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Comparison of the Effectiveness of Cognitive Behavioral Therapy and Intensive Solution-Focused Therapy on Resilience in Adolescents with Nonsuicidal Self-Injury

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1. Round 1

1.1. Reviewer 1

Reviewer:

The paragraph beginning “This applied study employed an experimental, two-arm, pretest–posttest design with a three-month follow-up” requires more precise methodological terminology. Because both groups received active psychological interventions and there was no untreated control condition, the study would be more accurately described as a randomized active-comparator trial rather than simply an “experimental study.” More importantly, the absence of a no-treatment or treatment-as-usual control condition limits the extent to which changes over time can be causally attributed to either intervention. Regression to the mean, spontaneous improvement, repeated testing, nonspecific therapeutic attention, and concurrent changes in school or family circumstances could partially account for the significant time effect. The manuscript should therefore consistently distinguish comparative treatment effects from absolute treatment efficacy and avoid implying that the design independently establishes that either intervention caused the observed changes.

The sampling description requires clarification because the paragraph stating that “Participants were initially recruited using convenience sampling” is followed by the statement that “two schools were randomly selected from eligible schools in the

city." These represent two different sampling stages, and the manuscript should explain their relationship explicitly. It should specify the total number of eligible schools, the method by which the two schools were randomly selected, whether all students referred for NSSI screening within those schools were approached, and at which stage convenience sampling occurred. If schools were randomly selected but students within those schools were recruited through availability or referral, the procedure should be described as a multistage process rather than simply convenience sampling. This clarification is important for assessing selection bias and external validity.

The statement that "Following confirmation of eligibility, participants were randomly allocated to one of the two active intervention groups" is insufficient for reproducibility and assessment of allocation bias. The manuscript should report exactly how the random sequence was generated, for example by computerized random-number generation, random-number tables, or another procedure; whether simple, block, or stratified randomization was used; who generated the allocation sequence; who enrolled participants; and whether allocation concealment was implemented. Given the small sample of 44 participants, clarification regarding block or stratified randomization is particularly important because relevant baseline factors such as age, NSSI severity, and depression severity could otherwise become unevenly distributed between groups by chance.

The description of the primary outcome measure raises a potentially important measurement issue that should be carefully verified. The manuscript states that the "Adolescent Resilience Scale developed by Oshio et al. (2003)" contains 21 items and assesses novelty seeking, emotional regulation, and positive future orientation, but then cites Cheraghi et al. (2017) as the Iranian validation of the instrument. Cheraghi et al. reported the Persian validation of the "Adolescent Resilience Questionnaire," which may not be identical to the 21-item Oshio scale. The authors should verify that the cited Iranian validation actually pertains to the exact instrument administered in this study. If two different resilience instruments have inadvertently been conflated, this represents a major methodological problem. The original scale name, number of items, subscales, scoring range, original citation, Persian validation citation, and psychometric properties of the exact Persian version used should all be reported accurately.

The intervention-dose difference requires more careful consideration in both Methods and interpretation. The manuscript reports that CBT consisted of eight 90-minute sessions over eight weeks, whereas ISFT consisted of six 90-minute sessions over six weeks. Although the authors appropriately note that the difference reflects the structures of the two therapeutic approaches, it nevertheless means that treatment exposure was not controlled across conditions. Participants in the CBT group received approximately 12 hours of therapy compared with approximately 9 hours in the ISFT group. Consequently, the comparison reflects two complete treatment packages rather than two interventions matched for therapist contact. This should be explicitly acknowledged as a design feature and potential confound, particularly when interpreting the absence of a significant between-group difference.

Authors uploaded the revised manuscript.

1.2. Reviewer 2

Reviewer:

The procedure used to identify nonsuicidal self-injury requires considerably greater methodological detail. The manuscript currently states that psychological records were reviewed to identify students "with a history of NSSI," but no standardized NSSI assessment instrument or operational diagnostic criterion is reported. It is essential to specify how NSSI was defined, how suicidal intent was differentiated from nonsuicidal intent, what minimum frequency or recency of self-injurious behavior was required, which forms of self-injury qualified, and whether classification was established through clinical interview, counselor records, self-report, or a validated measure. A history of a single remote episode of self-injury represents a substantially different clinical profile from recurrent current NSSI. Because NSSI is the defining characteristic of the study population, the eligibility assessment should be sufficiently rigorous and reproducible.

The paragraph describing the Patient Health Questionnaire-9 requires clarification regarding both depression assessment and suicide-risk screening. The manuscript states that adolescents with moderate or severe depressive symptoms were selected and that "a clinical interview was conducted by a psychologist," but neither the PHQ-9 cutoff scores nor the clinical interview

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format are reported. Please specify the score ranges used to define moderate and severe depression and indicate whether the interview was structured, semi-structured, or unstructured. This issue is particularly important because item 9 of the PHQ-9 assesses thoughts related to death or self-harm. Given that suicidal ideation constituted an exclusion criterion, the manuscript should explain how positive responses to this item were evaluated to distinguish nonsuicidal self-injury from suicidal thoughts and what immediate clinical action was taken when suicide risk was detected.

The sample-size calculation described in the paragraph beginning "The required sample size was estimated using G*Power version 3.1.9.2" is not aligned with the primary statistical analysis reported later in the manuscript. The calculation is stated to have been based on "ANCOVA (fixed effects, main effects and interactions)" with three covariates, whereas the actual inferential analysis was a two-group repeated-measures ANOVA with three measurement occasions, and no three-covariate ANCOVA is reported. This mismatch should be corrected. The authors should either recalculate and report the power analysis using the statistical model corresponding to the primary repeated-measures analysis or provide a strong justification for why an ANCOVA-based calculation was used. In addition, "effect size = 0.50" should identify the actual metric, such as Cohen's f, because a numerical effect size without specifying its statistical definition cannot be interpreted.

The eligibility paragraph needs greater internal consistency concerning depressive symptoms. The inclusion criteria require "moderate or severe depressive symptoms," meaning that the study did not merely examine adolescents with NSSI but specifically a subgroup with comorbid clinically relevant depressive symptoms. This characteristic should be incorporated consistently into the Introduction, participant description, Discussion, and interpretation of generalizability. The manuscript should also report the baseline severity of depressive symptoms by treatment group, ideally including mean PHQ-9 scores and standard deviations. Without demonstrating comparability in baseline depression severity, an important variable that could influence resilience and treatment responsiveness remains unaccounted for.

Given the vulnerability of the sample, the ethical and safety procedures require substantially more detail than the general statement that ethical approval and informed consent were obtained. The Methods section should report the ethics approval code and describe the protocol for monitoring suicidal ideation, suicide attempts, escalation of self-harm, or clinical deterioration throughout the six- to eight-week treatment period and the three-month follow-up. The manuscript should indicate whether suicide risk was reassessed at each treatment session, whether participants had access to emergency clinical services, whether parents or guardians were contacted under predefined risk conditions, and whether any participants required referral to higher levels of care. For a trial involving minors with NSSI and depressive symptoms, a clearly specified safety-monitoring protocol is an essential component of ethical reporting.

Authors uploaded the revised manuscript.

2. Revised

Editor's decision after revisions: Accepted.
Editor in Chief's decision: Accepted.

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