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Predicting Somatoform Disorder Symptoms Based on Alexithymia, Self-Critical Rumination, and Body Monitoring: Examining the Mediating Role of Interpersonal Sensitivity

Saeedeh. Yousefi[1], Maryam. Mazloom[1*]

[1] Department of Psychology, TeMS.C., Islamic Azad University, Tehran, Iran

*** Corresponding author email address**: Mazloom@iau.ac.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 Method section, the manuscript refers to "fulfillment of the study inclusion criteria," yet the actual inclusion and exclusion criteria are not reported. This is a major methodological omission. The authors should explicitly identify age limits, diagnostic requirements, minimum duration or severity of somatic symptoms, literacy requirements, medication status, presence of major medical conditions, neurological disorders, psychotic disorders, substance-use disorders, cognitive impairment, and any other criteria used to determine eligibility. These details are particularly important because physical diseases and psychiatric comorbidities could substantially confound associations among body monitoring, alexithymia, interpersonal sensitivity, and symptom severity.

In the paragraph describing the Toronto Alexithymia Scale, the sentence "It consists of 20 items assessing three principal dimensions: difficulty identifying feelings (5 items), difficulty describing feelings (5 items), and externally oriented thinking (8 items)" appears psychometrically inconsistent with the standard TAS-20 item allocation, because these numbers sum to 18 rather than 20. The authors should verify the item counts against the validated version actually administered and correct this section. More importantly, the reported mean alexithymia score of 106.62 appears impossible if the TAS-20 consists of 20

items rated from 1 to 5, because the maximum possible total is 100. This discrepancy is substantial and suggests either a scoring error, transcription error, use of a different version, or incorrect table labeling; it must be resolved before the results can be considered reliable.

In Table 2, the use of GFI, NFI, PCLOSE, and Hoelter alongside CFI, TLI, and RMSEA should be reconsidered. Some of these indices, particularly GFI and Hoelter's critical N, are no longer emphasized in contemporary SEM reporting guidelines because of known limitations. The authors should add the standardized root mean square residual (SRMR), which is currently one of the most widely recommended complementary fit indices, and provide confidence intervals for RMSEA. Reporting RMSEA without its 90% confidence interval limits evaluation of model precision. The manuscript would also benefit from specifying explicit a priori criteria for acceptable fit rather than interpreting each observed statistic retrospectively.

The path from self-critical rumination to somatoform disorder symptoms is reported in Table 3 as $\beta = .485$, with a confidence interval from .399 to .576 and $p = .001$, while the total effect is .593. This is an important result, but the manuscript should explicitly identify the mediation as partial rather than simply stating that a significant indirect effect exists. Because both the direct and indirect pathways are significant and have the same positive direction, the pattern is consistent with complementary partial mediation. Reporting this formally would make the interpretation more rigorous and distinguish it from full mediation or inconsistent mediation.

The alexithymia findings require considerably more scrutiny than they currently receive. The model shows alexithymia negatively predicting interpersonal sensitivity ($\beta = -.164$), while alexithymia has a nonsignificant positive direct association with somatoform symptoms ($\beta = .104$) and a significant negative indirect effect ($\beta = -.052$). The Discussion appropriately notes that this may represent "an inconsistent mediation or suppression-like pattern," but this issue should be tested rather than only speculated about. The authors should examine zero-order correlations among alexithymia, interpersonal sensitivity, and somatic symptoms and compare these correlations with the multivariate path coefficients. If alexithymia is positively correlated with interpersonal sensitivity at the bivariate level but becomes negative after controlling for the other predictors, this would provide evidence of statistical suppression or multicollinearity and materially alter the interpretation.

The statement in the Discussion that "The negative direction of the effect indicates that, within the scoring structure used in the present study, higher alexithymia was indirectly associated with lower somatoform disorder symptom scores through interpersonal sensitivity" is mathematically correct but potentially misleading clinically. Given the substantial literature associating alexithymia positively with somatic symptoms, the manuscript should not present this inverse mediated association as a straightforward substantive effect without first ruling out coding errors, reverse-scored items, scoring direction problems, or suppression. The authors should verify that higher scores on both the TAS-20 and IPSM represent greater pathology and should report the correlation matrix to allow readers to determine whether the negative structural coefficient reflects the raw relationship or emerges only after adjustment for self-critical rumination and body monitoring.

Response: Revised and uploaded the manuscript.

1.2. Reviewer 2

Reviewer:

The description of the MAIA requires substantial conceptual revision. The manuscript labels the variable "Body Monitoring," whereas the instrument is the Multidimensional Assessment of Interoceptive Awareness and assesses multiple qualitatively distinct dimensions of interoceptive awareness. The reported subscales also do not fully correspond to the standard MAIA terminology, particularly "Sustained Attention to the Body" and the combination "Body Listening and Trusting." The authors should identify the exact version and validated Persian adaptation used, describe its scoring procedure, explain whether a total score is psychometrically justified, and clarify why the broad construct of interoceptive awareness is being operationalized as "body monitoring." This distinction is theoretically important because adaptive interoceptive awareness is not equivalent to maladaptive hypervigilance toward bodily symptoms.

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In Table 1, several descriptive statistics appear incompatible with the scoring ranges described in the Method section. Most notably, self-critical rumination has a mean of 37.27 with SD = 7.932 on a scale described as ranging from 10 to 40. A standard deviation of nearly eight points combined with a mean only 2.73 points below the scale maximum raises the possibility of substantial ceiling effects or impossible individual scores if approximately normally distributed. Similarly, the alexithymia mean exceeds the stated scale maximum. The authors should audit the raw data, verify variable coding and transformations, and report the actual observed minimum and maximum for each principal variable so that readers can assess whether the descriptive statistics are plausible.

The paragraph assessing normality contains a statistical reporting problem. The authors write, for example, that "the Shapiro–Wilk test value was .980 and the Kolmogorov–Smirnov significance value was .200," but for other variables they appear to report values such as .591 and .196 without clarifying whether these are test statistics or p values. A Shapiro–Wilk statistic of .196 would indicate an extremely non-normal distribution, whereas a p value of .196 would support nonrejection of normality. The authors must separately report the test statistic and p value for each normality test, preferably in a dedicated table. Moreover, with N = 200, formal normality tests should not be interpreted in isolation; skewness, kurtosis, histograms, Q–Q plots, and multivariate normality should also be evaluated because SEM assumptions concern multivariate as well as univariate distributions.

The statistical-analysis paragraph states that "The statistical significance of the indirect effects was examined using a bootstrap procedure with 1,000 resamples and 95% confidence intervals." For mediation analysis, 1,000 bootstrap samples is relatively limited by contemporary standards. The authors should preferably use at least 5,000 bootstrap resamples and report bias-corrected or percentile bootstrap confidence intervals consistently. They should also specify the AMOS estimation method, most likely maximum likelihood, explain whether missing data were present, describe how missing observations were handled, and state whether assumptions such as multivariate normality, linearity, influential cases, and multicollinearity were formally examined.

The model-fit paragraph interprets the nonsignificant chi-square test as showing that "no statistically significant discrepancy was observed between the empirical covariance matrix and the model-implied covariance matrix." Although technically defensible, this interpretation should be qualified because chi-square is highly dependent on sample size and model complexity. More importantly, the model has only 3 degrees of freedom and is therefore nearly saturated, which can produce very favorable fit indices even when substantive model specification is limited. The authors should explicitly acknowledge the very low degrees of freedom and avoid presenting CFI = .977, GFI = .987, and related indices as unequivocal proof of strong model validity. Model fit should be interpreted jointly with theoretical coherence, residuals, standardized estimates, and alternative model comparisons.

Response: Revised and uploaded the manuscript.

2. Revised

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

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