

Health Anxiety and Quality of Life in Older Adults With Chronic Illness: The Mediating Roles of Emotion Regulation and Perceived Social Support

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E d i t o r	R e v i e w e r s
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1. Round 1

1.1. Reviewer 1

Reviewer:

The sampling description stating that “Tehran was divided into northern, southern, eastern, western, and central geographical sectors” needs considerably greater methodological detail. The authors should report the number and type of hospitals, health centers, geriatric clinics, and community centers selected from each sector, how these facilities were selected, how many participants were recruited from each facility, and whether recruitment was proportional to the estimated population of eligible older adults. Without these details, the claim of a “multistage sampling procedure” cannot be adequately evaluated, and it remains unclear whether the final sample approximates a probability sample or is primarily convenience-based within selected centers.

The inclusion criterion stating that participants should have “sufficient cognitive and sensory ability to understand and answer the questionnaire items” is too subjective and potentially introduces assessor-dependent selection. The manuscript should specify how cognitive capacity was determined. If a validated cognitive screening instrument such as the Mini-Mental State Examination, Montreal Cognitive Assessment, or another geriatric screening tool was used, the instrument and cutoff should be reported. If no standardized assessment was conducted, the authors should acknowledge this and explain exactly how

research assistants judged cognitive competence, because undetected cognitive impairment could materially affect the validity of self-reported anxiety, social support, emotion regulation, and quality of life.

The manuscript states that chronic illnesses included “cardiovascular disease, hypertension, diabetes mellitus, chronic respiratory disease, musculoskeletal disorders, chronic kidney disease, and other physician-confirmed conditions requiring ongoing medical care.” The definition of chronic illness should be standardized more rigorously. Please explain how diagnoses were verified—for example, through medical records, physician documentation, prescriptions, or participant self-report—and provide the distribution of the principal chronic diseases in the sample. Because disease type and severity may independently influence health anxiety and quality of life, the authors should also consider whether clinically heterogeneous conditions should be controlled statistically or examined in sensitivity/subgroup analyses.

In Table 1, the reported skewness and kurtosis values are uniformly modest, and the text concludes that these values indicate “no serious departure from univariate normality.” However, the SEM analysis also requires consideration of multivariate distributional assumptions. The Methods mention Mahalanobis distance but the Findings do not report the number of multivariate outliers, Mardia's coefficient, or how any identified outliers were treated. Please provide the relevant multivariate-normality diagnostics and explain whether maximum likelihood estimation was considered robust for the observed distributions or whether bootstrapped/robust standard errors were required.

The correlation table reports a substantial association between adaptive emotion regulation and quality of life ($r = .61$) and between perceived social support and quality of life ($r = .57$). Since all constructs were measured through self-report at the same assessment point, common-method variance should be empirically assessed rather than only mentioned as a limitation. The authors should consider an appropriate diagnostic, such as a common latent method factor approach within CFA or another defensible procedure, and report whether shared response method could account for a meaningful proportion of the observed covariance. This is especially important because the final model explains an unusually substantial 58% of variance in quality of life.

Response: Revised and uploaded the manuscript.

1.2. Reviewer 2

Reviewer:

In the Data Collection Tools section, the manuscript uses the Short Health Anxiety Inventory (SHAI) among participants who already have established chronic medical illnesses. This choice requires stronger justification because several SHAI items may function differently when respondents genuinely experience physical symptoms or realistic risk of disease progression. The authors should discuss the instrument's validity for medically ill older populations, report whether the Persian version has been psychometrically validated in Iranian older adults or clinical samples, and clarify whether any adaptation was made. Otherwise, elevated SHAI scores may partly reflect appropriate concern about real medical morbidity rather than pathological health anxiety.

The paragraph describing the WHOQOL-OLD states that it “consists of 24 items distributed across six domains,” yet the Findings report only a single total quality-of-life score. Please clarify the precise scoring procedure, including the possible range, whether raw or transformed scores were analyzed, and whether domain scores were examined before aggregation. Given the multidimensional nature of WHOQOL-OLD, it would also strengthen the article to report whether health anxiety and the proposed mediators have comparable relationships across autonomy, social participation, sensory abilities, intimacy, and other domains, rather than assuming that all quality-of-life dimensions behave identically.

A major conceptual and measurement issue concerns the statement, “For the mediation analyses, emotion regulation was modeled on the basis of the questionnaire's theoretically defined dimensions, with adaptive regulation being reflected primarily by greater cognitive reappraisal and lower reliance on maladaptive expressive suppression.” The standard Emotion Regulation Questionnaire measures cognitive reappraisal and expressive suppression as separate strategies and does not provide a validated “overall adaptive emotion regulation” score. The Findings nevertheless report an “Overall adaptive emotion regulation” mean

of 34.91 and use this construct in SEM. The authors must provide the exact formula and psychometric justification for creating this composite. Preferably, reappraisal and suppression should be modeled as separate constructs unless an independently validated scoring approach supports their combination.

Relatedly, the interpretation of expressive suppression as intrinsically “maladaptive” should be moderated. The functional consequences of suppression may depend on interpersonal context, cultural norms, and age, and this issue is particularly relevant in an Iranian older-adult sample. The manuscript should avoid automatically reverse-coding suppression into an adaptive-regulation composite without empirical validation. At minimum, the authors should test whether the proposed higher-order or composite emotion-regulation factor has adequate factorial validity and compare it with a two-factor ERQ model before using the composite as a mediator.

The Methods state that “prior to hypothesis testing, the internal consistency of all study measures was evaluated,” but reliability analysis alone is insufficient when translated instruments are administered to an older clinical population. The manuscript should report the exact Persian versions used, the source of each translation, previous validation evidence, and whether measurement invariance or factorial structure has been established in Iranian older adults. If the authors conducted confirmatory factor analyses for the current sample, construct-specific CFA information should be supplied, including the number of indicators, standardized loadings, error specifications, and any theoretically justified correlated residuals or item parcels.

Response: Revised and uploaded the manuscript.

2. Revised

Editor’s decision after revisions: Accepted.

Editor in Chief’s decision: Accepted.