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Comparison of the Effectiveness of Short-Term Psychodynamic Therapy and Integrated Acceptance and Commitment Therapy with Schema Therapy on Sleep Quality and Disability Caused by Tension-Type Headache in Insecurely Attached Nurses with Anxiety Symptoms

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1. Round 1

1.1 Reviewer 1

Reviewer:

The Introduction appropriately highlights occupational stress among nurses; however, the paragraph beginning with “Nursing in high-acuity hospital wards is emotionally and physiologically demanding” would benefit from recent epidemiological prevalence data regarding tension-type headache and sleep disturbance specifically among ICU and oncology nurses in Middle Eastern or Iranian populations to strengthen contextual grounding.

The paragraph discussing attachment theory states that “Insecurely attached individuals may have greater difficulty regulating emotions…” but does not sufficiently explain why attachment insecurity was selected as a primary screening criterion rather than a moderating variable. The manuscript would be theoretically stronger if the authors clarified the hypothesized mediating or moderating role of attachment insecurity in treatment response.

The rationale for integrating ACT with schema therapy remains conceptually underdeveloped. In the paragraph beginning “Integrating ACT with schema therapy may therefore be clinically meaningful…,” the authors should explain whether the

integration followed a published protocol, a theoretically synthesized framework, or an investigator-developed intervention model. Without such clarification, treatment reproducibility is limited.

The Methods section describes the design as “quasi-experimental,” yet participants were “randomly assigned by drawing lots to three groups.” These statements are partially contradictory. The authors should clarify whether the study is a randomized controlled trial with convenience sampling or a true quasi-experimental design, and they should justify the selected terminology according to methodological standards.

The sampling procedure described in the paragraph “First, 180 nurses volunteered for screening…” lacks sufficient detail regarding recruitment bias. The manuscript should explain how volunteers were approached, whether participation occurred during working hours, and whether ward supervisors influenced recruitment, as these factors may introduce coercion or self-selection bias.

The inclusion criterion “predominant insecure attachment according to the attachment questionnaire used in the study protocol” is insufficiently operationalized. The manuscript should specify the exact attachment instrument name, scoring method, cutoff values, psychometric properties, and classification algorithm used to define “predominant insecure attachment.”

In the Measures section, the authors acknowledge that the attachment instrument has “limited international indexing.” This represents a substantial methodological concern because attachment insecurity is a central construct in the study. The authors should provide supplementary psychometric evidence for the Persian instrument, including validity indices and reliability coefficients from prior Iranian studies.

The reported Cronbach’s alpha for the Headache Disability Inventory was .68, which is below the commonly accepted threshold for adequate internal consistency in clinical research. The authors should discuss the implications of this relatively low reliability coefficient on interpretation of treatment outcomes.

The psychodynamic intervention protocol described in the paragraph beginning “The psychodynamic intervention was based on the principles of intensive short-term dynamic psychotherapy…” lacks sufficient procedural specificity. The authors should provide session-by-session content or a summarized intervention table, including therapeutic techniques, emotional processing procedures, and fidelity monitoring methods.

The Results section would benefit from reporting adjusted means and confidence intervals rather than only F statistics and p-values. Confidence intervals are especially important given the small sample size and the large reported effect sizes (e.g., partial eta squared = .62).

The Discussion contains several mechanistic interpretations that exceed the empirical evidence generated by the study. For example, the statement “Psychodynamic work may improve sleep by reducing the internal pressure of unprocessed affect…” is theoretically plausible but was not directly measured. The authors should distinguish more carefully between empirical findings and theoretical interpretation.

Authors revised the manuscript and uploaded the updated document.

1.2 Reviewer 2

Reviewer:

Similarly, the integrated ACT-schema intervention requires more technical detail. The sentence “The sessions addressed mindfulness in stressful clinical environments…” is too broad for replication purposes. The authors should specify which ACT

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processes (e.g., cognitive defusion, acceptance, self-as-context) and which schema modes or maladaptive schemas were targeted in each session.

The manuscript states that both interventions were delivered by “the researcher and a master's-level therapist/psychologist,” but therapist allegiance effects and competency differences were not discussed. The authors should report therapist training duration, supervision procedures, adherence checks, and whether therapists delivered both interventions or only one condition.

The statistical analysis section indicates that “Shapiro-Wilk tests, Levene's tests, Box's M tests…” were conducted, but the actual test statistics and p-values are omitted. These assumption-testing results should either be reported in a supplementary table or summarized numerically in the Results section to support the validity of ANCOVA analyses.

The sample size of 10 participants per group raises concerns regarding statistical power and stability of effect size estimates. The manuscript would be strengthened by including an a priori or post hoc power analysis to justify the adequacy of the sample for multivariate analyses.

In Table 2, the descriptive statistics suggest that the integrated ACT-schema group demonstrated numerically lower post-test PSQI scores than the psychodynamic group (8.11 vs. 9.46), yet the Bonferroni analysis reports a significant advantage for the psychodynamic group. The authors should carefully verify the directionality of adjusted mean differences and ensure that the ANCOVA-adjusted estimates correspond correctly with the raw descriptive statistics.

The interpretation of headache disability findings appears inconsistent with the descriptive values. For example, the integrated ACT-schema group shows lower post-test emotional disability scores (12.96) compared with the psychodynamic group (14.68), yet the discussion repeatedly claims stronger psychodynamic effects. The authors should clarify whether lower scores indicate improvement and reconcile discrepancies between descriptive and adjusted inferential findings.

Authors revised the manuscript and uploaded the updated document.

2. Revised

Editor’s decision after revisions: Accepted.

Editor in Chief’s decision: Accepted.

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