Reviewer's report

Title: Success/failure condition influences attribution of control, negative affect, and shame among patients with Depression in Singapore

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Reviewer: Michael Moore

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The manuscript aims to examine differences between individuals suffering from Major Depressive Disorder (MDD; n = 72) and non-affected control participants (n = 73) in response to a Success or a Failure task and attributions following it. Results indicated that MDD participants demonstrated greater increases in negative affect (NA) in both conditions and more likely to make an external attribution for success and an internal attribution for failure.

The author(s) studied an interesting topic and make a good case for why replication in an Asian population adds value to the literature. However, the manuscript suffers from issues which dampen the enthusiasm that can be expressed for it.

1. It was unclear to me why the authors framed their hypotheses on post-task NA and shame. Wouldn't it be more interesting to study change in NA or shame in response to the Success/Failure Task? To test this, the authors could use time (pre- and post-task) as a within-subjects variable in a repeated-measures ANOVA. It seems to me that the study is set-up to look at change over time, but the statistics don't test this, explicitly.

2. Effect size statistics should be included to accompany the t- and F-test results. These statistics are, unlike p-values, relatively un-influenced by sample size and would allow the authors to talk about the size of the effect of the independent variable in question, without this discussion being influenced by the possibility of the test being under- or over-powered.

3. Were participants told that they had succeeded (in the case of the Success Task) or failed (in the case of the Failure Task) regardless of whether or not they actually succeeded or failed at the recall task?

4. Am I understanding correctly, that hospital patients were compared to an amalgamation of hospital staff and university students? This comparison would seem to involve
changing more than one variable at once, making causal statements problematic. For example, why not compare hospital patients with MDD to patients without MDD? As it stands, it's impossible to say if differences are due to MDD, being a patient, or level of education (as university students would have, presumably, higher education than the general population, by definition).

5. Why was there no pre-task assessment of attributions of control? Including this would also have allowed the researchers to examine change in attributions as a result of the Success/Failure Task.

6. How many items were used to measure shame? Is it just one (with all of the issues of unreliability that come with a single-item measure)?

7. How was MDD diagnosed (e.g., the Structured Clinical Interview for DSM)? Who performed the diagnostic assessment? Were disorders other than MDD also assessed?

8. I was left wondering what, if any, prior research had been done looking to induce NA or shame using the same, or similar, Success/Failure Tasks. Any research looking at attributions of success or failure using the same tasks as a function of depression? The authors cite "a lack of similar studies in Asian populations" (pg. 5), but it is unclear if "a lack" means zero studies or just very few.

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

No

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

No

Are the conclusions drawn adequately supported by the data shown?
If not, please explain in your comments to the authors.

Yes
Are you able to assess any statistics in the manuscript or would you recommend an additional statistical review? If an additional statistical review is recommended, please specify what aspects require further assessment in your comments to the editors.

I am able to assess the statistics

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