Mental Health and Lifestyle Journal

Year 2025
Volume 3
Issue 3

Prediction of Health Anxiety Based on Unhealthy Eating Behaviors and Health-Promoting Lifestyle

Sedigheh. Zamani[1], Sheida. Jabalameli[2*], Ahmad. Ghazanfari[3], Fariba. Arjmandi[4]

1 Department of Health Psychology, Na.C., Islamic Azad University, Najafabad, Iran
2 Department of Health Psychology, Na.C., Islamic Azad University, Najafabad, Iran | Clinical Research Development Center, Na.C., Islamic Azad University, Najafabad, Iran
3 Department of Psychology, ShK.C., Islamic Azad University, Shahrekord, Iran
4 Department of Medicine, Na.C., Islamic Azad University, Najafabad, Iran | Clinical Research Development Center, Na.C., Islamic Azad University, Najafabad, Iran
*Correspondence: jabalameli.sh@iau.ac.ir

Article type:
Original Research

Article history:
Received 04 April 2025
Revised 22 July 2025
Accepted 27 July 2025
Published online 01 August 2025

ABSTRACT

The present study aimed to investigate the predictive role of unhealthy eating behaviors and health-promoting lifestyle in explaining levels of health anxiety among members of the Overeaters Anonymous Association in Isfahan during 1403. This descriptive-correlational study was conducted on 400 members of the Overeaters Anonymous Association in Isfahan, selected through random convenient sampling. Data were collected using the Health Anxiety Questionnaire (Short Form) by Salkovskis and Warwick (2002), the Eating Attitudes Test-20 by Garner and Garfinkel (1979), and the Health-Promoting Lifestyle Profile-II by Walker and Hill-Polerecky (1997). All instruments had established validity and reliability in Iranian populations. Descriptive statistics were used to summarize demographic and main study variables. Pearson correlation coefficients examined associations between health anxiety and predictor variables, and multiple linear regression analysis was applied to assess the predictive power of unhealthy eating behaviors and health-promoting lifestyle for health anxiety. All analyses were conducted in SPSS-26 with a significance level set at $p < 0.01$. The results showed that health anxiety was positively and significantly correlated with unhealthy eating behaviors ($r = .54$, $p < .01$) and negatively and significantly correlated with health-promoting lifestyle ($r = -.48$, $p < .01$). Multiple regression analysis revealed that the model was significant, $F(2, 397) = 83.27$, $p < .01$, explaining 39% of the variance in health anxiety ($R^2adj = .39$). Unhealthy eating behaviors significantly and positively predicted health anxiety ($B = 0.71$, $\beta = .46$, $t = 8.97$, $p < .01$), whereas health-promoting lifestyle significantly and negatively predicted health anxiety ($B = -0.39$, $\beta = -.38$, $t = -7.83$, $p < .01$). The findings indicate that disordered eating patterns are a significant risk factor for elevated health anxiety, while engagement in health-promoting behaviors serves as a protective factor. Targeted interventions that reduce unhealthy eating behaviors and strengthen health-promoting lifestyle habits may be effective in mitigating health anxiety in at-risk populations.

Keywords: Health anxiety; Unhealthy eating behaviors; Health-promoting lifestyle

How to cite this article:
Zamani, S., Jabalameli, S., Ghazanfari, A., & Arjmandi, F. (2025). Prediction of Health Anxiety Based on Unhealthy Eating Behaviors and Health-Promoting Lifestyle. *Mental Health and Lifestyle Journal, 3*(3), 1-11. https://doi.org/10.61838/mhlj.3.3.6

© 2025 the authors. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial 4.0 International (CC BY-NC 4.0) License.

Introduction

Health anxiety is a complex psychological construct characterized by excessive worry about having or developing a serious illness, often accompanied by heightened monitoring of bodily sensations and misinterpretation of normal physical symptoms as indicators of disease (1). This phenomenon can lead to significant distress and functional impairment, influencing individuals' behaviors, social interactions, and overall well-being (2). Previous research has demonstrated that health anxiety is not merely a transient emotional state but is often linked to enduring cognitive and behavioral patterns, including maladaptive health behaviors and heightened attention to bodily cues (3). The COVID-19 pandemic further amplified public health concerns and revealed how perceived health threats can intensify anxiety and influence lifestyle choices (4, 5). Understanding the behavioral and lifestyle correlates of health anxiety is crucial for developing prevention and intervention strategies that address both psychological and behavioral dimensions of health.

One of the behavioral domains most consistently associated with health anxiety is eating behavior. Disordered eating patterns, ranging from restrictive dieting to binge eating, are often linked to heightened anxiety levels and body-related concerns (6, 7). Studies have shown that individuals with high health anxiety may adopt maladaptive dietary restrictions in an attempt to control perceived health risks, which paradoxically can exacerbate both physical and psychological distress (8). Emotional dysregulation, often manifesting in compulsive or avoidant eating behaviors, has been highlighted as a significant mediator between anxiety and eating disturbances (9, 10). Furthermore, occupational and environmental stressors, such as those observed in high-pressure work environments, have been associated with unhealthy eating habits and an increased risk of obesity (11). These findings underscore the importance of examining eating behaviors not only as isolated health concerns but also as integral components of a broader psychosocial profile influencing health anxiety.

Lifestyle factors, particularly those related to health promotion, also play a significant role in moderating the relationship between anxiety and overall well-being. Health-promoting lifestyle behaviors—such as regular physical activity, balanced nutrition, effective stress management, and maintaining supportive social relationships—are associated with better psychological outcomes and lower levels of health anxiety (12, 13). Evidence suggests that individuals with higher engagement in health-promoting activities tend to exhibit better coping strategies and greater resilience when facing health-related threats (14). Conversely, neglecting such behaviors can exacerbate the psychological burden of health anxiety, perpetuating a cycle of maladaptive coping and diminished health (4). Health beliefs and personal health responsibility, as dimensions of lifestyle, have been shown to significantly predict anxiety levels during public health crises (5), highlighting the need to integrate lifestyle interventions into mental health care strategies.

Psychological constructs such as alexithymia, emotional intelligence, and social anxiety further complicate the relationship between health anxiety, eating behaviors, and lifestyle patterns. Alexithymia, defined as difficulty in identifying and describing emotions, has been consistently linked to both heightened health anxiety and maladaptive eating behaviors (15, 16). Individuals with high alexithymia may engage in disordered eating as a maladaptive strategy to regulate undifferentiated emotional states (9). This emotional processing deficit can also reduce the likelihood of adopting consistent health-promoting behaviors, as self-care activities often require awareness of one's emotional and physical needs (17). Moreover, comorbidity between social anxiety and disordered eating is well-documented, with fears of negative social evaluation

influencing both dietary patterns and perceived health vulnerabilities (8, 18). These overlapping psychological dimensions suggest that effective interventions for health anxiety must address both behavioral habits and emotional regulation capacities.

Emerging evidence also points to the role of modern lifestyle factors, such as digital media use and exposure to societal body ideals, in shaping eating behaviors and anxiety. Social media has been associated with increased body dissatisfaction, restrained eating, and heightened social comparison, all of which may contribute to health anxiety (7, 19). Studies have reported that excessive engagement with online platforms can reinforce maladaptive coping patterns and exacerbate symptoms in individuals already vulnerable to anxiety and alexithymia (10, 20). The interplay between media consumption, body image concerns, and emotional regulation is especially pertinent in younger populations, where unhealthy eating behaviors can become entrenched early (21). These findings highlight the necessity of incorporating psychoeducational approaches that address media literacy and critical evaluation of health-related information as part of broader health anxiety interventions.

Given this multifaceted interplay between health anxiety, unhealthy eating behaviors, and health-promoting lifestyle factors, the current study seeks to explore the predictive role of these behavioral domains in shaping health anxiety levels.

Methods and Materials

Study Design and Participants

In this study, the research population consisted of all members of the Overeaters Anonymous Association in Isfahan during the year 1403. The sampling method was based on the requirements of structural equation modeling, in which the sample size is determined according to the ratio of participants to estimated parameters. Following established methodological recommendations, a ratio of 5:1 is considered minimal, 10:1 acceptable, and 20:1 ideal. Some researchers suggest 15 participants per observed variable, while others recommend between 10 and 20 participants per variable. Taking into account these guidelines, the likelihood of attrition, and the need to ensure robust statistical power, a total of 400 participants was targeted. The participants were selected using a random convenient sampling approach from the association's accessible members, ensuring representation of the population while accommodating logistical constraints. All participants were informed about the study's objectives, assured of confidentiality, and provided informed consent before data collection commenced.

Data Collection

The Health Anxiety Questionnaire (Short Form) developed by Salkovskis and Warwick in 2002 was used to measure health-related anxiety. This instrument is designed to assess the extent to which individuals experience anxiety concerning their health status. It consists of 18 items rated on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores indicating greater health anxiety. The total score ranges from 18 to 90, calculated by summing the responses across all items. The original developers reported a test–retest reliability coefficient of 0.90 and Cronbach's alpha coefficients ranging from 0.70 to 0.82, with construct validity of 0.72. In Iran, the questionnaire was first translated and validated by Narges in 2011, who confirmed its convergent validity through correlation with the Ahvaz

Hypochondriasis Inventory, yielding a coefficient of –0.75. In a study by Abdi in 2015, the Persian version demonstrated excellent reliability with a Cronbach's alpha of 0.88, supporting its psychometric robustness in Iranian populations.

Unhealthy eating behaviors were assessed using the Eating Attitudes Test (EAT-20), developed by Garner and Garfinkel in 1979 to evaluate maladaptive attitudes and behaviors related to eating. This instrument comprises 20 items divided into three subscales: dieting (items 1–10), bulimia and food preoccupation (items 11–15), and oral control (items 16–20). Responses are recorded on a six-point Likert scale ranging from 0 (never) to 5 (always), with higher scores indicating more severe disordered eating behaviors. The original developers reported high internal consistency with a Cronbach's alpha of 0.94 and a test–retest reliability coefficient of 0.84 over a two- to three-week interval. In Iran, Khodabakhsh and Kiaei (2014) reported a validity coefficient of 0.67 and Cronbach's alpha of 0.94. Subsequent research by Kaveh Ghahfarokhi and Tabebordbar (2017) confirmed stability with a two-week test–retest reliability of 0.89 and validity of 0.66. In the current study, the internal consistency of the EAT-20 was re-evaluated, yielding a Cronbach's alpha of 0.813, indicating satisfactory reliability for this sample.

The Health-Promoting Lifestyle Profile (HPLP-II), developed by Walker and Hill-Polerecky in 1997, was employed to measure health-promoting lifestyle behaviors. This questionnaire includes 54 items covering six subscales: nutrition (items 1–11), physical activity (items 12–24), health responsibility (items 25–32), stress management (items 33–38), interpersonal support (items 39–46), and self-actualization (items 47–54). Responses are given on a four-point Likert scale from 1 (never) to 4 (routinely), resulting in total scores ranging from 54 to 216, where higher scores reflect more health-promoting behaviors. The developers reported high internal consistency (Cronbach's alpha of 0.94 for the total scale and between 0.79 and 0.94 for subscales) and a three-week test–retest reliability of 0.89. The Persian version, validated by Mohammadi Zeidi, Pakpour, and Mohammadi Zeidi (2011), confirmed content validity and demonstrated Cronbach's alpha coefficients of 0.79 for nutrition, 0.86 for physical activity, 0.81 for health responsibility, 0.91 for stress management, 0.79 for interpersonal support, and 0.81 for self-actualization, indicating excellent reliability for each dimension.

Data Analysis

For data analysis, all collected responses were coded and entered into SPSS version 26 for statistical processing. Descriptive statistics, including means, standard deviations, and frequency distributions, were calculated to summarize participants' demographic and questionnaire data. Pearson correlation coefficients were computed to assess the strength and direction of associations between the dependent variable (health anxiety) and each independent variable (unhealthy eating behaviors and health-promoting lifestyle). Subsequently, linear regression analysis was conducted with health anxiety as the dependent variable and both unhealthy eating behaviors and health-promoting lifestyle as independent predictors. Statistical assumptions for regression, including normality, linearity, homoscedasticity, and absence of multicollinearity, were evaluated before conducting the inferential analyses. All statistical tests were interpreted at a significance level of $p < 0.05$.

Findings and Results

The demographic profile of the 400 participants in this study showed that the majority were in the age range of 26 to 33 years (n = 158, 39.5%), followed by 18 to 25 years (n = 126, 31.5%), 34 to 41 years (n = 74, 18.5%), and 42 years and older (n = 42, 10.5%). Most participants were female (n = 304, 76%), while males accounted for 24% (n = 96) of the sample. Regarding educational level, the largest group held a bachelor's degree (n = 178, 44.5%), followed by those with a master's or doctoral degree (n = 110, 27.5%), an associate degree (n = 64, 16%), and a diploma or lower (n = 48, 12%). In terms of economic status, the majority reported a moderate level (n = 249, 62.3%), with 23% (n = 92) reporting good economic status and 14.8% (n = 59) reporting poor economic conditions. Marital status distribution indicated that more than half of the participants were single (n = 212, 53%), followed by married individuals (n = 158, 39.5%) and divorced individuals (n = 30, 7.5%).

The descriptive statistics for the main variables of the study, including health anxiety, unhealthy eating behaviors, and health-promoting lifestyle, are presented in Table 1. As shown, the mean score for health anxiety was 62.79 (SD = 13.45), indicating a moderate to high level among participants. Unhealthy eating behaviors had a mean score of 81.45 (SD = 10.27), suggesting a relatively high prevalence of disordered eating patterns. The mean score for health-promoting lifestyle was 123.47 (SD = 18.83), reflecting a moderate engagement in adaptive lifestyle practices across the sample.

Table 1. Descriptive statistics for study variables

Variable	M	SD
Health Anxiety	62.79	13.45
Unhealthy Eating Behaviors	81.45	10.27
Health-Promoting Lifestyle	123.47	18.83

The correlation matrix between the dependent variable (health anxiety) and the independent variables (unhealthy eating behaviors and health-promoting lifestyle) is shown in Table 2. Pearson's correlation coefficients indicated that health anxiety was positively correlated with unhealthy eating behaviors ($r = .54$, $p < .01$) and negatively correlated with health-promoting lifestyle ($r = -.48$, $p < .01$). These correlations suggest that as disordered eating patterns increase, health anxiety tends to rise, whereas greater engagement in health-promoting behaviors is associated with lower levels of health anxiety.

Table 2. Pearson correlation coefficients between health anxiety and independent variables

Variable	Health Anxiety (r)	p
Unhealthy Eating Behaviors	.54	< .01
Health-Promoting Lifestyle	−.48	< .01

The results of the regression model summary are presented in Table 3. The model showed a statistically significant overall fit, $F(2, 397) = 83.27$, $p < .01$, with $R = .63$, $R^2 = .40$, and adjusted $R^2 = .39$, indicating that 39% of the variance in health anxiety was explained by the combination of unhealthy eating behaviors and health-promoting lifestyle. The regression sum of squares was 28,347.62, residual sum of squares was 42,636.14, and the total sum of squares was 70,983.76.

Table 3. Summary of regression analysis predicting health anxiety

Source	Sum of Squares	df	Mean Square	R	R^2	R^2adj	F	p

Regression	28,347.62	2	14,173.81	.63	.40	.39	83.27	< .01
Residual	42,636.14	397	107.41					
Total	70,983.76	399						

The multivariate regression coefficients are reported in Table 4. The results indicated that unhealthy eating behaviors had a significant positive predictive effect on health anxiety (B = 0.71, SE = 0.08, β = .46, t = 8.97, p < .01), while health-promoting lifestyle had a significant negative predictive effect (B = −0.39, SE = 0.05, β = −.38, t = −7.83, p < .01). The constant term was 58.42 (SE = 5.37, t = 10.88, p < .01). These findings confirm that higher levels of disordered eating are associated with increased health anxiety, whereas a more active engagement in health-promoting behaviors predicts lower health anxiety.

Table 4. Multiple regression coefficients predicting health anxiety

Predictor	B	SE	β	t	p
Constant	58.42	5.37	—	10.88	< .01
Unhealthy Eating Behaviors	0.71	0.08	.46	8.97	< .01
Health-Promoting Lifestyle	−0.39	0.05	−.38	−7.83	< .01

Discussion and Conclusion

The results of the present study indicated that unhealthy eating behaviors had a significant positive relationship with health anxiety, meaning that participants who reported higher levels of disordered eating patterns also tended to experience greater concern and worry about their health status. Conversely, health-promoting lifestyle behaviors were found to have a significant negative relationship with health anxiety, suggesting that individuals who engage in more consistent health-supportive activities—such as balanced nutrition, regular physical activity, stress management, and interpersonal support—exhibited lower levels of health-related anxiety. Furthermore, the regression analysis demonstrated that both unhealthy eating behaviors and health-promoting lifestyle behaviors significantly predicted health anxiety, with unhealthy eating behaviors emerging as a risk factor and health-promoting lifestyle as a protective factor. These findings emphasize the dual role of maladaptive and adaptive behaviors in shaping psychological responses to perceived health threats.

The positive association between disordered eating patterns and health anxiety aligns with prior research highlighting the role of maladaptive eating behaviors in exacerbating psychological distress (6). Disordered eating can function as both a symptom and a cause of heightened health concerns, as restrictive dieting, binge episodes, or compulsive food preoccupation may trigger physiological discomfort or medical issues that feed into existing anxiety. Moreover, individuals with high levels of health anxiety may attempt to exert control over their health status through extreme dietary practices, which can paradoxically worsen their mental state (7). This bidirectional relationship has been observed across clinical and non-clinical populations, indicating that unhealthy eating is not merely a nutritional issue but also a psychological phenomenon tied to anxiety regulation (8).

Psychological factors such as alexithymia and emotional dysregulation may further explain the link between disordered eating and health anxiety. Individuals who have difficulty identifying or expressing their emotions may turn to maladaptive eating as a form of emotion regulation, without recognizing the underlying affective drivers (9, 15). Alexithymia has been found to be associated with both higher health anxiety and more severe disordered eating behaviors (16), suggesting that deficits in emotional awareness

and processing contribute to maladaptive coping strategies. Furthermore, comorbidity between social anxiety and eating disturbances, as documented in previous studies (8, 18), indicates that interpersonal fears and negative evaluation concerns can intensify both health worries and maladaptive dietary habits. The findings of this study, therefore, reinforce the notion that interventions aimed at reducing health anxiety should incorporate components that address both eating patterns and underlying emotional processing difficulties.

In contrast, the negative association between health-promoting lifestyle behaviors and health anxiety found in this study supports existing evidence that adaptive health behaviors can buffer against psychological distress. Engagement in regular physical activity, balanced nutrition, effective stress management, and strong social support systems has been linked to lower levels of anxiety and improved mental well-being (12, 13). Such behaviors may enhance individuals' sense of control over their health, thereby reducing vulnerability to excessive worry (14). Previous studies have shown that health-promoting activities are positively associated with resilience and adaptive coping, which in turn mitigate the psychological impact of health-related fears (4). Additionally, interventions designed to improve health-promoting behaviors during public health crises, such as the COVID-19 pandemic, have been effective in lowering anxiety and enhancing well-being (1, 5).

The current findings are consistent with models that conceptualize health anxiety as a multifactorial condition influenced by both behavioral and cognitive-emotional factors. While maladaptive eating patterns can act as a stressor that exacerbates anxiety symptoms, engagement in health-promoting behaviors serves as a protective factor that reduces anxiety vulnerability. This dual influence echoes the behavioral medicine perspective, which emphasizes the interplay of health behaviors and psychological states in determining overall well-being (3). Furthermore, the mediating role of constructs such as self-esteem, body image satisfaction, and emotional intelligence, as suggested in previous research (7, 10), may help explain why some individuals with disordered eating behaviors develop heightened health anxiety, while others do not.

The findings also point to the potential role of sociocultural and environmental factors in shaping the relationship between eating behaviors, lifestyle, and health anxiety. Exposure to societal ideals regarding body shape and health, often amplified through social media, has been associated with increased restrained eating and body dissatisfaction (7, 19). Such pressures can trigger or worsen health anxiety by creating unrealistic standards and reinforcing fears about physical appearance and health outcomes. Furthermore, occupational and lifestyle stressors, such as those documented in workplace studies (11), may indirectly contribute to both unhealthy eating behaviors and heightened anxiety levels. This highlights the importance of considering contextual influences when designing interventions to reduce health anxiety.

Moreover, the association between health anxiety and maladaptive eating behaviors may be reinforced by cognitive biases, such as selective attention to health-related information and catastrophic interpretations of bodily sensations (2, 20). Individuals with health anxiety often engage in health-related information seeking, which can be exacerbated by online misinformation and health-related social media content. This excessive focus on perceived health threats may not only intensify anxiety but also disrupt normal eating patterns, as individuals modify their diets based on unverified or exaggerated health claims. Integrating media literacy and critical appraisal skills into health anxiety interventions could therefore be a valuable strategy.

Another noteworthy point is the role of comorbid psychological symptoms in the observed relationships. Depression, panic symptoms, and general anxiety disorders often co-occur with health anxiety and disordered eating, potentially amplifying the severity of both (10, 17). Additionally, studies on panic disorder and emotional intelligence suggest that improving emotion regulation skills may reduce both disordered eating and health anxiety (10). This indicates that interventions with a dual focus on emotional competence and behavioral change may yield more sustainable outcomes than those targeting either domain alone.

Overall, the results of this study contribute to a growing body of evidence supporting the intertwined nature of maladaptive and adaptive health behaviors in the development and maintenance of health anxiety. By confirming that disordered eating is a significant risk factor and health-promoting lifestyle is a protective factor, the findings underscore the need for comprehensive approaches to health anxiety management that address both ends of the behavioral spectrum. Future clinical and preventive efforts should consider the integration of nutritional counseling, lifestyle coaching, and psychological therapies aimed at improving emotional awareness and coping strategies.

Although the present study offers valuable insights, it is subject to several limitations that must be acknowledged. First, the cross-sectional design limits the ability to draw causal inferences regarding the relationships between health anxiety, eating behaviors, and health-promoting lifestyle. Longitudinal studies are needed to clarify the directionality of these associations. Second, the reliance on self-report questionnaires introduces the possibility of response bias, such as social desirability effects or inaccurate recall. Third, the sample was drawn from members of the Overeaters Anonymous Association in Isfahan, which may limit the generalizability of the findings to broader populations, particularly those without a history of disordered eating concerns. Additionally, cultural and contextual factors specific to the Iranian population may influence the observed relationships, and these influences might differ in other sociocultural contexts. Finally, the study did not control for certain psychological variables, such as depressive symptoms or general anxiety levels, which could have acted as confounding factors.

Future studies should adopt longitudinal designs to track changes in health anxiety, eating behaviors, and lifestyle patterns over time, allowing for clearer conclusions about causality. Expanding research to more diverse populations, including individuals without a history of eating concerns and those from different cultural backgrounds, would enhance the generalizability of findings. Investigating the potential mediating and moderating roles of psychological constructs such as self-esteem, emotional intelligence, and coping strategies could provide deeper insights into the mechanisms underlying the observed associations. Additionally, incorporating objective measures—such as wearable fitness trackers or dietary logs—could complement self-report data and improve accuracy. Finally, intervention-based studies testing the effectiveness of integrated programs that target both unhealthy eating and health-promoting lifestyle behaviors in reducing health anxiety would be highly valuable.

In practical terms, the findings suggest that interventions aimed at reducing health anxiety should adopt a holistic approach that simultaneously addresses maladaptive eating patterns and promotes adaptive lifestyle behaviors. Health professionals should consider incorporating nutritional counseling, physical activity promotion, and stress management training into therapeutic programs for individuals with elevated health anxiety. Psychoeducation about the relationship between lifestyle and psychological well-being may help individuals recognize the value of consistent health-promoting behaviors as a buffer against anxiety.

Furthermore, integrating emotional awareness training and coping skills development into intervention protocols could help reduce reliance on maladaptive eating as an emotion regulation strategy. Collaboration between mental health practitioners, dietitians, and fitness professionals may lead to more comprehensive and effective treatment outcomes.

Acknowledgments

The authors express their deep gratitude to all participants who contributed to this study.

Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

References

1. Karamian H. Investigating the Mediating Role of Health-Promoting Behaviors in the Relationship Between Coping Strategies and Health Anxiety During the COVID-19 Pandemic 2022.
2. Abadi DBN, Badihi M, Rabiee Z, Shokrolahi M. Effectiveness of Cognitive Analytic Therapy on Anxiety Sensitivity and Pain Catastrophizing in Patients With Chronic Pain and Alexithymia. The Journal of Tolooebehdasht. 2024. doi: 10.18502/tbj.v22i6.15212.
3. Abbasi Kamal R, Sobhe, Afsane. Comparison of Automatic Thoughts and Alexithymia with Anxiety in People with Hypertension and People without Hypertension in Zanjan. Journal of Health Promotion Management. 2022;11(1):61-71.
4. Farivar M, Azizi Aram S, Basharpour S. The Role of Health-Promoting Behaviors and Health Beliefs in Predicting COVID-19 Anxiety Among Nurses. Quarterly Journal of Nursing Management. 2020;9(4):10-1.
5. Fathi A, Sadeghi S, Maleki Rad AA, Rostami H, Abdolmohammadi K. Effect of Health-promoting Lifestyle and Psychological Well-being on Anxiety Induced by Coronavirus Disease 2019 in Non-medical Students. Journal of Arak University of Medical Sciences. 2020;23(5):698-709. doi: 10.32598/jams.23.Cov.1889.2.
6. Khodabakhsh MR, Kiani F. The role of anxiety and alexithymia in predicting disordered eating behaviors among students:implication for health promotion. Shenakht Journal of Psychology and Psychiatry. 2015;1(3):63-73.

7. Fu T, Wang J, Xu S, Yu J, Sun G. Media Internalized Pressure and Restrained Eating Behavior in College Students: The Multiple Mediating Effects of Body Esteem and Social Physique Anxiety. Frontiers in Psychology. 2022;13. doi: 10.3389/fpsyg.2022.887124.
8. Levinson CA, Rodebaugh TL. Social Anxiety and Eating Disorder Comorbidity: The Role of Negative Social Evaluation Fears. Eating Behaviors. 2012;13(1):27-35. doi: 10.1016/j.eatbeh.2011.11.006.
9. Del Bianco C, Ulivi M, Liguori C, Pisani A, Mercuri NB, Placidi F, et al. Alexithymia, impulsiveness, emotion, and eating dyscontrol: similarities and differences between narcolepsy type 1 and type 2. Sleep and Biological Rhythms. 2023;21(1):39-50. doi: 10.1007/s41105-022-00414-4.
10. Oussi A, Hamid K, Bouvet C. Managing emotions in panic disorder: A systematic review of studies related to emotional intelligence, alexithymia, emotion regulation, and coping. Journal of Behavior Therapy and Experimental Psychiatry. 2023;79:101835.
11. Nishitani N, Sakakibara H, Akiyama I. Eating behavior related to obesity and job stress in male Japanese workers. Nutrition. 2009;25(1):45-50.
12. Atadokht A, Rahimi S, Valinejad S. The Role of Health Promoting Lifestyle and Religious Orientation in Predicting Quality of Life and Death Anxiety in Elders. Aging Psychology. 2018;4(2):143-54.
13. Chafjiri RT, Shirinkam F, Karimi H. Investigating the effect of education on health-promoting lifestyle am ong the elderly of Ramsar in 2017. Journal of family medicine and primary care. 2018;7(3):612-7. doi: 10.4103/jfmpc.jfmpc_306_17.
14. Fathi A, Sadeghi S, Maleki Rad AA, Sharifi Rahnmo S, Rostami H, Abdolmohammadi K. The Role of Cyberspace Use on Lifestyle Promoting Health and Coronary Anxiety in Young People. IJPCP. 2020;26(3):332-47.
15. Habibi Asgarabad M, Salehi Yegaei P, Jafari F, Azami-Aghdash S, Lumley MA. The relationship of alexithymia to pain and other symptoms in fibromyalgia: A systematic review and meta-analysis. European Journal of Pain. 2023;27(3):321-37.
16. Dong Z, Zhou J, Conti A, Westwood SJ, Fu X, Liu Q, et al. Association between alexithymia and non-suicidal self-injury in psychiatric patients: the mediating role of self-esteem and the moderating role of emotional intelligence. Journal of Psychiatric Research. 2023;162:57-64.
17. Quinto RM, De Vincenzo F, Graceffa D, Bonifati C, Innamorati M, Iani L. The Relationship between Alexithymia and Mental Health Is Fully Mediated by Anxiety and Depression in Patients with Psoriasis. International Journal of Environmental Research and Public Health. 2022;19(6):3649. doi: 10.3390/ijerph19063649.
18. Terzioğlu MA, Uğurlu TT. Social Media Addiction in Medical Faculty Students; The Relationship With Dissociation, Social Anxiety, and Alexithymia. Pamukkale Medical Journal. 2023. doi: 10.31362/patd.1321281.
19. Lyvers M, Salviani A, Costan S, Thorberg FA. Alexithymia, Narcissism and Social Anxiety in Relation to Social Media and Internet Addiction Symptoms. International Journal of Psychology. 2022;57(5):606-12. doi: 10.1002/ijop.12840.
20. Ogawa M, Saito A, Karukivi M, Lahti S. Associations of Sensory Sensitivity, Pain Catastrophizing, and Alexithymia With Dental Anxiety. European Journal of Oral Sciences. 2024;132(2). doi: 10.1111/eos.12973.
21. Zarei Davijani A, Dabiri S, Jabbari Moghadam S, Fakhri P, Molaraza Z, editors. Prediction of Social Anxiety Based on Childhood Trauma with the Mediating Role of Alexithymia in Adolescents. 2nd National Conference on Child and Adolescent Clinical Psychology; 2022; Ardabil.