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Effectiveness of a Continuous Care Model for Treatment Adherence Based on the ACT Approach on Perceived Stress in Patients with Diabetes

Mina. Khajeh Babarsad[1], Mahtab. Moraveji[2], Mansour. Ali Mahdi[3*], Sayed Abbas. Haghayegh[4]

[1] Department of Health Psychology, Ki.C., Islamic Azad University, Kish, Iran
[2] Department of Nursing & Midwifery, Za.C., Islamic Azad University, Zanjan, Iran
[3] Department of Psychology, TeMS.C., Islamic Azad University, Tehran, Iran
[4] Department of Psychology, Na.C., Islamic Azad University, Najafabad, Iran

*** Corresponding author email address**: M.alimahdi@iau.ir

Editor	Reviewers
Izet Pehlić Full professor for Educational sciences, Islamic pedagogical faculty of the University of Zenica, Bosnia and Herzegovina izet.pehlic@unze.ba	**Reviewer 1:** Mahdi Khanjani Associate Professor, Department of Psychology, Allameh Tabataba'i University, Tehran, Iran. Email: khanjani_m@atu.ac.ir **Reviewer 2:** Zahra Yousefi Assistant Professor, Department of Psychology, Isfahan Branch (Khorasgan), Islamic Azad University, Isfahan, Iran. Email: Z.yousefi1393@khuisf.ac.ir

1. Round 1

1.1. Reviewer 1

Reviewer:

In the Study Design and Participants section, the sentence "Thirty eligible participants were selected through purposive sampling and randomly assigned to an experimental group (n = 15) and a control group (n = 15)" raises concerns regarding sample-size adequacy. No a priori power analysis or other sample-size justification is provided. The authors should report how the sample of 30 participants was determined, preferably using an a priori calculation based on the anticipated group-by-time interaction, significance level, statistical power, number of groups, number of repeated measurements, expected effect size, and assumed correlation among repeated measures. Given the relatively large reported partial η^2 values, the possibility of effect-size inflation in a small sample should also be acknowledged.

The participant recruitment process needs substantially greater detail. In the paragraph describing the population as "patients diagnosed with type 1 or type 2 diabetes who were living in Isfahan, Iran, in 2024," it is unclear where participants were identified and recruited. The authors should state whether recruitment occurred through diabetes clinics, hospitals,

endocrinology practices, primary healthcare centers, community organizations, or advertisements. The number of individuals screened, excluded before allocation, declining participation, and completing each assessment should be reported. A participant flow diagram would markedly improve transparency and allow readers to evaluate potential selection and attrition biases.

The intervention is described as an "ACT-based continuous care model for treatment adherence," but the theoretical and procedural integration of ACT with the continuous care model is not sufficiently operationalized. The intervention paragraph includes acceptance, mindfulness, emotional regulation, lifestyle management, family support, education, and problem solving, but it is unclear which elements derive specifically from ACT and which derive from continuous care or general diabetes education. The authors should explain the conceptual framework linking these components and explicitly map core ACT processes—acceptance, cognitive defusion, present-moment awareness, self-as-context, values, and committed action—to specific intervention sessions. This would strengthen intervention construct validity.

The control condition should be described more precisely. The Methods state that "the control group did not receive a psychological intervention during the study period and continued their routine medical care." The authors should define what routine care consisted of, including medical consultations, nursing education, medication management, glucose-monitoring support, dietary counseling, or other services. It should also be stated whether the experimental group received the same routine diabetes care in addition to the psychological intervention. Without this information, it is difficult to determine whether the observed effects can be attributed specifically to ACT-based continuous care rather than to differences in healthcare contact or attention.

The manuscript should address the potential influence of nonspecific treatment factors. Because the experimental group received eight 90-minute sessions whereas the control group received no psychological contact, the observed differences may partly reflect therapist attention, peer support, expectancy effects, group cohesion, or increased monitoring rather than the specific ACT-based components. The authors should acknowledge this limitation explicitly in the Discussion. Future studies should preferably use an active control condition, such as diabetes education, supportive counseling, or attention-matched health sessions, to distinguish specific intervention effects from nonspecific therapeutic effects.

The Statistical Analysis paragraph requires clarification regarding the repeated-measures model specification. The manuscript states that "The effectiveness of the ACT-based continuous care intervention on perceived stress was evaluated using a mixed repeated-measures analysis of variance," but it should explicitly identify time as the within-subject factor with three levels and group as the between-subject factor with two levels. More importantly, the authors should state whether baseline values were incorporated solely as the first repeated measurement or whether any baseline adjustment was undertaken. Given the small sample, the authors should also explain how missing data were handled and whether analyses followed an intention-to-treat or complete-case approach.

Response: Revised and uploaded the manuscript.

1.2. Reviewer 2

Reviewer:

The inclusion criterion combining patients with type 1 and type 2 diabetes requires methodological justification. The sentence "The inclusion criteria were a confirmed diagnosis of type 1 or type 2 diabetes" treats two clinically distinct diseases as a single population, although treatment regimens, age of onset, insulin dependence, disease burden, and self-management demands can differ substantially between these groups. The authors should report the number and proportion of participants with each diabetes type in each study arm and indicate whether diabetes type was balanced between groups. Ideally, a sensitivity analysis or at least a discussion of possible heterogeneity attributable to diabetes type should be included.

The demographic description in the Findings section is currently insufficiently quantitative. The manuscript states that "The participants in the experimental and control groups were generally comparable in terms of their demographic characteristics" and that the groups showed "approximately similar" distributions in sex, marital status, and education. These statements should be replaced or supplemented with exact frequencies, percentages, means, standard deviations, and inferential baseline

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comparisons where appropriate. In particular, mean age and standard deviation should be provided separately for each group, rather than only stating the age range of 20–40 years, so that baseline comparability can be evaluated objectively.

The Data Collection Tool section should more clearly identify which version of the Perceived Stress Scale was administered. The manuscript describes the PSS generically but later cites psychometric evidence for the "PSS-10." The authors should explicitly state that the 10-item version was used, report its possible total score range, identify the positively worded items that are reverse-scored, and explain whether the Persian version was used exactly as validated or whether any wording was modified. This is particularly important because the reported group means near 50 appear incompatible with the conventional PSS-10 scoring range of 0–40. The discrepancy must be resolved because it raises a fundamental concern regarding either the instrument version, the scoring procedure, or the reported descriptive statistics.

Closely related to the preceding issue, the descriptive results require verification because the reported pretest means of 49.80 and 49.60 cannot occur if the conventional PSS-10 scoring method of 0–4 per item is used, yielding a total range of 0–40. The authors should audit the raw dataset, scoring algorithm, reverse scoring, and data-entry procedures and then revise either the Methods or Results accordingly. If a different PSS version was used, such as the 14-item scale, this must be clearly stated throughout the manuscript, and the validity evidence cited should correspond to that exact version. This issue should be resolved before any interpretation of treatment effects is considered reliable.

The intervention description is useful but insufficient for replication. The paragraph beginning "The experimental group participated in an eight-session ACT-based continuous care program" should identify who delivered the intervention, including professional discipline, academic qualifications, ACT training, clinical experience, and supervision arrangements. The authors should also indicate whether a written manual was used, whether sessions were individual or group-based, the number of participants per group session if applicable, and whether treatment fidelity was assessed using checklists, session recordings, independent raters, or supervision. Without these details, intervention reproducibility and internal validity remain difficult to evaluate.

Response: Revised and uploaded the manuscript.

2. Revised

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

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