






The Effectiveness of Acceptance and Commitment Therapy on Psychological Symptoms and Dysfunctional Attitudes in Maladjusted Couples Referred to Counseling and Psychological Services Centers

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1. Round 1

1.1. Reviewer 1

Reviewer:

In the second paragraph of the Introduction, the sentence “Psychological symptoms in couples experiencing marital conflict often manifest in the form of depression, anxiety, emotional exhaustion, irritability, hopelessness, and chronic stress” overgeneralizes symptom presentation without differentiating between transient distress and clinically elevated symptomatology. The manuscript would benefit from clarifying whether the study population demonstrated subclinical distress or met clinically meaningful thresholds on the DASS-21. This distinction is particularly important for interpreting the clinical significance of the intervention outcomes.

The paragraph introducing dysfunctional attitudes relies heavily on Beckian cognitive theory but does not adequately explain why ACT, rather than traditional cognitive restructuring approaches, would specifically target dysfunctional attitudes. Since ACT theoretically focuses more on cognitive defusion than cognitive modification, the authors should elaborate on the

mechanism by which ACT is expected to reduce dysfunctional beliefs. Without this clarification, the theoretical alignment between the intervention and the dependent variable remains underdeveloped.

The literature review contains numerous citations supporting ACT efficacy; however, the manuscript lacks a coherent synthesis of previous findings. For example, in the paragraph beginning with “Several empirical studies have demonstrated the effectiveness of ACT in improving psychological and relational outcomes among couples,” the cited studies involve different populations, therapeutic modifications, and outcome variables. The review currently reads as a list of supportive studies rather than a critical integration of evidence. The authors should synthesize effect patterns, inconsistencies, and methodological gaps in the prior literature.

The rationale for the present study remains somewhat weak because the identified research gap is insufficiently specific. In the paragraph beginning with “Despite the expanding literature on couple interventions,” the authors claim that few studies have simultaneously examined psychological symptoms and dysfunctional attitudes; however, they do not demonstrate why this combination is theoretically or clinically important. The manuscript would be strengthened by articulating a conceptual model linking dysfunctional attitudes to symptom maintenance within distressed couples.

The Methods section does not adequately describe participant eligibility criteria. In the paragraph beginning with “The present study employed a quasi-experimental design,” there is no explanation regarding inclusion criteria, exclusion criteria, duration of marital maladjustment, psychiatric comorbidities, medication use, or concurrent psychotherapy. Without these details, the reproducibility of the study and interpretation of treatment effects are substantially limited.

The sampling strategy raises concerns regarding internal and external validity. The use of convenience sampling from counseling centers may have introduced substantial self-selection bias, yet the manuscript does not discuss how this may have affected treatment responsiveness. Couples voluntarily seeking counseling are often more motivated for change, which may artificially inflate intervention effectiveness. The authors should explicitly address this limitation both methodologically and in the Discussion section.

The description of random assignment is insufficiently detailed. The sentence “participants were randomly assigned into two groups” does not specify the randomization procedure, allocation concealment strategy, or whether assignment was conducted by an independent researcher. Without such information, it is difficult to assess the extent to which selection bias was minimized. The CONSORT framework for randomized and quasi-experimental studies should be consulted for improving methodological transparency.

Table 1 presents descriptive statistics but does not report confidence intervals or effect trends over time. In addition, the table combines psychological symptoms into a total score despite earlier emphasizing separate depression, anxiety, and stress dimensions. Given that the DASS-21 includes distinct subscales, separate analyses for each dimension would provide a more clinically informative understanding of treatment effects.

The ANCOVA results reported in Tables 2 and 3 require fuller statistical reporting. For example, the authors report F values and η^2 , but adjusted means and confidence intervals are absent. Reporting only significance values limits interpretability. Furthermore, the reported effect sizes ($\eta^2 = 0.512$ and 0.522) are extremely large for psychotherapy interventions and should be interpreted cautiously, particularly given the small sample size.

The Findings section occasionally overstates causal inference. For example, the sentence “Acceptance and Commitment Therapy significantly affected psychological symptoms” implies strong causality despite the quasi-experimental nature of the design and the use of convenience sampling. The authors should adopt more cautious language such as “was associated with significant reductions” or “demonstrated significant posttest differences.”

Response: Revised and uploaded the manuscript.

1.2. Reviewer 2

Reviewer:

The psychometric description of the DASS-21 requires clarification. The manuscript reports Cronbach's alpha coefficients from previous studies and then reports internal consistency coefficients for the current sample; however, it does not specify whether reliability was calculated separately for pretest and posttest administrations. In addition, the reported Cronbach's alpha coefficients from prior studies appear unusually high (e.g., 0.97), and the authors should justify these values or verify their accuracy.

The description of the Dysfunctional Attitudes Questionnaire is incomplete because no psychometric properties are reported for the present sample. While the scoring system and subscales are described, there is no information regarding internal consistency, construct validity, or cultural adaptation in Iranian populations. Since dysfunctional attitudes constitute a primary outcome variable, psychometric adequacy should be explicitly demonstrated.

The Intervention section lacks procedural specificity necessary for replication. The paragraph beginning with "The Acceptance and Commitment Therapy (ACT) intervention was implemented over the course of 8 consecutive weeks" provides only a broad conceptual summary of ACT components. The authors should include a session-by-session protocol or at minimum specify which ACT exercises, metaphors, mindfulness practices, and experiential activities were employed during each session.

The manuscript does not indicate whether therapist competence or treatment fidelity was assessed. Since therapist effects can significantly influence psychotherapy outcomes, the qualifications, ACT training background, supervision process, and fidelity monitoring procedures should be reported. Without fidelity assessment, it cannot be confirmed that the intervention was consistently delivered according to ACT principles.

The Data Analysis section is methodologically underdeveloped. The authors state that ANCOVA was used after testing homogeneity of variances with Levene's test; however, ANCOVA assumptions extend beyond homogeneity of variance. The manuscript does not report testing for homogeneity of regression slopes, normality of residuals, linearity, or absence of multicollinearity. These omissions weaken confidence in the statistical conclusions.

Response: Revised and uploaded the manuscript.

2. Revised

Editor's decision after revisions: Accepted.

Editor in Chief's decision: Accepted.