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A Comparison of the Effectiveness of Dialectical Behavior Therapy and Metacognitive Therapy on Self-Injurious Behaviors and Self-Criticism in Women with Major Depressive Disorder

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1. Round 1

1.1. Reviewer 1

Reviewer:

The comparative rationale for selecting DBT and MCT requires greater specificity. The Introduction appropriately describes DBT as targeting emotion regulation and behavioral coping and MCT as targeting rumination, attentional processes, and metacognitive beliefs; however, the manuscript ultimately states only that the two approaches may “improve emotion regulation, reduce maladaptive cognitive processes, and alleviate depressive symptoms.” Please articulate explicit comparative hypotheses. For example, one could theoretically expect DBT to exert stronger effects on self-injurious behavior because of its direct focus on distress tolerance and behavioral alternatives, whereas MCT might exert stronger effects on internalized self-criticism because of its direct focus on repetitive self-referential cognition. Stating such hypotheses would make the comparative design more theoretically informative.

The sampling procedure needs clarification. The Methods state that “Forty-eight eligible volunteers were selected through nonrandom purposive sampling and randomly assigned to two experimental groups and one control group.” Please describe exactly how potential participants were approached, how many women were screened, how many were excluded and for what

reasons, and how many declined participation. A participant-flow diagram would be valuable. In addition, the randomization procedure should be reported in reproducible detail, including who generated the allocation sequence, the method used to generate random assignments, whether allocation concealment was implemented, and whether assessors were blinded to group membership.

The intervention fidelity procedures are insufficiently described. For DBT, the manuscript reports that experts evaluated content and face validity and that "Cohen's kappa coefficient was calculated… (κ = .79)," while MCT reports κ = .82. It is unclear precisely what was coded, who the raters were, how many sessions were observed, and whether kappa represented agreement on protocol content before treatment or actual therapist adherence during treatment. Please distinguish intervention-development validity from treatment-fidelity assessment. For a comparative psychotherapy trial, adherence should ideally be assessed from session recordings or structured checklists by independent raters, with separate indices for DBT and MCT fidelity and possible treatment contamination.

Therapist-related information is missing and represents a potentially important source of bias. Please report how many therapists delivered DBT and MCT, their professional qualifications, years of clinical experience, formal training in the respective interventions, supervision arrangements, and whether the same therapist delivered both treatments. If different therapists administered the two approaches, therapist effects could be confounded with treatment effects; if one therapist delivered both, allegiance and contamination effects become relevant. This information is essential for evaluating internal validity and reproducibility of the trial.

The control condition should be defined more explicitly. The Methods describe two active interventions but provide no detailed account of what occurred with participants assigned to the control group during the eight-week intervention period. Please state whether this was a wait-list, treatment-as-usual, no-treatment, attention-control, or another condition, and whether control participants received any psychological or medical care during this period. The interpretation that DBT and MCT were "effective" depends strongly on the comparator; superiority to a no-treatment control demonstrates a different level of evidence than superiority to an active intervention.

Authors revised the manuscript and uploaded the document.

1.2. Reviewer 2

Reviewer:

The sample-size justification is currently absent and should be added. The manuscript reports 16 participants per group but does not indicate whether this number resulted from an a priori power analysis. Given the three-group repeated-measures design and the manuscript's principal objective of comparing DBT directly with MCT, statistical power for detecting between-treatment differences is especially important. Please report the assumed effect size, α level, statistical power, number of groups and measurements, anticipated attrition, and software used for sample-size estimation. The nonsignificant DBT–MCT differences cannot be interpreted confidently as equivalence if the study was insufficiently powered to detect clinically meaningful differences.

The diagnostic procedure for major depressive disorder should be described more rigorously. The Methods report "confirmation of MDD by an experienced psychiatrist at the clinic through a diagnostic interview based on the text-revised fifth edition of the Diagnostic and Statistical Manual of Mental Disorders." Please specify whether a standardized structured or semi-structured diagnostic interview was employed, such as SCID-based assessment, or whether diagnosis was based on an unstructured clinical interview. The qualifications and diagnostic training of the psychiatrist should also be stated. Furthermore, relevant psychiatric comorbidities should be reported because conditions such as borderline personality disorder, anxiety disorders, eating disorders, and posttraumatic stress disorder could substantially influence both self-injury and treatment response.

The use of a BDI-II score "one standard deviation above the mean (32)" as an inclusion criterion needs methodological justification. It is unclear what reference population produced the mean and standard deviation from which the cutoff of 32 was derived, and a score of 32 conventionally reflects relatively severe depressive symptomatology rather than simply diagnostic

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presence. Please explain why this threshold was selected, provide the source supporting it, and distinguish clearly between use of the BDI-II for symptom severity and the diagnostic interview for establishing MDD. Otherwise, the inclusion criterion risks unnecessarily narrowing the clinical spectrum and limiting external validity.

The manuscript should provide more detailed information about medication status and participant safety. The Methods state that participants had "no psychiatric medication use" and no substance use by self-report, yet the population consisted of women with MDD and clinically relevant self-injurious behavior. Please clarify whether women currently receiving antidepressant medication were excluded, whether medication discontinuation was required, and how ethical concerns surrounding treatment withholding were addressed. Given the presence of self-injurious behavior, the manuscript should also report the suicide/self-harm risk assessment procedure, criteria for referral or withdrawal, emergency management protocol, and whether participants had access to clinical support during the study.

The operationalization of the principal self-injury outcome requires reconsideration. The manuscript states that the "functional section can be used in inferential statistical analyses; scores range from 0 to 78, with higher scores indicating more self-injurious behaviors." This wording may be psychometrically problematic because the functional section primarily assesses reasons/functions associated with self-injury rather than the frequency or severity of self-injurious acts themselves. Please clarify exactly which ISAS score was analyzed and justify its interpretation as "self-injurious behaviors." If the functional score was used, the outcome should be described more accurately, or behavioral frequency/severity data from the ISAS behavioral section should also be analyzed.

The psychometric quality of the comparative self-criticism subscale deserves explicit attention. The Methods report a Persian Cronbach's alpha of only .55 for comparative self-criticism, which is below commonly accepted standards for internal consistency. This is a potentially important measurement limitation because comparative self-criticism is one of the principal dependent variables. Please report internal consistency coefficients calculated from the present sample at baseline, and preferably at each measurement point. If reliability remains low, interpretation of the treatment effect on this subscale should be appropriately qualified, and consideration should be given to whether measurement error may have affected estimates of treatment efficacy.

Authors revised the manuscript and uploaded the document.

2. Revised

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

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