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The Role of Spirituality Therapy Emphasizing the Teachings of Islam in Enhancing Resilience and Reducing Depressive Symptoms Among Families of Children with Autism

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1. Round 1

1.1. Reviewer 1

Reviewer:

The manuscript does not currently provide an a priori sample-size justification. Given that the study includes only 15 participants per group and uses covariance-based analyses with two dependent variables, statistical power is a serious concern. The authors should report whether a power analysis was conducted before recruitment, including the assumed effect size, α level, desired statistical power, number of groups, and number of covariates. If no a priori analysis was performed, this should be acknowledged as a methodological limitation. The unusually large reported effect sizes further increase the importance of demonstrating that the sample was adequate and that estimates are not unstable because of small-sample bias.

In the paragraph describing the Connor-Davidson Resilience Scale, the item numbering of the subscales appears internally inconsistent. For example, item 3 is apparently listed under both “control” and “spiritual influences,” and the item sequence for perceived personal competence is presented in an unusual order. The authors should verify the scoring structure against the validated version actually administered. In addition, the manuscript currently describes a 1-to-5 response format and a total

range of 25–125, whereas commonly used versions of the CD-RISC are often scored differently. The exact Persian version used, response anchors, scoring procedure, subscale structure, and total-score interpretation should therefore be checked carefully and reported from the original validation source rather than inferred from secondary descriptions.

The psychometric reporting for both outcome measures should include reliability estimates from the present sample, not only historical coefficients. The current instrument sections cite previous Cronbach's alpha and test–retest coefficients, but internal consistency can vary across populations and translations. The authors should report Cronbach's alpha, or preferably omega if available, for the CD-RISC and BDI-13 in the present sample. Because the study uses pretest and posttest measurements, reliability estimates at each assessment stage would be particularly informative. This is especially important because measurement error can substantially affect ANCOVA estimates in a small sample.

The BDI-13 paragraph should be revised for both terminology and psychometric clarity. The sentence "The measure assesses several domains of depressive symptomatology, including affective or emotional, cognitive, motivational, and physiological or somatic symptoms" is reasonable, but the manuscript should specify whether the BDI-13 was used purely as a continuous symptom-severity measure or whether categorical cutoffs were applied. If categorical interpretations were not used, they should not be implied. In addition, because the article refers to "depression" in several places, the authors should avoid implying a clinical diagnosis and instead consistently use "depressive symptoms" unless participants were assessed diagnostically.

Authors revised the manuscript and uploaded the document.

1.2. Reviewer 2

Reviewer:

In the Introduction, the paragraph beginning "A second major psychological construct relevant to families of children with autism is resilience" needs greater theoretical precision. The manuscript currently treats resilience partly as a trait, partly as a coping capacity, and partly as an outcome. Because the Connor-Davidson Resilience Scale is used as the primary measure, the authors should explicitly state the operational definition of resilience adopted in this study and explain how it corresponds to the CD-RISC conceptualization. The sentence referring to resilience as "a dynamic process" should also be reconciled with the use of a self-report scale that measures individual-level perceived resilience. Clarifying this issue is important because the theoretical construct and the measurement model should be aligned.

The paragraph stating that "Spirituality generally encompasses a person's search for meaning, purpose, transcendence, connection with the sacred, and a coherent framework for interpreting life experiences" should more carefully distinguish spirituality, religiosity, spiritual well-being, religious coping, and spirituality therapy. These constructs are related but not interchangeable. Because the intervention explicitly incorporates Qur'anic concepts, prayer, reliance on God, gratitude, forgiveness, and Islamic teachings, it appears to be a religiously integrated psychological intervention rather than a generic spirituality intervention. The authors should provide an operational definition of "Islamic spirituality therapy," explain its theoretical foundations, and clarify how it differs from religious counseling, spiritual education, and conventional psychotherapy incorporating religious content.

The final portion of the Introduction identifies an empirical gap, but the sentence "Fewer intervention studies have directly examined whether a structured spirituality therapy program grounded explicitly in Islamic teachings can simultaneously enhance resilience and reduce depressive symptoms among families of children with autism" should be strengthened. The authors should explicitly identify what is novel about the present study relative to prior studies on spiritual vitality in parents of children with ASD and spirituality therapy in other populations. At present, novelty appears to rest primarily on the combination of population and outcomes. The authors should explain whether the intervention protocol itself is novel, adapted from an existing protocol, or newly developed, and why the Khoy context provides a meaningful contribution rather than only a geographically different replication.

In the "Study Design and Participants" section, the manuscript states that "A total of 30 participants were selected and subsequently randomly assigned to an experimental group and a control group, with 15 participants in each group." The randomization procedure must be described in detail. It is insufficient to state that participants were randomly assigned. The

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authors should specify who generated the allocation sequence, which method was used, whether allocation concealment was implemented, and whether assignment occurred after baseline assessment. With a small sample of 30 participants, imbalance in important covariates is possible, so the manuscript should also report baseline comparability of the two groups in key demographic and clinical variables.

The participant recruitment procedure requires substantial clarification. The sentence “Participants were recruited using purposive and convenience sampling from eligible families attending these centers” does not identify inclusion and exclusion criteria. The authors should specify eligibility criteria for the caregiving parent, including minimum age, relationship to the child, duration of caregiving, literacy, willingness to participate in an explicitly Islamic intervention, and whether participants were required to have clinically relevant depressive symptoms. Criteria concerning the child should also be reported, including confirmed ASD diagnosis and age range. Exclusion criteria should cover concurrent psychological treatment, severe psychiatric disorders, medication changes if relevant, absence from intervention sessions, and incomplete questionnaire data.

Authors revised the manuscript and uploaded the document.

2. Revised

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

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