






The Effectiveness of Schema Therapy on Fear of Negative Evaluation and Cognitive Flexibility in Adolescents

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1. Round 1

1.1. Reviewer 1

Reviewer:

The conceptual distinction between “cognitive flexibility” and “psychological flexibility” remains somewhat blurred throughout the Introduction and Discussion sections. For example, the sentence “Recent studies have demonstrated that schema-focused interventions contribute to increased psychological flexibility and adaptive coping capacities” introduces psychological flexibility without adequately differentiating it from the primary outcome variable of cognitive flexibility. The authors should clarify whether these constructs are theoretically overlapping, hierarchical, or distinct, and explain why cognitive flexibility was prioritized as the dependent variable.

The literature review is extensive but largely descriptive rather than analytical. In the paragraph beginning with “Previous studies have highlighted the importance of therapeutic interventions targeting fear of negative evaluation,” the authors summarize prior findings without critically identifying methodological limitations, inconsistencies, or unresolved gaps in the

literature. A more analytical synthesis would help justify the novelty of the present study beyond merely combining two variables in one intervention design.

The manuscript repeatedly emphasizes “schema therapy” but does not specify the exact therapeutic protocol or manual used. In the Intervention section, the sentence “The therapeutic sessions included psychoeducation regarding schemas and emotional needs...” remains overly general. The authors should provide a detailed session-by-session protocol, specify whether the intervention was adapted from Young’s standard schema therapy model, and clarify which schema modes or maladaptive schemas were primarily targeted in adolescents.

The sampling procedure raises concerns regarding external validity. The sentence “Using convenience sampling, 30 participants were selected as the sample” indicates a nonprobability method, yet the manuscript later makes relatively broad conclusions regarding adolescent mental health. The authors should discuss how convenience sampling may have introduced selection bias, particularly considering that participants were already help-seeking adolescents attending counseling centers.

The inclusion and exclusion criteria are insufficiently operationalized. The phrase “having no severe psychiatric disorders that would interfere with participation” is vague and clinically imprecise. The manuscript should specify how psychiatric status was assessed, whether structured diagnostic interviews were conducted, who conducted screening, and whether participants were receiving concurrent psychiatric medication or psychotherapy.

The manuscript repeatedly references “adolescents” as a homogeneous developmental category without considering developmental variability within adolescence. Early, middle, and late adolescence involve substantially different cognitive and interpersonal capacities. The absence of age-stratified analyses weakens the developmental interpretation of the findings.

The intervention integrity and therapist competence are not addressed. The manuscript does not specify who conducted the schema therapy sessions, whether therapists were trained or supervised in schema therapy, or whether treatment fidelity was assessed. Without fidelity monitoring, it is difficult to determine whether the intervention was consistently delivered across sessions.

Response: Revised and uploaded the manuscript.

1.2. Reviewer 2

Reviewer:

The psychometric description of the Cognitive Flexibility Inventory requires greater scrutiny. The manuscript reports Cronbach’s alpha coefficients of 0.55 and 0.57 for two subscales yet describes these values as “acceptable reliability.” From a psychometric standpoint, coefficients below .60 are generally considered weak. The authors should either justify the use of these subscales with supporting evidence or acknowledge this limitation explicitly in the discussion.

The manuscript does not provide sufficient demographic information regarding participants. Beyond noting that participants were adolescents from Tehran, no information is given about age distribution, gender composition, socioeconomic status, educational level, or family structure. These variables are highly relevant because fear of negative evaluation and cognitive flexibility may vary substantially across demographic contexts. A demographic table is strongly recommended.

The Data Analysis section states that “covariance analysis procedures” were used, yet the Findings section later refers to “multivariate analysis of covariance (MANCOVA).” The statistical reporting lacks precision regarding whether repeated-measures ANCOVA, MANCOVA, or mixed ANOVA procedures were actually implemented. The authors should clearly define the analytical model, specify covariates, and report statistical assumptions comprehensively.

Table 2 presents “Time,” “Time × Group,” and “Group” effects, which resembles a repeated-measures ANOVA framework rather than a traditional ANCOVA design. This creates methodological inconsistency because ANCOVA typically controls for baseline scores rather than estimating time interactions. The statistical strategy should therefore be reconsidered and rewritten to ensure consistency between the stated design and reported analyses.

The authors report highly significant findings despite the small sample size ($n = 30$), but no statistical power analysis is presented. Given the limited sample, the manuscript should include an a priori or post hoc power analysis to demonstrate

whether the study was adequately powered to detect medium or large effects. Without this information, interpretation of the effect sizes remains uncertain.

The manuscript would benefit from reporting confidence intervals alongside p-values and effect sizes. For example, in the sentence “schema therapy significantly increased cognitive flexibility,” the results would be more informative if accompanied by 95% confidence intervals. Reliance solely on p-values limits interpretability and does not fully align with contemporary reporting standards in psychological research.

In the Discussion section, the authors occasionally overstate causal implications. For example, the sentence “Schema therapy appears to reduce these maladaptive reactions by helping individuals identify dysfunctional schemas” implies a direct mechanism, yet mediational variables were not empirically measured in the study. The interpretation should therefore be presented more cautiously and framed as a theoretical explanation rather than an established causal pathway.

Response: Revised and uploaded the manuscript.

2. Revised

Editor’s decision after revisions: Accepted.

Editor in Chief’s decision: Accepted.