

The Effect of Positive Psychology on Enhancing Subjective Well-Being (Subjective Happiness/Life Satisfaction) in an Orphaned Adolescent Diagnosed with Comorbid Depression and Anxiety Disorders: A Case Report

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E d i t o r	R e v i e w e r s
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1. Round 1

1.1. Reviewer 1

Reviewer:

In the participant description, the sentence “He had lost both parents in separate road traffic accidents at the age of 14” raises an important clinical issue that is insufficiently addressed in the manuscript. Sudden parental bereavement can be associated not only with depression and anxiety but also with prolonged grief symptoms, posttraumatic stress symptoms, attachment-related difficulties, and adjustment disorder. The authors should report whether these alternative or co-occurring conditions were screened, ruled out, or considered in the clinical formulation. Without this information, attribution of the participant’s symptom pattern solely to comorbid depression and anxiety is potentially incomplete.

In the Methods, the sentence “In 2023, because of persistent symptoms of depression and anxiety, he sought assistance from his school counseling center” should be expanded to describe the referral and diagnostic pathway more rigorously. The manuscript should indicate who conducted the clinical evaluation, that evaluator’s professional qualifications, whether DSM

or ICD diagnostic criteria were used, whether a structured or semi-structured diagnostic interview was administered, and whether there was any prior history of psychiatric treatment, psychotropic medication, hospitalization, self-harm, or suicidal ideation. These details are essential in a clinical case report involving a vulnerable adolescent.

The ethical procedures are currently underdeveloped. In the participant section, there is no explicit statement regarding institutional ethics approval, assent from the adolescent, consent from the legally authorized guardian or welfare authority, protection of confidentiality, or permission to publish a detailed clinical case. Because the participant was a minor living in institutional care and had no available parents or grandparents, the authors should explicitly state who had legal authority to provide consent for participation and publication. They should also confirm that identifying details were sufficiently anonymized and that the study complied with applicable ethical standards for research involving minors and vulnerable populations.

In the Data Collection Tools section, the statement “The Depression-Anxiety Scale (DA-14), derived from the Depression Anxiety Stress Scales originally developed by Lovibond and Lovibond in 1995” should be corrected and standardized. The standard instrument is generally referred to as the Depression Anxiety Stress Scales-21 (DASS-21), from which the depression and anxiety subscales were selected. The authors should explain whether they simply administered 14 items from the validated DASS-21 or used an independently validated “DA-14” form. If only two subscales were extracted, evidence should be provided that scoring and interpretation remain psychometrically valid when the stress subscale is omitted.

The reported “effect size” terminology should be revised. In the Results, statements such as “the effect size, or percentage of change, for depression was -39.58% ” conflate percentage change with standardized effect size. A baseline-relative percentage change is not equivalent to a conventional effect-size statistic such as standardized mean difference, Tau-U, NAP, or standardized mean change. The manuscript should consistently call these values “percentage change from baseline” unless a formally defined single-case effect-size metric was calculated. If the authors wish to retain the term effect size, they should provide the exact formula, methodological citation, and interpretive framework.

There appears to be an internal inconsistency in the reported depression treatment mean and percentage change. Table 1 reports baseline depression = 16.00 and treatment = 9.67, which corresponds to a reduction of approximately 39.56%, consistent with the reported 39.58%. However, the manuscript should explicitly indicate whether treatment values represent means across intervention observations rather than final-session scores. The current wording repeatedly states “at the end of the intervention,” yet Table 1 appears to contain phase means. The authors should distinguish phase mean, immediate post-treatment score, and last treatment observation throughout the text.

Authors revised and uploaded the document.

1.2. Reviewer 2

Reviewer:

The scoring description for the depression and anxiety measures requires greater precision. The sentence “The scores for each seven-item subscale are summed and multiplied by two” is appropriate for comparison with the original DASS-42 severity thresholds, but the manuscript should specify exactly which severity cutoff values were applied to depression and anxiety and whether these were validated in adolescents. The participant was 15 years old, yet much of the cited psychometric evidence appears to come from adult or student populations. The authors should justify the developmental appropriateness of the scale and its cutoff interpretation for this adolescent case.

The manuscript should reconsider the operationalization of subjective well-being. In the Data Collection Tools section, the sentence “Subjective well-being was operationalized as the combined scores of subjective happiness and satisfaction with life” assumes that raw scores from two distinct instruments can be summed directly into a single total. This is psychometrically questionable because the Subjective Happiness Scale and Satisfaction With Life Scale differ in item number, content, and construct emphasis. The authors should provide a theoretical and psychometric justification for summing these raw scores, or

alternatively analyze subjective happiness and life satisfaction separately and avoid presenting the arithmetic sum as a validated overall subjective well-being scale.

The description of cutoff points for subjective happiness, life satisfaction, and total subjective well-being should be revised. The statement that “16 [was] considered the interpretive midpoint or cutoff” for subjective happiness and “20 [was] considered the interpretive midpoint or cutoff” for life satisfaction risks conflating a mathematical midpoint with a clinically validated cutoff. Unless empirical cutoff scores have been established and validated for these instruments in comparable adolescent populations, the manuscript should refer to these values only as scale midpoints rather than diagnostic or clinical cutoffs. The same concern applies to the proposed cutoff of 36 for the combined subjective well-being score.

The intervention protocol is described in sufficient thematic detail, but the sentence “The intervention was based on the positive psychology approach developed by Seligman et al. (2005)” requires stronger treatment-fidelity documentation. The authors should specify whether the seven sessions were adapted directly from Seligman et al.’s exercises, from a published treatment manual, or from a locally developed protocol. They should also state who delivered the intervention, the therapist’s training and experience, whether supervision was provided, whether session adherence was monitored, and whether any fidelity checklist was used. Without such information, reproducibility of the intervention is limited.

The dosage and temporal structure of the intervention should be reconciled with the assessment schedule shown in the figures. The Methods state that there were “seven weekly 60-minute sessions,” but the figures label observations as sessions 1, 2, 3, 5, 7, 9, 10, and 11, suggesting that outcome measurement did not occur at every treatment session or that session numbering includes baseline and follow-up assessments. The authors should explicitly explain the measurement timeline, identify which points correspond to baseline, intervention, post-treatment, and follow-up, and ensure that the x-axis labels do not imply missing intervention sessions.

In the Data Analysis section, the sentence “Visual inspection of score changes across assessment points was supplemented by the Percentage of Non-Overlapping Data (PND)” requires more methodological detail. For each outcome, the authors should specify how the most extreme baseline score was selected, how ties were handled, and the exact numerator and denominator used in the PND calculation. Because only a small number of observations were available, the authors should also acknowledge the statistical limitations of PND, including its sensitivity to extreme baseline values and limited discrimination when all intervention points exceed the baseline criterion.

Authors revised and uploaded the document.

2. Revised

Editor’s decision after revisions: Accepted.

Editor in Chief’s decision: Accepted.