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The Effectiveness of Trauma-Focused Mentalization-Based Group Therapy on Psychological Distress and Cognitive Errors in Women with War Experience

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1. Round 1

1.1 Reviewer 1

Reviewer:

In the paragraph beginning with "Psychological distress is a broad clinical construct that can include anxiety...", the construct of psychological distress is described conceptually, yet its distinction from PTSD, depression, and generalized anxiety remains unclear. Because the study focuses on trauma survivors, the authors should explicitly explain why psychological distress (measured by the K10) was selected as the primary outcome instead of disorder-specific measures and discuss its conceptual overlap with trauma-related psychopathology.

The paragraph beginning "Cognitive errors are another clinically important outcome in trauma-exposed populations" provides an overview of cognitive distortions but does not sufficiently explain why cognitive errors are theoretically expected to change following mentalization-based therapy. The authors should expand this section by explicitly connecting cognitive distortions to reflective functioning and explaining the proposed causal pathway through which improved mentalization reduces maladaptive cognitive processing.

In the paragraph beginning "Mentalization refers to the capacity to understand one's own behavior...", the theoretical background is well written; however, it primarily summarizes the general concept of mentalization without discussing trauma-

specific adaptations of Mentalization-Based Therapy (MBT). Since the intervention is described as trauma-focused MBT, the authors should clearly differentiate standard MBT from trauma-focused MBT and identify which components were specifically modified for trauma-exposed women.

In the paragraph interpreting Table 3, the manuscript states that "The partial eta squared value indicates a large multivariate effect." While this interpretation is correct, the discussion should place the observed effect size in context by comparing it with previous MBT or trauma intervention studies. Reporting observed statistical power or confidence intervals for effect sizes would further strengthen interpretation.

Regarding Table 4, the authors employed ANCOVA despite having three repeated measurements (pre-test, post-test, follow-up). The manuscript should justify why repeated-measures ANCOVA, mixed-effects modeling, or linear mixed models were not selected, as these approaches are generally more appropriate for repeated longitudinal data and allow more robust handling of within-subject correlations.

Authors revised the manuscript and uploaded the updated document.

1.2 Reviewer 2

Reviewer:

The final paragraph of the Introduction states, "The main hypothesis was that women receiving the intervention would show lower psychological distress and fewer cognitive errors..." The hypotheses remain relatively general. The manuscript would benefit from explicitly identifying the primary and secondary hypotheses and clarifying whether maintenance of treatment effects at follow-up represents a confirmatory hypothesis or an exploratory objective.

In the Methods section under Participants and Sampling, the sentence "The statistical population consisted of women with war experience in Tabriz in 1404." raises several methodological concerns. First, the use of the Persian calendar year should be converted into the Gregorian calendar to comply with international publication standards. Second, the manuscript should clarify precisely how "war experience" was operationally defined, including whether participants were veterans, internally displaced persons, refugees, civilians exposed to missile attacks, or relatives of casualties.

In the Eligibility Criteria section, the manuscript states that participants were required to demonstrate "at least a moderate level of psychological distress." However, the threshold used for determining moderate distress is not reported. The authors should specify the exact K10 cut-off score employed, provide a supporting citation, and explain whether clinical interviews were used to verify eligibility or whether inclusion relied solely on self-report questionnaires.

The Intervention section describes the protocol as "adapted from trauma-focused mentalization-based principles." This description is insufficient for replication. The manuscript should specify whether the intervention was adapted from an existing manual or developed by the authors. If author-developed, details regarding expert validation, pilot testing, treatment fidelity, therapist training, supervision procedures, and adherence monitoring should be included.

Table 1 provides a comprehensive session-by-session protocol; however, several sessions include sophisticated therapeutic components (e.g., grief work, meaning reconstruction, cognitive restructuring, and relapse prevention) within only ten sessions. The authors should justify how these multiple therapeutic objectives were realistically achieved within the allocated treatment duration and discuss whether treatment fidelity was assessed across sessions.

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In the Measures section, the manuscript states that "Psychological distress was measured with the Kessler Psychological Distress Scale" and "Cognitive errors were measured with the Cognitive Errors Questionnaire." However, no psychometric properties are reported for the present sample. The manuscript should report internal consistency coefficients (Cronbach's alpha or McDonald's omega), previous validation studies in the Iranian population, and reliability estimates calculated using the current dataset.

In the Statistical Analysis section, the authors mention that all statistical assumptions were satisfied, stating that "The reported significance levels for these assumption tests were greater than .05." However, no actual test statistics or p-values are presented. The manuscript should provide the results of Shapiro-Wilk, Levene's Test, Box's M Test, and homogeneity of regression slopes either within the text or in a supplementary table to allow readers to independently evaluate statistical assumptions.

Table 2 presents descriptive statistics across three measurement occasions, yet no confidence intervals or graphical presentation accompanies these findings. Including estimated marginal means with 95% confidence intervals or a longitudinal line graph would substantially improve interpretation of treatment trajectories and facilitate visualization of maintenance effects over time.

Authors revised the manuscript and uploaded the updated document.

2. Revised

Editor’s decision after revisions: Accepted.

Editor in Chief’s decision: Accepted.

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