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Enhancing Emotional Awareness in Children with Symptoms of Oppositional Defiant Disorder: A Comparison of the Effectiveness of Parent–Child Interaction Therapy and the Coping Cat Program

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1. Round 1

1.1. Reviewer 1

Reviewer:

The age range of 7–12 years encompasses important developmental differences in emotional vocabulary, metacognition, cognitive restructuring, parent dependence, and the capacity to complete self-report measures. The “Study Design and Participants” paragraph should report the mean age, standard deviation, age distribution, sex distribution, school grade, socioeconomic characteristics, parental education, family structure, baseline symptom severity, and relevant clinical characteristics separately for each group. A baseline-comparability analysis is also needed to demonstrate whether random allocation produced sufficiently equivalent groups. Without these demographic and clinical data, readers cannot assess sample representativeness or whether developmental differences may explain the observed variability.

The reported scores raise a serious measurement inconsistency that must be resolved before publication. The “Data Collection Tools” section states that the Emotional Awareness Questionnaire contains 28 items scored from 1 to 3, producing “total scores ranging from 28 to 84.” However, Table 1 reports a posttest mean of 112.20 in the Parent–Child Interaction

Therapy group and pretest means exceeding 84 in all groups. These values are mathematically incompatible with the stated scoring range. The authors must verify the instrument version, number of items, response scale, reverse-scoring procedure, and total-score calculation. If a different version or composite score was used, it must be described accurately; otherwise, the descriptive and inferential analyses may be based on incorrectly computed scores.

The attribution of the measure should be checked carefully. The manuscript refers to “Rieffe’s Emotional Awareness Questionnaire” and describes five dimensions, but emotional-awareness instruments developed by Rieffe and colleagues have appeared in different versions with varying item numbers and subscales. The authors should provide the complete name and original citation of the exact version administered, state whether an authorized Persian translation was used, and describe the translation and cultural-adaptation process. The validity evidence reported for the Iranian version should include more than test–retest reliability, particularly construct validity, factor structure, internal consistency, convergent validity, and appropriateness for children aged 7–12 years.

The qualitative interview procedure is also underreported. The paragraph describing the semi-structured interview protocol should state whether parents and children were interviewed jointly or separately, who conducted the interviews, the interviewer’s relationship to participants, interview duration, location, mode, and whether field notes were recorded. Joint parent–child interviews may introduce conformity, parental influence, or social-desirability bias, especially when children are asked to discuss treatment effects. The authors should explain how children’s independent perspectives were protected and how developmentally appropriate interviewing techniques were used.

The deductive content-analysis procedure requires a more rigorous account of coding and trustworthiness. The sentence “A preliminary coding framework was developed based on the dimensions of emotional awareness and the mechanisms proposed by Parent–Child Interaction Therapy and the Coping Cat program” suggests a strongly theory-driven analysis that may have constrained the identification of unexpected findings. The authors should explain how deductive and emergent codes were distinguished, how disagreements were resolved, how many coders participated, and whether a codebook or audit trail was maintained. Credibility procedures such as member checking, peer debriefing, negative-case analysis, reflexive journaling, triangulation, and thick description should be reported where applicable.

The statistical-assumptions paragraph is presently too vague and should report empirical evidence. Statements such as “the distributions were approximately normal” and “the assumption of homogeneity of variance was satisfied” should be supported by the names and results of the diagnostic tests used, including Shapiro–Wilk statistics, Levene’s tests at each measurement occasion, and any assessment of influential observations. Because the groups were small and posttest variability differed markedly across conditions, particularly with standard deviations of 9.675, 18.352, and 21.697, the robustness of the mixed ANOVA should be discussed. The authors may also consider sensitivity analyses using robust methods or a linear mixed-effects model.

Response: Revised and uploaded the manuscript.

1.2. Reviewer 2

Reviewer:

The reliability reporting in the measurement paragraph should be revised to conform to psychometric and APA conventions. The sentence “Rieffe et al. (2008) reported a test–retest reliability coefficient of .82 for the overall questionnaire” should specify the time interval between administrations, the type of coefficient used, and the sample in which reliability was estimated. More importantly, the authors should report reliability estimates derived from the present sample, preferably McDonald’s omega or Cronbach’s alpha for the total scale and relevant dimensions at pretest and posttest. Reliance solely on coefficients from previous studies does not establish that the instrument operated reliably in the current clinical sample.

The intervention paragraph is too general to permit replication. The description beginning “The first intervention group received Parent–Child Interaction Therapy” should specify the number of sessions, session frequency, session duration, treatment setting, format, participating family members, therapist qualifications, supervision arrangements, and criteria for

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completing each treatment phase. Standard Parent–Child Interaction Therapy is typically competency-based rather than merely session-based; therefore, the manuscript should state whether parents were required to achieve mastery criteria before progressing from child-directed interaction to parent-directed interaction and whether standard coding systems were used to assess skill acquisition.

The description of the Coping Cat intervention similarly lacks essential procedural detail. The sentence "The second intervention group received cognitive behavioral therapy based on the Coping Cat program" should clarify which edition or adaptation of the program was used, whether it retained the standard individual format, how many sessions were delivered, whether exposure tasks were included, and how the protocol was modified for children with oppositional symptoms rather than primary anxiety disorders. Since Coping Cat was designed principally for childhood anxiety, the theoretical and clinical rationale for applying it to children with oppositional defiant symptoms must be strengthened, particularly if participants were not required to present clinically significant anxiety.

Treatment fidelity requires objective documentation rather than the general statement that it "was supported through adherence to the principal components of each therapeutic model." The authors should report whether sessions were audio- or video-recorded, whether fidelity checklists were completed, what proportion of sessions was independently rated, and whether interrater agreement was calculated. Therapist effects should also be addressed. If the same therapist delivered both interventions, the risk of allegiance and contamination should be discussed; if different therapists delivered the interventions, differences in training, experience, and therapeutic competence should be reported.

The control condition should be characterized more precisely. The manuscript states that the control group "received no intervention during the study period and remained on a waiting list," but it is unclear whether participants continued routine educational, medical, pharmacological, or counseling services. The authors should specify whether treatment as usual was permitted, monitored, or prohibited and whether any control-group participants initiated new services during the study. Attrition, protocol deviations, and adverse events should be reported for all three groups. A participant-flow diagram would also strengthen transparency, even if the journal does not require full CONSORT formatting.

The qualitative sampling procedure requires substantial elaboration. The methods state that "21 parent–child dyads from the two intervention groups participated in semi-structured interviews," but the authors do not explain how these dyads were chosen from the 30 eligible intervention participants. The selection strategy should be described, including whether maximum-variation, criterion, intensity, or convenience sampling was used and whether participants were selected according to quantitative response patterns, such as high responders, low responders, or contrasting cases. In a sequential explanatory design, purposive selection based on quantitative outcomes would be methodologically preferable and should be explicitly documented.

Response: Revised and uploaded the manuscript.

2. Revised

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

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