

The Effectiveness of Emotional Schema Therapy on Defense Mechanisms, Emotional Distress Tolerance, and Psychosomatic Symptoms in Married Women with Psychosomatic Disorder Symptoms

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1. Round 1

1.1. Reviewer 1

Reviewer:

The Introduction repeatedly states that psychosomatic symptoms are associated with emotional suppression and maladaptive defenses; however, the theoretical integration between emotional schema theory and psychosomatic symptom formation remains somewhat descriptive rather than analytically developed. For example, the paragraph beginning with “Emotional schema therapy provides a theoretically relevant approach for addressing these processes” would benefit from a clearer mechanistic model explaining how emotional schemas influence autonomic activation, somatic amplification, and defensive somatization pathways.

The authors indicate that assumptions of MANCOVA were tested; however, important statistical details are omitted. The manuscript states that “all significance values were greater than .05,” yet the actual Kolmogorov–Smirnov statistics, Levene statistics, Box’s M test results, and regression slope interaction statistics are not reported. These values should be presented explicitly for transparency and reproducibility.

Table 1 reports substantial posttest improvements in the experimental group, especially for emotional distress tolerance and mature defenses, but the manuscript does not provide confidence intervals or adjusted means after covariance control. Including adjusted posttest means and 95% confidence intervals would strengthen the interpretability of the ANCOVA findings.

The interpretation of the “negative appraisal of distress” component in Table 2 appears conceptually confusing. An increase from 13.07 to 18.40 is interpreted as improvement, but the manuscript does not clarify whether higher scores on this subscale indicate more adaptive or more maladaptive functioning. This creates interpretive ambiguity and requires immediate clarification.

The Results section repeatedly reports statistically significant findings but provides minimal clinical interpretation of effect sizes. For example, emotional distress tolerance showed $\eta^2 = .53$, which represents a very large effect; however, the discussion does not adequately contextualize the practical or clinical magnitude of this change.

Authors revised the manuscript and uploaded the document.

1.2. Reviewer 2

Reviewer:

The statement “This issue is especially important among married women, who may experience multiple family, emotional, and social pressures” risks overgeneralization and requires empirical support from gender-specific psychosomatic literature. The manuscript currently relies primarily on conceptual reasoning rather than evidence-based epidemiological or psychosocial findings regarding married women’s vulnerability to psychosomatic symptoms. Additional contemporary sources should be incorporated.

The literature review does not sufficiently distinguish emotional schema therapy from related interventions such as emotion-focused therapy, cognitive behavioral therapy, acceptance and commitment therapy, and dialectical behavior therapy. Because the intervention is presented as uniquely suited for psychosomatic symptoms, the manuscript should explicitly articulate what differentiates emotional schema therapy from broader emotion regulation approaches.

The authors mention “symptoms of psychosomatic disorder” throughout the paper, but the diagnostic criteria and clinical threshold used to identify participants remain unclear. The manuscript does not specify whether participants met DSM-5-TR diagnostic criteria, received clinical interviews, or were identified solely through self-report questionnaires. This ambiguity substantially weakens the study’s diagnostic precision and threatens construct validity.

In the Method section, the sentence “with at least 15 participants considered for each group” is insufficient as a justification for sample size determination. The study should include an a priori power analysis specifying expected effect size, alpha level, desired power, and statistical assumptions. The current explanation appears arbitrary and does not demonstrate adequate methodological rigor.

The manuscript does not report participant demographic characteristics beyond marital status. Important variables such as age, educational level, employment status, duration of marriage, psychiatric medication use, medical comorbidities, and socioeconomic status should be reported because these variables may substantially influence psychosomatic symptoms and emotional regulation processes.

The intervention section lacks sufficient procedural detail for replication. For example, the manuscript states that “adaptive alternatives” and “healthier strategies for managing distress” were introduced, but it does not describe the specific techniques, exercises, homework assignments, or therapist interventions used during sessions. A more structured session-by-session protocol table or appendix is strongly recommended.

The manuscript does not identify the therapist qualifications, training background, supervision process, or treatment fidelity procedures. Since therapist competence and adherence are critical in psychotherapy research, the absence of fidelity monitoring raises concerns regarding intervention consistency and reproducibility.

The control group received no intervention during the study period, which introduces the possibility that observed improvements were partially attributable to nonspecific therapeutic factors such as attention, expectancy, or group support. The study design would be substantially stronger with an active comparison condition or placebo-control intervention.

Authors revised the manuscript and uploaded the document.



2. Revised

Editor's decision: Accepted.

Editor in Chief's decision: Accepted.