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Comparing the Effectiveness of Dialectical Behavior Therapy and Metacognitive Therapy on Cognitive Fusion and Self-Criticism in Women with Generalized Anxiety Disorder

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1. Round 1

1.1. Reviewer 1

Reviewer:

The eligibility paragraph states that participants were required to obtain “a score of at least 10 on the Generalized Anxiety Disorder-7 Questionnaire” and also receive diagnostic confirmation from a psychiatrist according to DSM-5-TR criteria. The diagnostic procedure needs clarification. Please specify whether a structured or semi-structured diagnostic interview was used, the name of the interview if applicable, whether psychiatrists received standardized diagnostic instructions, and whether inter-rater reliability was assessed. Because the GAD-7 is a screening/severity measure rather than a stand-alone diagnostic instrument, the manuscript should clearly distinguish screening from formal diagnostic confirmation.

In the GAD-7 instrument paragraph, the authors should verify all scoring information carefully. The seven items are scored from 0 to 3, producing a possible total score of 0–21; therefore, any statement elsewhere in the manuscript indicating a 0–20 range should be corrected. The authors should also clarify whether the additional functional-impairment question was used analytically or only descriptively, because it is not included in the conventional total GAD-7 score. Since a cutoff score of 10

constituted an inclusion criterion, the rationale for selecting this threshold should also be explicitly linked to its established screening interpretation.

The manuscript states that statistical assumptions were examined, but the actual results of those tests should be reported. Specifically, the authors should provide information concerning normality or distributional adequacy, homogeneity of variance, and Mauchly's test of sphericity for each outcome. If sphericity was violated, the manuscript should identify whether Greenhouse–Geisser or Huynh–Feldt corrections were applied and report the corrected degrees of freedom. With only 15 participants per condition, violations of distributional assumptions may have greater consequences, so simply stating that assumptions were "evaluated" is not sufficient for methodological transparency.

The Results section should explicitly establish baseline comparability among the three groups. Before attributing post-intervention differences to treatment, the authors should report whether DBT, MCT, and control participants differed at baseline in age, education, marital status, GAD symptom severity, cognitive fusion, internalized self-criticism, comparative self-criticism, or other clinically relevant variables. Statistical testing of baseline outcome differences should not replace descriptive assessment, but group-specific means and standard deviations are necessary. If important baseline imbalance was present, a more appropriate analytic strategy such as a mixed model or covariate-adjusted analysis should be considered.

Authors revised the manuscript and uploaded the document.

1.2. Reviewer 2

Reviewer:

The statement that participants had "no current use of psychiatric medications based on self-report and information available in participants' clinical records" requires further methodological justification. Excluding all participants receiving pharmacotherapy may create a highly selected GAD sample that differs from routine clinical populations, thereby limiting external validity. The authors should explain why medication use was an exclusion criterion, how medication status was verified, whether recent discontinuation was assessed, and whether other psychoactive medications were considered. The Discussion should also acknowledge that the results may not generalize to women receiving combined pharmacological and psychological treatment.

The manuscript does not provide sufficient information regarding psychiatric comorbidity. The DSM-5-TR diagnosis of GAD frequently co-occurs with depressive disorders, other anxiety disorders, trauma-related disorders, insomnia, and personality-related difficulties, all of which could influence cognitive fusion and self-criticism. The eligibility criteria should state whether major psychiatric comorbidities were assessed and whether any diagnoses were exclusionary. If participants with comorbid conditions were retained, their prevalence should be reported by treatment group and considered when interpreting treatment effects. This is particularly important because the selected dependent variables are transdiagnostic rather than specific to GAD.

The intervention paragraph states that DBT was delivered "in eight 90-minute group sessions held once weekly," but the manuscript should clarify the extent to which this intervention represents standard DBT versus a DBT skills-training adaptation. Comprehensive DBT ordinarily includes multiple treatment modes, whereas the described protocol primarily consists of mindfulness, distress tolerance, emotion regulation, and interpersonal-effectiveness skills. The intervention should therefore be labeled precisely, for example as a DBT skills-training intervention if appropriate, and the authors should explain the rationale for adapting the model to eight sessions for GAD. This distinction is important for treatment reproducibility and for preventing readers from interpreting the findings as evidence regarding comprehensive DBT.

The metacognitive therapy paragraph similarly requires greater attention to treatment-model fidelity. The sentence stating that the first MCT session included "identification of periods of rumination" and several subsequent references to "rumination" and "negative beliefs about depression" appear more consistent with a depression-focused protocol than a GAD-specific MCT protocol. Given that worry rather than depressive rumination is the central repetitive-thinking process in GAD, the authors should explain whether the Larijani protocol was modified for generalized anxiety disorder and, if so, how. References to

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"negative beliefs about depression" should be reconsidered unless depressive beliefs were intentionally targeted and clinically justified in this GAD sample.

The manuscript reports that "the content and face validity of the intervention protocol were assessed by experts" and provides Cohen's kappa coefficients of .82 for DBT and .80 for MCT. This procedure is insufficiently described and conceptually unclear. Cohen's kappa is ordinarily used to quantify agreement between raters classifying categorical observations; therefore, the authors should specify the number and qualifications of experts, exactly what they rated, the response categories used, how kappa was calculated, and why kappa was considered an appropriate measure of intervention content validity. If conventional content-validity indices such as CVI or CVR were actually used, the statistical terminology should be corrected.

The statement that both interventions were "implemented by the researcher" raises a potentially important therapist-allegiance and performance-bias issue. Please provide the researcher's clinical qualifications, professional training in DBT and MCT, experience delivering each intervention, and whether clinical supervision was provided. More importantly, treatment fidelity should be documented through session checklists, independent ratings, audio/video review, supervision records, or another standardized procedure. Because a single therapist delivered both active conditions, even subtle differences in enthusiasm, competence, adherence, or expectancy could contribute to the observed superiority of DBT.

The description of the control group as receiving no study intervention requires clarification. Please state whether this was a wait-list control, treatment-as-usual control, or no-treatment control, and specify what clinical services participants were permitted to receive during the eight-week intervention and two-month follow-up periods. Given that participants had a diagnosed anxiety disorder, the ethical management of the control condition should be explained, including whether participants were offered treatment after completion of follow-up. Monitoring for outside psychotherapy, psychiatric medication initiation, or other mental health interventions during the study should also be reported because such exposure could contaminate group comparisons.

The Data Analysis section states that "repeated-measures analysis of variance" was used for cognitive fusion, internalized self-criticism, and comparative self-criticism, but the manuscript should report the full inferential model rather than only general statements about statistical significance. For each outcome, readers should be provided with the time effect, group effect, and group × time interaction, including F statistics, degrees of freedom, exact p values, and an appropriate effect-size estimate such as partial eta squared. Pairwise Bonferroni comparisons should include mean differences, confidence intervals, and adjusted p values. Without these statistics, it is difficult to evaluate the magnitude, precision, and clinical relevance of the treatment effects.

Authors revised the manuscript and uploaded the document.

2. Revised

Editor's decision: Accepted.

Editor in Chief's decision: Accepted.

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