


# Effectiveness of Mindfulness-Based Cognitive Therapy on Perceived Social Support and Resilience in Individuals with Morbid Obesity

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### E d i t o r

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### R e v i e w e r s

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## 1. Round 1

### 1.1. Reviewer 1

Reviewer:

Introduction, paragraph 2, states “Individuals with stronger perceived social support networks generally demonstrate greater emotional stability...”; however, the manuscript does not clarify whether social support is expected to mediate or moderate outcomes for individuals with morbid obesity. A theoretical clarification would help position perceived social support more precisely within the research model.

Introduction, paragraph 3, references multiple studies on resilience, yet the conceptual distinction between “resilience as a trait” and “resilience as a dynamic process” is not fully articulated. This distinction is critical because MBCT interventions typically target process-oriented resilience.

Introduction, paragraph 4, includes the sentence “Neuroscientific evidence indicates that mindfulness practices enhance functional connectivity in prefrontal regions...”; however, these claims would benefit from clearer linkage to how such neural changes are expected to influence obesity-related psychological functioning.

Intervention section, the paragraph describing session content lists activities in great detail; however, the manuscript does not specify adherence monitoring, facilitator training, or fidelity checks. Omitting these weakens confidence in standardized delivery of MBCT.

Data Analysis section, states “MANCOVA assumptions were examined...” but provides only summary statements. The manuscript should present complete assumption test outputs or at least elaborate on distributions, skewness, and kurtosis.

Findings, Table 1, lists mean heights in the experimental group as 151.46 cm, which seems inconsistent with the stated BMI values (e.g., BMI 104.39). This suggests potential data entry or unit-conversion errors that require verification.

Findings, MANCOVA section, the sentence “Normality was confirmed” based solely on non-significant Kolmogorov–Smirnov tests is insufficient; given the small sample size ( $n=15$  per group), these tests have low power. The authors should support normality claims using graphical diagnostics.

Response: Revised and uploaded the manuscript.

## 1.2. Reviewer 2

Reviewer:

Introduction, paragraph 5, synthesizes evidence from Iranian studies but does not address potential cultural moderators that could influence responsiveness to MBCT. Explicit discussion of cultural adaptation of MBCT for Iranian obese populations would strengthen the argument.

Methods, Study Design and Participants, contains the statement “30 individuals were selected through purposive sampling...”. Because purposive sampling limits generalizability, the authors should justify this choice and describe the recruitment strategy more transparently, including exclusion rates and reasons for non-participation.

Methods, Inclusion Criteria, lists “absence of psychological disorders” as a requirement; however, the manuscript does not explain how this was assessed beyond “self-report.” The absence of standardized screening tools raises concerns regarding internal validity.

Measures section, specifically the description of the MSPSS, repeats reliability metrics from previous studies, but the manuscript does not report confirmatory factor analyses for the current sample. Including psychometric evidence from the present study would enhance methodological rigor.

Measures section, in describing the CD-RISC, includes the text “In the present study, internal consistency reliability... was calculated as .78.” This value appears low compared to previous reported reliabilities (.89 to .94). The manuscript should discuss potential reasons for this discrepancy.

Findings, narrative below Table 2, the authors claim “This distribution demonstrates that most participants in both groups fall within the lower weight ranges.” This interpretation is inconsistent with the study’s focus on morbid obesity; the text should clarify how “lower ranges” are defined in a morbid-obesity sample.

Findings, Table 3, shows baseline differences between groups—for example, the control group scores much higher on pretest perceived social support (45.06 vs. 36.99). Such imbalance raises threats to internal validity. The manuscript should discuss this limitation explicitly.

Response: Revised and uploaded the manuscript.

## 2. Revised

Editor’s decision after revisions: Accepted.

Editor in Chief’s decision: Accepted.