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# Comparison of the Effectiveness of Acceptance and Commitment Therapy and Meaning-Centered Therapy Based on Rumi's Thoughts on Pain Catastrophizing and Distress Tolerance in Men with Gastric Cancer

Kosar. Ansari[1], Asghar. Noruzi[2*], Gholamreza. Khalili[3]

[1] PhD Student, Department of Psychology, Sari Branch, Islamic Azad University, Sari, Iran
[2] Assistant Professor, Department of Psychology, Sari Branch, Islamic Azad University, Sari, Iran
[3] Assistant Professor, Department of Psychology, Gorgan Branch, Islamic Azad University, Gorgan, Iran

*** Corresponding author email address**: 2091474029@iau.ir

| Editor | Reviewers |
|---|---|
| Mohsen Golparvar<br>Professor, Department of Psychology, Isfahan (Khorasgan) Branch, Islamic Azad University, Isfahan, Iran<br>mgolparvar@khuisf.ac.ir | **Reviewer 1:** Hooman Namvar<br>Assisstant Professor, Department of Psychology, Saveh Branch, Islamic Azad University, Saveh, Iran. Email: hnamvar@iau-saveh.ac.ir<br>**Reviewer 2:** Elham Azarakhsh<br>Department of Psychology, Islamic Azad University, Qom Branch, Qom, Iran. Email: elhamazarakhsh@qom.iau.ac.ir |

## 1. Round 1

### *1.1. Reviewer 1*

Reviewer:

"Gastric cancer is the fourth most common cancer and the second leading cause of cancer-related deaths." While this statement is informative, it lacks a recent global reference. Consider citing a WHO or recent meta-analysis for updated statistics.

The inclusion criteria list male patients aged 45–75, but it is unclear why younger or older individuals were excluded. Was age a confounding factor, or were younger patients less likely to experience pain catastrophizing?

The text states that participants were "randomly assigned," but no details on the randomization method (e.g., block randomization, simple randomization) are provided. Clarifying the procedure enhances reproducibility.

The Pain Catastrophizing Questionnaire (Rahmati et al., 2017) is cited, but no psychometric properties (e.g., reliability, validity in cancer patients) are reported. Including internal consistency (Cronbach's alpha) for the study sample would improve credibility.

The session outline lacks specific techniques. The discussion on "challenging avoidance behaviors" would be stronger with an example exercise or reference to ACT protocols.

The phrase "Participants explore how to stay focused on life's meaning and pleasures even in the midst of hardship" is abstract. What specific techniques or exercises were used to help patients reinterpret suffering?

The table reports mean and standard deviations but does not include effect sizes. Were Cohen's d or $\eta^2$ calculated? Effect sizes provide a clearer understanding of clinical significance.

The results report Wilks' Lambda values but do not mention post-hoc power analyses. Given the small sample (n=45), was statistical power sufficient? If post-hoc power calculations were conducted, adding them would strengthen the robustness of the findings.

Response: Revised and uploaded the manuscript.

### *1.2. Reviewer 2*

Reviewer:

The discussion on distress tolerance would benefit from elaboration on its relevance in oncology settings. How does low distress tolerance affect cancer treatment adherence or quality of life? A reference to psycho-oncology research would strengthen this section.

The connection between Meaning-Centered Therapy (MCT) and Persian mystical literature is compelling. However, the rationale for using Rumi's thoughts in clinical interventions needs a stronger empirical foundation. Have prior studies validated the integration of Rumi's philosophy into psychotherapy?

"The sample was selected using voluntary and convenient sampling methods..." This approach introduces a potential selection bias. How was representativeness ensured? A justification for convenience sampling in clinical settings should be provided.

The statement, "Meaning Therapy based on Rumi's thoughts had a greater impact on improving magnification and rumination components," is vague. Consider specifying the percentage reduction or Cohen's d for clarity.

While the study aligns with previous findings, the discussion lacks a direct comparison with similar interventions in oncology patients. Were there prior studies comparing ACT and MCT in cancer patients?

The explanation of why MCT might be more effective in reducing magnification and rumination is based on philosophical arguments. Could a psychological model (e.g., meaning reconstruction theory) be incorporated for a stronger scientific explanation?

The study found no significant difference between ACT and MCT in distress tolerance. This could be due to overlapping mechanisms (e.g., mindfulness elements in both). Consider discussing potential common therapeutic factors.

Response: Revised and uploaded the manuscript.

## 2. Revised

Editor's decision after revisions: Accepted.

Editor in Chief's decision: Accepted.



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