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Comparing the Effectiveness of Self-Compassion Therapy and Contextual Schema Therapy on Body Image Concerns in Women with Breast Cancer After Mastectomy

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1. Round 1

1.1. Reviewer 1

Reviewer:

In the Introduction paragraph beginning with “The extent of the psychological harm associated with mastectomy,” contextual schema therapy is characterized as a third-wave therapeutic approach. The theoretical justification for this classification remains insufficiently developed. The authors should explain how contextual schema therapy differs from conventional schema therapy, particularly regarding functional contextualism, acceptance, cognitive defusion, psychological flexibility, and schema mode modification. A clearer conceptual distinction is necessary because several cited studies investigate conventional schema therapy rather than contextual schema therapy, and their findings cannot automatically be treated as evidence supporting the effectiveness of the specific intervention examined in this study.

In the paragraph beginning with “Self-compassion therapy, in turn, emphasizes compassionate acceptance of suffering,” the theoretical foundations of the intervention require further elaboration. The authors should distinguish Neff's multidimensional conceptualization of self-compassion from Gilbert's compassion-focused therapeutic framework and clarify how these theoretical perspectives inform the intervention protocol. Specifically, the manuscript should explain whether the treatment primarily targets self-kindness, common humanity, mindfulness, shame reduction, self-criticism, or threat-related emotional

regulation. This clarification would strengthen intervention construct validity and provide a more coherent explanation of the anticipated changes in postoperative body image concerns.

In the Body Image Concern Inventory paragraph, the authors report “a validity coefficient of 0.98 based on internal consistency using Cronbach’s alpha and a Cronbach’s alpha internal consistency coefficient of 0.90.” This statement contains a fundamental psychometric ambiguity because Cronbach's alpha estimates internal consistency reliability rather than validity. The authors should consult the original instrument development study and the Iranian validation study to distinguish evidence of reliability from evidence of construct, convergent, criterion-related, or factorial validity. Furthermore, the internal consistency of the instrument within the present sample should be reported, preferably using both Cronbach's alpha and McDonald's omega where appropriate. The empirical justification for the cutoff score of 57 should also be clarified.

In the Procedure paragraph describing “eight weekly 90-minute sessions of self-compassion therapy, based on Gilbert’s protocol,” the manuscript provides insufficient information regarding treatment standardization and intervention fidelity. Gilbert's cited publication discusses the theoretical origins and nature of compassion-focused therapy but does not necessarily constitute a complete standardized eight-session treatment manual. The authors should identify the precise manual or adaptation procedure used to develop the intervention, explain whether its content was reviewed by independent clinical experts, and report therapist qualifications, professional experience, intervention-specific training, supervision procedures, and methods of assessing adherence to the protocol.

Authors revised the manuscript and uploaded the document.

1.2. Reviewer 2

Reviewer:

In the Introduction paragraph stating that “no study has directly compared contextual schema therapy with self-compassion therapy for body image concerns in women with breast cancer after mastectomy,” the novelty claim is expressed too categorically. The authors should explain the scope of the literature review supporting this assertion, including the databases consulted, relevant search terms, publication period, and consideration of related comparative interventions. Existing research comparing schema-oriented and compassion-based interventions in other medical populations should also be critically discussed. The research gap should be formulated around the specific population, intervention protocols, outcome variable, and follow-up assessment rather than relying exclusively on an unqualified assertion of originality.

In the opening paragraph of the Materials and Methods section, the study is described as quasi-experimental despite the subsequent statement that participants were randomly assigned to three groups using simple random allocation. The authors should clarify the methodological basis for this classification. Nonprobability recruitment does not, by itself, preclude classification as a randomized controlled trial when treatment allocation is genuinely randomized. The manuscript should distinguish random sampling from random assignment and provide sufficient information about sequence generation, allocation concealment, implementation of the allocation procedure, and possible sources of selection bias. The study design should subsequently be labeled in accordance with the actual methodological procedures.

In the Materials and Methods paragraph stating that “the sample size was estimated at approximately 15 participants per group,” the sample size justification is insufficiently reproducible. The authors should identify the statistical software or computational procedure used for the power analysis and report the assumed correlation between repeated measurements, nonsphericity correction factor, number of groups, number of assessment occasions, and specific statistical effect for which power was calculated. Moreover, Cohen's conventional benchmarks classify an f value of 0.30 as intermediate between medium and large effects rather than unequivocally large. The empirical or theoretical rationale for selecting this effect size should therefore be provided.

In the Procedure paragraph stating that the Body Image Concern Inventory was administered to 200 women and that “45 patients with the highest body image concern scores were selected as the final sample,” the recruitment procedure raises concerns regarding selection bias, restricted score variability, and regression to the mean. The authors should report how many of the 200 screened participants met all eligibility criteria, how many declined participation, and whether selection was based

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exclusively on scores exceeding 57 or on ranking participants according to symptom severity. A participant flow diagram documenting screening, eligibility assessment, allocation, attrition, and final analysis would substantially improve methodological transparency.

In the paragraph describing the inclusion and exclusion criteria, the authors identify breast cancer diagnosis, a history of mastectomy, age between 20 and 65 years, and elevated body image concerns as principal eligibility requirements. However, potentially important clinical characteristics remain insufficiently addressed. The authors should clarify whether cancer stage, time elapsed since surgery, unilateral versus bilateral mastectomy, breast reconstruction status, ongoing chemotherapy or radiotherapy, hormonal treatment, cancer recurrence, psychiatric comorbidity, and psychotropic medication use were assessed or controlled. These factors may independently influence body image concerns and psychological treatment responsiveness, potentially introducing clinically meaningful heterogeneity into the study sample.

Authors revised the manuscript and uploaded the document.

2. Revised

Editor's decision: Accepted.
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