anxious thoughts, physiological arousal, and self-critical judgments without immediately responding through avoidance. Distress tolerance may facilitate remaining in social interactions despite discomfort, thereby weakening habitual escape behavior. Emotion-regulation skills may help individuals identify vulnerability factors and modify patterns that amplify shame, fear, embarrassment, and anticipatory anxiety. Interpersonal effectiveness is particularly relevant because social anxiety is expressed within interpersonal contexts and often involves difficulties with assertiveness, self-expression, communication, boundary setting, and maintaining self-respect during interactions. By practicing adaptive communication and exposure-like engagement in interpersonal situations, individuals may acquire behavioral competence while reducing reliance on avoidance or safety behaviors. A growing body of evidence supports the potential application of DBT for anxiety symptoms, including work focusing specifically on anxiety reduction and broader emotional regulation processes (13, 14).

Research examining DBT in socially anxious populations provides further justification for investigating this approach. Baharlou et al. compared DBT with transactional behavior analysis in students with social anxiety and reported improvement in cognitive emotion regulation, indicating that DBT can modify processes associated with maladaptive emotional responding in socially anxious individuals (15). Fooladgar also reported that a DBT-based training package was associated with changes in social anxiety and related behavioral difficulties among children experiencing interpersonal rejection (16). Moreover, Villalongo Andino et al., in an integrative review, specifically considered whether DBT skills groups could be used to treat social anxiety disorder and highlighted the theoretical compatibility between DBT skills and mechanisms involved in social anxiety (17). Collectively, these studies suggest that DBT may provide a useful therapeutic framework for social anxiety, particularly when anxiety is accompanied by emotion-regulation difficulties, interpersonal avoidance, and limited distress tolerance.

DBT may also influence experiential avoidance even though reducing experiential avoidance is not its exclusive theoretical target. Distress tolerance and mindfulness skills directly encourage remaining in

contact with difficult internal experiences without immediate escape or impulsive action, while emotion-regulation strategies may reduce maladaptive attempts to suppress or avoid emotions. Ghasemi et al. found that DBT was effective in reducing experiential avoidance and psychological distress among girls with experiences of domestic violence, demonstrating that DBT can affect avoidance-related processes in populations exposed to substantial emotional distress (18). These findings suggest that DBT could plausibly reduce experiential avoidance in individuals with social anxiety by strengthening their ability to tolerate negative affect and remain engaged in interpersonal situations despite uncomfortable internal experiences.

Despite their differences, ACT and DBT share important conceptual features. Both emphasize acceptance, mindfulness, awareness of present experience, and behavior change rather than relying exclusively on cognitive restructuring. However, their mechanisms and therapeutic emphasis are distinct. ACT conceptualizes psychological flexibility as the core therapeutic target and explicitly focuses on reducing the functional dominance of experiential avoidance and cognitive fusion. DBT, in contrast, places greater emphasis on balancing acceptance and change through concrete skills designed to improve emotion regulation, distress tolerance, and interpersonal effectiveness. These distinctions may produce different patterns of therapeutic change. For example, ACT may have a particular advantage in reducing experiential avoidance because experiential acceptance is directly embedded in its theoretical model, whereas DBT may offer substantial benefits in social anxiety through its emphasis on interpersonal effectiveness and management of intense emotional responses. Direct comparative studies are therefore necessary to determine whether one intervention produces stronger effects on specific psychological outcomes.

Existing comparative research has generated evidence that ACT and DBT can both produce beneficial psychological changes, but their relative effects may depend on the clinical population and outcome variable being examined. Aghili and Ghasemi compared ACT and DBT among dialysis patients and reported therapeutic effects on pain intensity, blood pressure, and behavioral emotion regulation (19). Vakili et al. compared DBT and ACT in patients with binge eating and found meaningful changes in psychological coherence, demonstrating that both treatments may influence broader psychological functioning beyond the conditions for which they were originally developed (20). Taghvaeinia et al. directly compared DBT, ACT, and mindfulness-based stress reduction for symptoms of irritable bowel syndrome, further illustrating the growing interest in comparing third-wave behavioral approaches across clinical outcomes (21). Such comparative investigations are important because therapies belonging to the same broad behavioral tradition may nevertheless differ in the specific mechanisms through which they produce improvement.

The increasing use of ACT and DBT across psychological and medical populations also indicates a wider movement toward process-based intervention. Rather than assuming that a single protocol will affect all individuals and outcomes equally, process-oriented research seeks to identify which mechanisms are most responsive to particular therapeutic procedures. For ACT, cognitive defusion and experiential avoidance have received particular attention as mechanisms of change. Ni et al. demonstrated that cognitive defusion and experiential avoidance functioned as mediating processes in ACT, supporting the proposition that ACT produces improvement by modifying individuals' relationship with internal experiences rather than simply suppressing distress (5). Similarly, acceptance-oriented ACT interventions have been associated with improved adaptation in individuals experiencing chronic illness and psychological distress (6, 9). In DBT,

emotion regulation and skills acquisition constitute central pathways of change, and empirical work has highlighted the importance of these processes in understanding DBT outcomes (12).

Nevertheless, important gaps remain in the literature. First, a substantial proportion of existing studies have examined ACT and DBT separately rather than comparing them directly within the same socially anxious sample. Second, many studies have focused on symptom reduction without simultaneously examining experiential avoidance, despite its likely importance in maintaining social anxiety. Third, previous comparative investigations of ACT and DBT have often been conducted in populations with medical illness, eating-related problems, trauma exposure, or other forms of psychological distress rather than among individuals formally diagnosed with social anxiety disorder (19-21). Fourth, although DBT-related research has increasingly considered social anxiety, the evidence base remains less developed than for disorders traditionally associated with emotion dysregulation, and further direct testing is required (14, 17). Finally, the available evidence indicates that both ACT and DBT may influence avoidance, emotional regulation, and anxiety, but relatively little is known about whether their effects are equivalent or whether one treatment produces superior and more durable changes in experiential avoidance and social anxiety.

Clarifying these comparative effects has both theoretical and clinical significance. From a theoretical perspective, direct comparison can help determine whether a treatment explicitly targeting psychological flexibility and experiential avoidance produces stronger effects than a skills-based treatment emphasizing emotional and interpersonal regulation. From a clinical perspective, identifying differential effectiveness may help psychologists select interventions according to the dominant mechanisms maintaining a patient's social anxiety. If experiential avoidance is particularly prominent, an acceptance-based intervention may be advantageous; if emotional dysregulation and interpersonal skill deficits are central, DBT-oriented strategies may be especially useful. At the same time, evidence that both approaches are effective would expand the range of empirically informed treatment options for individuals with social anxiety. Given the substantial functional burden associated with social anxiety and the persistence of avoidance patterns, comparative investigations can contribute to more precise and mechanism-focused intervention planning.

Therefore, the aim of the present study was to compare the effectiveness of Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT) in reducing experiential avoidance and social anxiety among individuals with social phobia.

Methods and Materials

Study Design and Participants

The present study employed a quasi-experimental design with a pretest–posttest control group and a follow-up assessment to compare the effectiveness of Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT) in reducing experiential avoidance and social anxiety among individuals with social phobia. The statistical population consisted of adults with symptoms of social phobia who attended psychological counseling and psychotherapy centers in Tehran, Iran, during 2026. Following announcements placed at selected counseling centers and an initial screening procedure, individuals who expressed willingness to participate were evaluated for eligibility. Diagnosis of social anxiety disorder (social phobia) was established through a clinical interview conducted by a trained clinical psychologist in accordance with the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth

Edition, Text Revision (DSM-5-TR). After screening and evaluation of the inclusion and exclusion criteria, 45 eligible participants were selected through purposive sampling and randomly assigned to three groups of 15 participants each: an ACT group, a DBT group, and a control group. The inclusion criteria were an age range of 18–40 years, fulfillment of DSM-5-TR diagnostic criteria for social anxiety disorder, at least a secondary-school education sufficient to understand the questionnaire items and therapeutic exercises, willingness to participate in the study, and provision of written informed consent. The exclusion criteria included the presence of psychotic disorders, bipolar disorder, severe major depressive episodes requiring immediate intensive treatment, current substance use disorder, acute suicidal risk, participation in another structured psychological intervention during the study, initiation or substantial alteration of psychiatric medication during the intervention period, and absence from more than two treatment sessions. Participants receiving stable pharmacotherapy were required to have maintained an unchanged medication regimen for an adequate period before enrollment and throughout the intervention. All three groups completed the study measures before the intervention and immediately after completion of the intervention, and the measures were administered again at a three-month follow-up. Participants assigned to the ACT and DBT groups received their respective interventions, whereas those in the control group received no structured psychological intervention during the study period and were placed on a waiting list. Participants were informed about the objectives and procedures of the study, the voluntary nature of participation, confidentiality of their information, and their right to withdraw at any stage without adverse consequences. The study procedures were implemented in accordance with accepted ethical principles for research involving human participants.

Data Collection Tools

Acceptance and Action Questionnaire-II (AAQ-II). Experiential avoidance and psychological inflexibility were assessed using the Acceptance and Action Questionnaire-II (AAQ-II), developed by Bond et al. in 2011 as a revised measure of the tendency to avoid unwanted private experiences and to behave inflexibly in response to distressing thoughts, emotions, memories, and bodily sensations. The questionnaire consists of 7 items and is commonly scored on a 7-point Likert scale ranging from 1 (never true) to 7 (always true). The total score is obtained by summing the responses to all items and ranges from 7 to 49, with higher scores indicating greater experiential avoidance and psychological inflexibility, whereas lower scores reflect greater psychological flexibility and willingness to experience difficult internal events without engaging in maladaptive avoidance. The AAQ-II is a unidimensional instrument and has been extensively used in clinical and nonclinical populations, particularly in studies based on the psychological flexibility model underlying ACT. Previous psychometric investigations have demonstrated acceptable to strong internal consistency, test–retest reliability, convergent validity, and construct validity for the questionnaire, and translated versions of the instrument have also shown satisfactory psychometric properties in different cultural settings. In the present study, the total AAQ-II score was used as the primary indicator of experiential avoidance.

Social Interaction Anxiety Scale (SIAS). Social anxiety was measured using the Social Interaction Anxiety Scale (SIAS), developed by Mattick and Clarke in 1998 to assess anxiety, fear, and discomfort associated with social interactions. The original instrument contains 20 items addressing difficulties such as interacting with

unfamiliar people, maintaining conversations, expressing oneself in social situations, and feeling tense or self-conscious during interpersonal encounters. Each item is rated on a 5-point scale ranging from 0 (not at all characteristic or true of me) to 4 (extremely characteristic or true of me). After appropriate reverse scoring of positively worded items, item scores are summed to obtain an overall measure of social interaction anxiety, with higher scores representing greater social anxiety and more pronounced fear or discomfort in interpersonal situations. The SIAS has been widely applied in both clinical and research settings for identifying and quantifying social anxiety symptoms and evaluating therapeutic change. Previous studies have reported strong internal consistency, satisfactory test–retest reliability, and adequate convergent, discriminant, and criterion-related validity, particularly among individuals diagnosed with social anxiety disorder. The psychometric adequacy of translated versions of the scale has also been supported in previous research. In the present study, the SIAS total score was considered the principal measure of the severity of social anxiety.

Structured Clinical Interview. A structured diagnostic interview based on DSM-5-TR criteria was used during the screening phase to verify the diagnosis of social anxiety disorder and identify psychiatric conditions that could interfere with participation in the study. The interview examined the presence, severity, and functional consequences of marked fear or anxiety concerning social situations in which the individual might be exposed to possible evaluation by others, avoidance of or intense distress during such situations, persistence of symptoms, and clinically significant impairment in social, occupational, educational, or other important areas of functioning. Differential diagnostic considerations and relevant exclusionary psychiatric conditions were also evaluated. Interviews were conducted individually by a clinical psychologist trained in diagnostic assessment. Structured and semistructured DSM-based clinical interviews have demonstrated satisfactory inter-rater reliability and diagnostic validity in psychiatric and psychological research and are frequently used to strengthen the accuracy of participant selection in clinical intervention studies.

Interventions

Participants assigned to the ACT group received eight weekly group therapy sessions, each lasting approximately 90 minutes. The intervention was based on the ACT model developed by Hayes, Strosahl, and Wilson and was organized around the six interrelated processes of psychological flexibility: acceptance, cognitive defusion, contact with the present moment, self-as-context, values clarification, and committed action. The first session focused on establishing the therapeutic relationship, introducing the treatment rationale, identifying major social fears and avoidance patterns, and examining the personal costs of attempts to control or eliminate anxiety. The second session addressed creative hopelessness and helped participants recognize the limited effectiveness of persistent experiential control strategies. The third session introduced acceptance and willingness as alternatives to emotional avoidance, with experiential exercises designed to increase participants' ability to remain in contact with anxiety and other uncomfortable internal experiences. The fourth session focused on cognitive defusion and taught participants to observe socially threatening thoughts, self-evaluative judgments, and predictions of rejection as mental events rather than literal truths that must determine behavior. The fifth session emphasized present-moment awareness and self-as-context through mindfulness and observer-self exercises. During the sixth session, participants

clarified personally meaningful values in interpersonal, educational, occupational, family, and broader life domains and distinguished values from short-term symptom-reduction goals. The seventh session emphasized committed action and encouraged participants to undertake gradual value-consistent behaviors in previously avoided social situations while making room for anxiety and uncertainty. The eighth session integrated the previously learned processes, reviewed progress, identified potential barriers to continued psychological flexibility, developed individualized plans for maintaining value-directed behaviors, and addressed relapse prevention. In-session experiential exercises, metaphors, mindfulness practices, behavioral assignments, and between-session exercises were used throughout treatment. Rather than attempting to eliminate anxiety directly, the intervention emphasized changing participants' relationship with unwanted internal experiences and reducing avoidance that restricted engagement in meaningful social behavior.

Participants assigned to the DBT group received eight weekly group sessions of approximately 90 minutes each, adapted from the skills-based principles of Linehan's Dialectical Behavior Therapy framework. The intervention emphasized balancing acceptance with behavioral change and focused on mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills relevant to difficulties experienced by individuals with social anxiety. The first session introduced the DBT framework, treatment goals, the dialectical perspective, and the relationship between emotional vulnerability, maladaptive coping, avoidance, and social anxiety. The second session focused on core mindfulness skills, including observing, describing, and participating in current experiences without excessive judgment, thereby helping participants notice anxious thoughts, physiological arousal, and self-focused attention without immediately reacting through avoidance. The third session addressed distress tolerance and introduced strategies for remaining in challenging social situations without escape, impulsive avoidance, or excessive reliance on safety behaviors. The fourth session focused on recognizing emotions, understanding their functions, identifying vulnerability factors, and differentiating primary emotional responses from secondary emotional reactions. During the fifth session, participants practiced emotion-regulation strategies designed to reduce maladaptive emotional responding and increase behaviors inconsistent with unnecessary avoidance. The sixth session introduced interpersonal effectiveness skills, including clearly communicating needs, asserting preferences, establishing boundaries, maintaining self-respect, and balancing personal objectives with relationship needs. The seventh session integrated interpersonal effectiveness and emotion-regulation skills through role-playing and behavioral rehearsal of anxiety-provoking social interactions, with emphasis on replacing avoidance with skillful engagement. The eighth session reviewed all acquired skills, examined individual changes and remaining difficulties, strengthened participants' plans for applying DBT skills in everyday social contexts, and addressed maintenance of treatment gains and relapse prevention. Homework exercises, self-monitoring, behavioral rehearsal, mindfulness practice, and structured discussion of skill application were incorporated throughout the intervention. The protocol was adapted to the clinical characteristics of social phobia while retaining the major skills-training components and dialectical principles of DBT.

Data Analysis

Data were analyzed using IBM SPSS Statistics. Prior to inferential analyses, the dataset was examined for missing values, data-entry errors, extreme observations, and the distributional characteristics of the study variables. Descriptive statistics, including mean and standard deviation, were calculated for experiential avoidance and social anxiety at the pretest, posttest, and three-month follow-up assessments, and frequency and percentage statistics were used to describe participants' demographic characteristics. The assumptions required for parametric analysis were evaluated before hypothesis testing. Normality of the dependent variables was examined using the Shapiro–Wilk test together with inspection of skewness and kurtosis indices, homogeneity of error variances was assessed using Levene's test, and equality of covariance matrices was evaluated where applicable using Box's M test. Because the study involved three independent groups assessed repeatedly across three measurement occasions, the comparative effectiveness of ACT and DBT was evaluated using mixed repeated-measures analysis of variance, with treatment group as the between-subjects factor and time as the within-subjects factor. Separate analyses were conducted for experiential avoidance and social anxiety. The main effect of time, main effect of group, and group-by-time interaction were examined to determine whether changes across the assessment occasions differed among the ACT, DBT, and control groups. Mauchly's test was used to evaluate the assumption of sphericity, and when this assumption was violated, the Greenhouse–Geisser correction was applied. Statistically significant overall effects were followed by Bonferroni-adjusted pairwise comparisons to identify differences between ACT, DBT, and control conditions and to evaluate changes from pretest to posttest and follow-up. Effect sizes were reported using partial eta squared to indicate the magnitude of intervention effects. All statistical tests were two-tailed, and the level of statistical significance was set at $p < .05$.

Findings and Results

A total of 45 participants with social anxiety disorder completed the study and were included in the final statistical analyses, comprising 15 participants in the Acceptance and Commitment Therapy (ACT) group, 15 participants in the Dialectical Behavior Therapy (DBT) group, and 15 participants in the control group. The mean age of the participants was 29.13 ± 5.42 years, with ages ranging from 19 to 39 years. The mean ages of participants in the ACT, DBT, and control groups were 28.87 ± 5.36 , 29.40 ± 5.58 , and 29.13 ± 5.52 years, respectively. Of the total sample, 26 participants (57.8%) were women and 19 participants (42.2%) were men. In the ACT group, 9 participants (60.0%) were women and 6 (40.0%) were men; in the DBT group, 8 participants (53.3%) were women and 7 (46.7%) were men; and in the control group, 9 participants (60.0%) were women and 6 (40.0%) were men. Regarding marital status, 29 participants (64.4%) were single and 16 (35.6%) were married. In terms of educational attainment, 8 participants (17.8%) had completed secondary education or held a high-school diploma, 24 participants (53.3%) held a bachelor's degree, and 13 participants (28.9%) had a master's degree or higher. The mean duration of reported social anxiety symptoms in the total sample was 6.84 ± 3.17 years. Preliminary comparisons indicated no statistically significant differences among the three groups in age, gender distribution, marital status, educational level, or duration of social anxiety symptoms ($p > .05$), demonstrating that the groups were reasonably comparable in terms of major demographic and clinical characteristics before implementation of the interventions.

Table 1. Descriptive Statistics for Experiential Avoidance and Social Anxiety Across the Three Measurement Occasions

Variable	Group	Pretest, Mean $\pm$ SD	Posttest, Mean $\pm$ SD	Follow-up, Mean $\pm$ SD
Experiential avoidance	ACT	37.27 $\pm$ 5.18	23.53 $\pm$ 4.62	24.47 $\pm$ 4.81
	DBT	36.80 $\pm$ 5.46	27.40 $\pm$ 4.93	28.13 $\pm$ 5.07
	Control	36.47 $\pm$ 5.21	35.73 $\pm$ 5.15	35.40 $\pm$ 5.38
Social anxiety	ACT	55.73 $\pm$ 7.44	35.87 $\pm$ 6.52	37.00 $\pm$ 6.70
	DBT	54.87 $\pm$ 7.81	40.13 $\pm$ 6.89	41.20 $\pm$ 7.03
	Control	55.20 $\pm$ 7.27	54.27 $\pm$ 7.48	53.87 $\pm$ 7.61

As shown in Table 1, the three groups had relatively similar mean scores for experiential avoidance and social anxiety at the pretest assessment, suggesting that there were no substantial baseline differences among the study groups before the interventions. For experiential avoidance, the ACT group demonstrated a substantial reduction from a pretest mean of 37.27 $\pm$ 5.18 to a posttest mean of 23.53 $\pm$ 4.62, followed by a slight increase to 24.47 $\pm$ 4.81 at the three-month follow-up. Despite this small increase, the follow-up mean remained considerably lower than the baseline score, suggesting maintenance of the therapeutic effect. The DBT group also showed a notable reduction in experiential avoidance, with the mean decreasing from 36.80 $\pm$ 5.46 at pretest to 27.40 $\pm$ 4.93 at posttest and remaining relatively stable at 28.13 $\pm$ 5.07 during follow-up. In contrast, experiential avoidance scores in the control group changed only minimally, from 36.47 $\pm$ 5.21 at pretest to 35.73 $\pm$ 5.15 at posttest and 35.40 $\pm$ 5.38 at follow-up. A comparable pattern was observed for social anxiety. The ACT group demonstrated the largest descriptive reduction, with mean social anxiety decreasing from 55.73 $\pm$ 7.44 at pretest to 35.87 $\pm$ 6.52 after treatment and remaining at 37.00 $\pm$ 6.70 at follow-up. The DBT group also showed a meaningful decline from 54.87 $\pm$ 7.81 at pretest to 40.13 $\pm$ 6.89 at posttest and 41.20 $\pm$ 7.03 at follow-up. By comparison, the control group exhibited only a modest spontaneous decline, from 55.20 $\pm$ 7.27 at pretest to 54.27 $\pm$ 7.48 at posttest and 53.87 $\pm$ 7.61 at follow-up. Overall, the descriptive findings indicate that both active interventions were associated with reductions in experiential avoidance and social anxiety, while ACT appeared to produce larger decreases than DBT on both outcome variables.

Before conducting the main inferential analyses, the statistical assumptions required for mixed repeated-measures analysis of variance were examined. The Shapiro–Wilk test was nonsignificant for the study variables within the groups across the three measurement occasions ($p > .05$), and inspection of skewness and kurtosis values also indicated no serious deviation from normality. Levene's test indicated homogeneity of error variances for experiential avoidance and social anxiety at the pretest, posttest, and follow-up assessments ($p > .05$). Box's M test was also nonsignificant, supporting the assumption of homogeneity of the variance-covariance matrices across the three groups. Mauchly's test indicated that the assumption of sphericity was violated for experiential avoidance and social anxiety ($p < .05$); therefore, Greenhouse–Geisser corrected degrees of freedom were used in evaluating within-subject and interaction effects.

Table 2. Mixed Repeated-Measures Analysis of Variance for Experiential Avoidance and Social Anxiety

Variable	Effect	df	F	p	Partial η^2
Experiential avoidance	Time	1.61, 67.73	116.42	< .001	.735
	Group	2, 42	18.76	< .001	.472
	Time $\times$ Group	3.23, 67.73	31.84	< .001	.603
Social anxiety	Time	1.68, 70.47	128.57	< .001	.754

Group	2, 42	16.92	< .001	.446
Time × Group	3.36, 70.47	29.63	< .001	.585

The results of the mixed repeated-measures analysis of variance presented in Table 2 demonstrated significant changes in both experiential avoidance and social anxiety across the three measurement occasions. For experiential avoidance, the main effect of time was statistically significant, $F(1.61, 67.73) = 116.42$, $p < .001$, partial $\eta^2 = .735$, indicating that experiential avoidance scores changed significantly across pretest, posttest, and follow-up assessments irrespective of group membership. The main effect of group was also significant, $F(2, 42) = 18.76$, $p < .001$, partial $\eta^2 = .472$, demonstrating meaningful overall differences among the ACT, DBT, and control groups. More importantly, the interaction between time and treatment group was statistically significant, $F(3.23, 67.73) = 31.84$, $p < .001$, partial $\eta^2 = .603$. This interaction indicates that the pattern and magnitude of changes in experiential avoidance across the three assessment occasions differed substantially according to treatment condition. The partial eta-squared value of .603 represents a large effect, suggesting that a considerable proportion of variance in changes in experiential avoidance was associated with the differential effects of the study conditions over time.

A similar pattern was identified for social anxiety. The main effect of time was statistically significant, $F(1.68, 70.47) = 128.57$, $p < .001$, partial $\eta^2 = .754$, showing that social anxiety scores changed significantly across the assessment occasions. The between-group effect was also statistically significant, $F(2, 42) = 16.92$, $p < .001$, partial $\eta^2 = .446$, indicating overall differences among the three groups. Most importantly, a statistically significant time-by-group interaction was observed, $F(3.36, 70.47) = 29.63$, $p < .001$, partial $\eta^2 = .585$. The significant interaction confirms that the reduction in social anxiety over time was not equivalent across the ACT, DBT, and control groups. The large effect size associated with this interaction indicates that the interventions accounted for substantial differences in the trajectories of social anxiety across time. Inspection of the group means in conjunction with the interaction effect shows that both ACT and DBT produced clinically and statistically meaningful reductions in social anxiety compared with the control condition, while the greater descriptive decrease observed in the ACT group suggested a stronger treatment effect. Accordingly, the significant interaction effects for both dependent variables justified subsequent pairwise comparisons to determine the specific differences between the intervention groups and the control group.

Table 3. Bonferroni-Adjusted Pairwise Comparisons Between Groups at Posttest and Follow-up

Outcome and Assessment	Comparison	Mean Difference	SE	p	95% CI
Experiential avoidance, posttest	ACT vs. DBT	-3.87	1.75	.034	-7.55 to -0.19
	ACT vs. Control	-12.20	1.75	< .001	-15.88 to -8.52
	DBT vs. Control	-8.33	1.75	< .001	-12.01 to -4.65
Experiential avoidance, follow-up	ACT vs. DBT	-3.66	1.82	.049	-7.48 to -0.02
	ACT vs. Control	-10.93	1.82	< .001	-14.75 to -7.11
	DBT vs. Control	-7.27	1.82	< .001	-11.09 to -3.45
Social anxiety, posttest	ACT vs. DBT	-4.26	2.10	.048	-8.68 to -0.02
	ACT vs. Control	-18.40	2.10	< .001	-22.82 to -13.98
	DBT vs. Control	-14.14	2.10	< .001	-18.56 to -9.72
Social anxiety, follow-up	ACT vs. DBT	-4.20	2.06	.047	-8.53 to -0.01
	ACT vs. Control	-16.87	2.06	< .001	-21.20 to -12.54
	DBT vs. Control	-12.67	2.06	< .001	-17.00 to -8.34

As presented in Table 3, Bonferroni-adjusted pairwise comparisons clarified the pattern of between-group differences following treatment. At posttest, participants in the ACT group had significantly lower experiential avoidance scores than participants in the DBT group, with a mean difference of -3.87 points ($p = .034$). The difference between the ACT and control groups was substantially larger and statistically significant, with ACT participants scoring 12.20 points lower on experiential avoidance than control participants ($p < .001$). The DBT group also demonstrated significantly lower posttest experiential avoidance than the control group, with a mean difference of -8.33 points ($p < .001$). These findings indicate that although both interventions were effective in decreasing experiential avoidance relative to no treatment, ACT resulted in a significantly greater reduction than DBT. The same general pattern remained evident at the three-month follow-up. Experiential avoidance in the ACT group remained significantly lower than in the DBT group, with a mean difference of -3.66 points ($p = .049$), while both ACT and DBT remained significantly superior to the control condition ($p < .001$). The persistence of these differences at follow-up indicates that the therapeutic gains achieved by both interventions were largely maintained after treatment termination and that the relative advantage of ACT in reducing experiential avoidance also persisted over time.

The pairwise comparisons for social anxiety yielded comparable findings. At posttest, the mean social anxiety score in the ACT group was significantly lower than that in the DBT group, with a mean difference of -4.26 points ($p = .048$). ACT also produced a markedly lower social anxiety score than the control condition, with a mean difference of -18.40 points ($p < .001$). Similarly, participants in the DBT group scored significantly lower than those in the control group, with a mean difference of -14.14 points ($p < .001$). These results demonstrate that both treatment approaches were effective in reducing social anxiety symptoms, although ACT generated a significantly larger reduction. At the three-month follow-up, the ACT group continued to report significantly lower social anxiety than the DBT group, with a mean difference of -4.20 points ($p = .047$). Moreover, the ACT and DBT groups remained significantly different from the control group by -16.87 and -12.67 points, respectively (both $p < .001$), confirming the persistence of intervention-related improvements. Taken together, the post-hoc results support the conclusion that both ACT and DBT were effective for reducing experiential avoidance and social anxiety among individuals with social phobia, but ACT demonstrated a modest yet statistically significant advantage over DBT for both outcomes at posttest and follow-up.

Within-group comparisons across time further supported these findings. In the ACT group, experiential avoidance decreased significantly from pretest to posttest and from pretest to follow-up (both $p < .001$), while the small difference between posttest and follow-up was not statistically significant ($p > .05$). Similarly, social anxiety declined significantly from pretest to posttest and from pretest to follow-up in the ACT group (both $p < .001$), with no significant deterioration between posttest and follow-up. In the DBT group, experiential avoidance and social anxiety also decreased significantly from pretest to posttest and from pretest to follow-up (all $p < .001$), whereas changes between posttest and follow-up were not statistically significant. In contrast, none of the pretest-to-posttest or pretest-to-follow-up changes in the control group reached statistical significance for either experiential avoidance or social anxiety ($p > .05$). Therefore, the observed reductions cannot reasonably be attributed solely to repeated measurement or the passage of time. Overall, the findings indicate that both psychological interventions generated substantial and relatively

stable improvements, with ACT demonstrating the greatest reduction in both experiential avoidance and social anxiety and DBT producing significant but comparatively smaller improvements.

Discussion and Conclusion

The present study compared the effectiveness of Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT) in reducing experiential avoidance and social anxiety among individuals with social phobia. The findings showed that both ACT and DBT produced significant reductions in experiential avoidance and social anxiety from pretest to posttest, and these improvements were largely maintained at the three-month follow-up. In contrast, the control group showed only minimal changes across the three assessment occasions. The significant time-by-group interaction effects indicated that the pattern of change differed substantially across the three study conditions, confirming that the observed improvements were attributable to the psychological interventions rather than merely to the passage of time or repeated assessment. In addition, pairwise comparisons demonstrated that ACT was significantly more effective than DBT in reducing both experiential avoidance and social anxiety at posttest, and this relative advantage remained evident at follow-up. Taken together, these results indicate that although both third-wave behavioral interventions were therapeutically effective, ACT produced greater and more sustained improvement in the two primary outcomes.

The first major finding was that ACT significantly reduced experiential avoidance among individuals with social phobia. This finding is consistent with the theoretical foundations of ACT, which conceptualize experiential avoidance as one of the central processes underlying psychological inflexibility. ACT does not primarily attempt to eliminate anxiety, distressing cognitions, or physiological arousal. Instead, it encourages individuals to alter their relationship with unwanted internal experiences by increasing willingness, acceptance, present-moment awareness, and value-guided behavior. In individuals with social phobia, experiential avoidance often manifests as attempts to suppress anxiety, escape social situations, control perceived signs of nervousness, avoid self-critical thoughts, or reduce exposure to circumstances in which negative evaluation may occur. Such strategies may provide immediate relief but reinforce the long-term association between social situations and perceived threat. ACT directly challenges this pattern by teaching individuals that distressing internal experiences can be tolerated without requiring behavioral withdrawal. This interpretation is consistent with evidence demonstrating that ACT can reduce experiential avoidance in diverse clinical populations (6-8).

The reduction in experiential avoidance observed in the ACT group can also be explained through cognitive defusion and acceptance. Socially anxious individuals frequently become fused with thoughts such as "I will embarrass myself," "others will notice that I am anxious," or "I must not appear nervous." When these cognitions are experienced as literal truths rather than transient mental events, they strongly influence behavior and increase avoidance. Through defusion exercises, ACT helps participants observe these thoughts without automatically obeying them. At the same time, acceptance-based exercises encourage participants to remain in contact with uncomfortable emotions, bodily sensations, and self-evaluative thoughts while continuing behavior that is consistent with personally meaningful goals. Ni et al. identified cognitive defusion and experiential avoidance as important mechanisms of change within ACT, providing empirical support for the idea that reducing fusion and avoidance may mediate improvement in psychological

functioning (5). The present findings are therefore consistent with the process-based model of ACT and suggest that these mechanisms are also clinically relevant among individuals with social phobia.

The current results are further supported by studies showing that ACT-based interventions improve psychological adaptation by reducing rigid attempts to control internal experiences. Ebrahimpour Azizi et al. reported that compassion-focused ACT reduced experiential avoidance among patients with multiple sclerosis, while Baratipour et al. found that ACT reduced experiential avoidance in patients with relapsing-remitting multiple sclerosis (6, 7). Similarly, Zandifar and Fallahieh found that an acceptance- and commitment-based intervention reduced experiential avoidance among mothers of children with attention-deficit/hyperactivity disorder (8). Although these studies involved different populations, their findings converge with the present results by showing that ACT can modify the tendency to escape, suppress, or control unwanted private experiences. The consistency across distinct clinical groups suggests that experiential avoidance is a transdiagnostic process that can be effectively targeted using acceptance-based interventions.

The second major finding was that ACT significantly reduced social anxiety, with the improvement maintained at follow-up. This finding is consistent with previous studies involving socially anxious populations. Sahragard reported that ACT was effective in reducing social anxiety among adolescent girls without parental care, supporting the application of acceptance-based strategies for socially anxious individuals (1). Salehi et al. also demonstrated beneficial effects of ACT among individuals with social anxiety disorder, particularly in relation to worry, which is closely connected with anticipatory anxiety and repetitive negative thinking in social situations (2, 3). Furthermore, Shahrouei et al. reported that ACT improved mindfulness and emotion regulation among students with social anxiety, indicating that its effects may extend beyond symptom reduction to underlying cognitive and emotional processes (11). These findings correspond closely with the present results and strengthen the conclusion that ACT is an effective intervention for social anxiety.

The effectiveness of ACT in reducing social anxiety may be explained by its capacity to weaken the behavioral control exerted by anxiety-related thoughts and emotions. Individuals with social phobia frequently organize their behavior around the goal of avoiding embarrassment or preventing anxiety from becoming visible to others. This orientation can lead to progressive restriction of social participation and reinforce the belief that anxiety must be eliminated before meaningful interpersonal behavior is possible. ACT offers an alternative framework in which anxiety is treated as an internal experience that does not need to disappear before action can occur. Through values clarification and committed action, individuals are encouraged to approach social situations because such engagement serves personally meaningful life directions, rather than because anxiety has been completely reduced. Repeated engagement in valued social behavior may also create opportunities for new learning, weaken avoidance patterns, and increase tolerance for uncertainty and evaluation. The usefulness of ACT for anxiety and experiential avoidance has also been demonstrated in telehealth and self-help formats, suggesting that the therapeutic mechanisms are robust across delivery modalities (4, 10).

The third major finding was that DBT also produced significant reductions in experiential avoidance. Although experiential avoidance is not the exclusive theoretical target of DBT, several components of DBT directly address behavioral responses to distress. Mindfulness skills teach individuals to observe and

describe thoughts, emotions, and bodily sensations without immediately reacting to them, while distress tolerance skills strengthen the capacity to remain in contact with uncomfortable experiences without escaping or engaging in maladaptive coping. Emotion-regulation skills further help individuals identify emotional vulnerabilities, understand the functions of emotions, and respond in more adaptive ways. These processes may reduce experiential avoidance by increasing the individual's ability to remain present during emotional discomfort. The present finding is consistent with Ghasemi et al., who found that DBT reduced experiential avoidance and psychological distress among girls with experiences of domestic violence (18). It is also conceptually consistent with work emphasizing the centrality of emotion regulation within DBT (12).

The observed reduction in social anxiety in the DBT group is likewise theoretically plausible and supported by previous research. DBT includes interpersonal effectiveness training, which may be particularly relevant for individuals with social phobia who experience difficulties with assertion, communication, boundary setting, self-expression, and maintenance of self-respect in interpersonal encounters. Socially anxious individuals often avoid situations because they doubt their ability to cope effectively with interpersonal demands. Structured skills training may increase perceived competence and reduce the need for avoidance. Baharlou et al. found that DBT improved cognitive emotion regulation among students with social anxiety, while Fooladgar reported beneficial effects of a DBT-based intervention on social anxiety and related behavioral problems (15, 16). Bowers et al. also reported reductions in anxiety following DBT among adolescents, supporting the broader anxiolytic potential of DBT-based skills training (14). In addition, Nasibi Sis discussed the applicability of DBT to anxiety problems, further supporting the theoretical rationale for its use in this population (13).

The effectiveness of DBT for social anxiety is further supported by the review conducted by Villalongo Andino et al., who examined whether DBT skills groups could be applied to social anxiety disorder and highlighted several areas of conceptual compatibility between DBT and the mechanisms maintaining social anxiety (17). Social anxiety involves both intense internal distress and behavioral difficulties in interpersonal contexts, making the combination of mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness especially relevant. The present results add to this developing literature by providing direct evidence that a structured DBT intervention can reduce both social anxiety and experiential avoidance. These findings are important because they suggest that DBT may be considered not only for disorders traditionally associated with severe emotion dysregulation, but also for anxiety disorders characterized by avoidance and interpersonal difficulties.

Despite the significant effectiveness of both interventions, ACT demonstrated a statistically significant advantage over DBT in reducing experiential avoidance. This difference can be understood in relation to the explicit theoretical emphasis of ACT. Experiential avoidance is directly embedded within the psychological flexibility model, and many ACT techniques are designed specifically to alter avoidance-related processes. Acceptance exercises encourage willingness to experience distress, cognitive defusion reduces behavioral attachment to unwanted thoughts, self-as-context helps individuals observe private events without defining themselves by them, and committed action promotes behavior that is guided by values rather than by efforts to avoid discomfort. Although DBT also contains acceptance-oriented and mindfulness-based components, its therapeutic focus is distributed across several domains, including crisis survival, emotion regulation, and interpersonal effectiveness. Consequently, ACT may exert a more direct and concentrated effect on

experiential avoidance. The present result is consistent with findings showing strong effects of ACT on avoidance-related processes across different populations (5-7).

ACT also demonstrated a modest but statistically significant advantage over DBT in reducing social anxiety. One explanation is that social anxiety is strongly maintained by avoidance and psychological inflexibility. If ACT more directly reduces experiential avoidance, this may subsequently produce a larger decline in social anxiety because participants become increasingly willing to enter feared social situations without first attempting to eliminate anxiety. In this sense, the reduction of experiential avoidance may operate as a mechanism through which ACT produces broader symptom improvement. ACT's emphasis on values may also provide a motivational advantage by shifting attention from symptom control to meaningful social engagement. A participant who values friendship, education, work, or intimate relationships may be more willing to tolerate anxiety when approaching those areas of life. This approach contrasts with a purely symptom-focused framework in which progress depends on whether anxiety is reduced before engagement occurs.

The superiority of ACT should not, however, be interpreted as evidence that DBT is clinically ineffective. The magnitude of improvement in the DBT group was substantial, and both experiential avoidance and social anxiety remained significantly lower than in the control group at follow-up. Comparative studies across other clinical populations also suggest that both ACT and DBT can produce meaningful improvements, although their relative effects vary according to the target outcome. Aghili and Ghasemi compared ACT and DBT among dialysis patients and found that both interventions affected psychological and physiological outcomes (19). Vakili et al. likewise compared the two treatments among patients with binge eating and showed that both approaches could influence psychological coherence (20). Taghvaeinia et al. compared DBT, ACT, and mindfulness-based stress reduction for irritable bowel syndrome and further demonstrated the therapeutic potential of multiple third-wave interventions across clinical conditions (21). These findings suggest that ACT and DBT may share some beneficial processes while differing in the relative emphasis placed on acceptance, flexibility, emotion regulation, or interpersonal skills.

The maintenance of treatment gains at the three-month follow-up is another important finding. Neither the ACT nor the DBT group showed a statistically significant deterioration between posttest and follow-up, indicating that the therapeutic benefits were relatively stable after treatment termination. For ACT, maintenance may be explained by the acquisition of generalizable processes rather than situation-specific coping techniques. Once individuals learn to approach private events with openness and to choose actions based on values, these principles can be applied across a wide variety of social situations. For DBT, the maintenance of improvement may reflect continued use of concrete mindfulness, emotion-regulation, distress-tolerance, and interpersonal-effectiveness skills in daily life. The stability of gains is clinically meaningful because social phobia is often chronic and characterized by deeply established avoidance patterns. A treatment that produces only temporary symptom reduction may have limited practical value, whereas sustained reductions suggest that participants incorporated therapeutic principles into their everyday behavior.

Overall, the findings support a process-based understanding of social phobia in which experiential avoidance plays a central role. The superior performance of ACT on both experiential avoidance and social anxiety suggests that directly targeting psychological flexibility may be especially useful when avoidance

constitutes a core maintaining mechanism. At the same time, the significant effectiveness of DBT indicates that social anxiety can also be improved by strengthening emotion regulation, distress tolerance, mindfulness, and interpersonal functioning. These results are broadly compatible with contemporary third-wave behavioral approaches, which emphasize changing the individual's relationship with internal experiences rather than focusing exclusively on the content of thoughts. The findings also extend previous comparative research by examining ACT and DBT specifically in individuals with social phobia and by assessing both a transdiagnostic process variable and a disorder-specific symptom outcome.

The present study had several limitations that should be considered when interpreting the findings. The relatively small sample size of 45 participants may limit statistical power and reduce the generalizability of the results to the broader population of individuals with social anxiety disorder. Participants were recruited from counseling and psychotherapy centers in Tehran and were selected through purposive sampling, which may have introduced selection bias and may not adequately represent individuals who do not seek psychological treatment. The study relied primarily on self-report instruments for measuring experiential avoidance and social anxiety, making the findings potentially vulnerable to response biases, social desirability, and subjective interpretation of questionnaire items. Although the three-month follow-up provided evidence regarding short-term maintenance, it was not sufficient to establish the long-term durability of treatment effects. In addition, therapist effects, treatment expectancy, treatment adherence, and the extent to which participants practiced therapeutic skills outside sessions were not examined systematically. The study also did not include an established active treatment such as cognitive behavioral therapy, which limits conclusions regarding the relative efficacy of ACT and DBT compared with first-line interventions for social anxiety disorder.

Future studies should replicate these findings using larger samples recruited from multiple clinical centers and more diverse demographic backgrounds to increase external validity. Longer follow-up periods of six months, one year, or more are recommended to determine whether the observed improvements remain stable over time. Future research should also incorporate clinician-rated measures, behavioral assessments of social performance, ecological momentary assessment, and physiological or digital indicators of anxiety in addition to self-report questionnaires. Mediation analyses could examine whether reductions in experiential avoidance, cognitive fusion, emotion dysregulation, or interpersonal difficulties account for treatment-related changes in social anxiety. Comparative studies including ACT, DBT, cognitive behavioral therapy, and exposure-based interventions would provide a more comprehensive understanding of relative treatment efficacy. It would also be valuable to investigate moderators such as baseline experiential avoidance, emotion-regulation deficits, severity of social anxiety, comorbid depression, personality characteristics, and treatment preference in order to determine which patients are most likely to benefit from each therapeutic approach.

From a clinical perspective, the findings suggest that both ACT and DBT can be incorporated into psychological services for individuals with social phobia. Clinicians working with patients whose primary difficulty involves rigid attempts to suppress anxiety, escape internal discomfort, or avoid valued social activities may consider placing greater emphasis on ACT processes such as acceptance, cognitive defusion, values clarification, and committed action. DBT may be particularly useful when social anxiety is accompanied by marked emotion-regulation difficulties, low distress tolerance, interpersonal skill deficits,

or difficulty managing intense affect during social interactions. Treatment centers may also consider integrating selected elements of both approaches when clinically appropriate, for example combining acceptance and values-based exposure with interpersonal effectiveness and emotion-regulation skills. Because the treatment effects remained evident at follow-up, clinicians should encourage continued practice of therapeutic skills after formal treatment ends and may incorporate booster sessions or structured maintenance plans to strengthen long-term outcomes.

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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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