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Articles

The Italian Version of the Illness Identity Questionnaire: A Preliminary Psychometric Validation in Adults with Chronic Illness

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Abstract

Introduction: Illness identity, defined as the extent to which a chronic condition is integrated into one's sense of self, is a key construct for psychological adjustment and quality of life. In the absence of validated instruments in Italian, this study aimed to translate, culturally adapt, and validate the Illness Identity Questionnaire (IIQ).

Methods: A cross-sectional study was conducted with 132 adults diagnosed with a chronic condition for at least six months. The factorial structure of the 25-item scale was examined using confirmatory factor analysis (CFA). Reliability (McDonald's ω and Cronbach's α) and construct validity were assessed through inter-factor correlations.

Results: CFA provided support for the original four-factor structure, showing overall acceptable but not optimal fit indices and adequate factor loadings. The alternative unidimensional model showed poor fit. Reliability ranged from satisfactory to excellent. Inter-factor correlations supported construct validity and were consistent with the theoretical model.

Conclusions: The study demonstrates promising preliminary psychometric properties of the Italian version of the IIQ and represents a useful tool for assessing adaptation to chronic illness.

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1. Introduction

Over recent decades, the prevalence of chronic diseases has increased substantially worldwide, partly due to population ageing and advances in medical treatments that have improved survival rates. Data from the World Health Organization (WHO, 2022, 2023) highlighted that non-communicable chronic diseases (NCDs) account for approximately 74% of all global deaths, and millions of individuals live with at least one chronic condition. Literature about NCDs documented a higher prevalence of psychopathological disorders, as well as a detrimental impact of these conditions on quality of life (Gürhan et al., 2019; Lebel et al., 2020).

A focus on NCDs is relevant because the extent to which a chronic illness is integrated into patients' identity appears to be associated with disease management and adherence to medical treatments (Shneider et al., 2024). Studies examining the relationship between illness identity and treatment adherence have shown that difficulties in integrating the illness into one's sense of self are negatively associated with adherence to medical treatments (Commissariat et al., 2020; Oris et al., 2016; Peters & Brown, 2022; Rassart et al., 2021). Higher levels of identity integration allow individuals to reduce conflicts between their self-concept and the demands imposed by the illness, thereby promoting a greater sense of self-continuity and facilitating sustained engagement in daily self-care behaviors, which are often required over the long term (Oris et al., 2018; Shneider et al., 2024; Van Bulck et al., 2019).

Similarly, the extent to which a chronic condition is integrated into one's identity appears to be associated with health-related quality of life (HRQoL), defined as the perceived physical and psychological well-being of the individual (Shneider et al., 2024). Several studies (Commissariat et al., 2020; Luyckx et al., 2018; Meyer & Lamash, 2021; Rassart et al., 2021; Van Bulck et al., 2021) suggest that the non-integration of illness identity is negatively associated with HRQoL. In contrast, greater identity integration may foster psychological adjustment by reducing internal conflicts related to illness, thereby supporting a more coherent self-concept and contributing to better perceived well-being (Oris et al., 2018).

According to Charmaz (1991), integrating a chronic illness entails a process of acceptance and adaptation, through which individuals reorganize their daily activities and life routines. Conversely, when integration is limited or absent, illness may either become overly dominant, permeating and redefining one's identity, or be deliberately compartmentalized and kept separate from the self (Oris et al., 2016).

Collectively, these findings underscore the clinical relevance of assessing illness identity as a potentially modifiable psychological process implicated in long-term adjustment and disease self-management (Hajdarevic et al., 2025; Shneider et al., 2024).

Illness identity is defined as the degree to which a chronic illness is integrated into an individual's sense of self (Charmaz, 1995). Therefore, such constructs reflect not only how individuals perceive their illness and its treatment, but also the extent to which the illness has influenced how they think about themselves and the degree to which it has become part of their self-concept (Van Bulck et al., 2019).

Illness identity can be interpreted as a response shift mechanism: a cognitive and narrative process through which individuals reorganize their standards, values, and identity references in response to illness. This process, influenced by relational and sociocultural contexts, in turn shapes the way the illness is interpreted, addressed, and managed in daily life, guiding behavioral choices and adherence to treatments (Charmaz, 1995; Sprangers & Schwartz, 1999; Sematlane et al., 2022).

To operationalize this concept, Oris and colleagues developed the Illness Identity Questionnaire (IIQ) (Oris et al., 2016, 2018), a self-report measure specifically designed to assess how individuals relate chronic illness to their sense of self. The IIQ provides a standardized assessment of illness identity and has been applied across different clinical populations, demonstrating satisfactory psychometric properties in previous validation studies (Luyckx et al., 2018; Oris et al., 2016; Van Bulck et al., 2018). The IIQ assesses illness identity states: rejection, characterized by the active denial of the illness as part of the self; engulfment, in which the illness dominates one's identity and daily life; acceptance, reflecting the acknowledgment of the illness as one aspect of the self without overwhelming it; and enrichment, whereby the illness experience is perceived as contributing positively to personal growth and self-understanding. Within this framework, engulfment and rejection are generally conceptualized as less adaptive forms of illness identity, whereas acceptance and enrichment reflect more adaptive identity processes. However, rather than representing fixed and mutually exclusive categories, these states can be understood as manifestations of a broader and more dynamic process of identity negotiation in the context of chronic illness (Paterson, 2001; Telford et al., 2006).

Despite the growing relevance of illness identity in health psychology research, a validated Italian version of the Illness Identity Questionnaire (IIQ) is currently lacking. To the authors' knowledge, the IIQ has been validated only in Dutch, English, Danish, and Spanish and has been applied to various chronic illness populations primarily in Belgium, Germany, and the United States (Ingersgaard et al., 2022; Patten et al., 2024). The absence of a validated Italian version of the IIQ limits the systematic investigation of illness identity in Italian-speaking populations and restricts its application in both research and clinical contexts.

Given that nearly 24 million people in Italy are affected by chronic diseases (Istituto Superiore di Sanità, [ISS], 2019) and the growing recognition of identity-related processes in psychological adjustment, a culturally adapted and psychometrically valid version of the IIQ is needed. A culturally specific instrument would allow researchers and clinicians to capture the particular ways in which illness identity is constructed and negotiated within the Italian sociocultural context. Such an instrument would also lay the groundwork for the development and evaluation of targeted psychological interventions aimed at promoting more adaptive forms of illness identity integration, ultimately supporting better disease self-management and quality of life in Italian-speaking patients.

2. Methods

The present study employed a cross-sectional design to examine the psychometric properties of the Italian version of the Illness Identity Questionnaire. The study followed international guidelines for test adaptation (International Test Commission [ITC], 2018) and was implemented through a structured translation procedure (Beaton et al., 2000). The study was approved by the Ethics Committee of Pegaso University (PROT./E 003815, 13 June 2025) and conducted in accordance with the Declaration of Helsinki. All participants provided informed consent prior to participation. Data was collected using an online survey administered via Google Forms. The questionnaire was administered anonymously.

2.1. Participants

Participants were recruited using a non-probabilistic convenience sampling strategy, primarily through snowball sampling (Goodman, 1961). The survey link was initially distributed through personal and professional networks and subsequently shared among potential participants. The inclusion criteria were being age >18 years old, being fluent Italian, and having received a diagnosis of a chronic illness at least six months prior to participation.

A total of 132 participants took part in the study. Participants provided information on gender, age, medical condition, time since diagnosis. Age was reported in 5-year categorical ranks, spanning from 25-30 years to over 70 years. Participants also indicated the duration of their illness since diagnosis using predefined time intervals. The presence of a chronic illness was confirmed through a self-reported open-ended question regarding diagnosis "In case of a chronic condition, what is your illness?". In tables 1 and 2 demographic and clinical characteristics of the sample are reported.

Table 1*Demographic Characteristics of Participants*

Variables		
	<i>n</i>	%
Gender		
Female	96	72.73
Male	36	27.27
Age		
25-30	37	28.03
31-35	7	5.30
36-40	9	6.82
41-45	10	7.57
46-50	18	13.64
51-55	12	9.09
56-60	20	15.15
61-65	11	8.33
66-70	6	4.54
>70	2	1.51

Table 2*Clinical Characteristics of Participants*

Chronic condition (macro-category)/ Time from diagnosis	<i>n</i>	0-5 years	6-10 years	11-15 years	16-20 years	21-25 years	More than 26	Prefer not to say
Metabolic / Endocrine	32	8	8	5	4	3	3	1
Cardiovascular	16	3	2	2	4	1	3	1
Respiratory	9	2	2	2	1	1	1	
Gastrointestinal	28	11	7	2	4	3	1	
Neurological	5		3	1				1
Rheumatologic / Musculoskeletal	14	3	4	3		2	2	
Autoimmune / Systemic	4	2	1		1			
Oncological	5		1	1				3
Ophthalmologic	14	6	4	2	1		1	
Other chronic condition	2							
Prefer not to say	3	2	1					

2.2. Measure

The Illness Identity Questionnaire (IIQ) consists of 25 items assessing four dimensions of illness identity: rejection, engulfment, acceptance, and enrichment. "Rejection" refers to a position in which the individual actively excludes the illness from their self-concept (e.g., "I refuse to see my illness as part of myself"); "Engulfment" describes a condition where the illness becomes so pervasive that it dominates both identity and everyday life (e.g., "My illness dominates my life"); "Acceptance" involves recognizing the illness as one part of oneself without allowing it to become overwhelming (e.g., "My illness simply belongs to me as a person"); "Enrichment" reflects a perspective in which the experience of illness is viewed as an opportunity for personal growth and a deeper understanding of oneself (e.g., "Because of my illness, I have grown as a person"). Items are rated on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Previous studies reported satisfactory internal consistency coefficients for the four subscales (α ranging from .75 to .95).

2.2.1. Translation/adaptation procedure

The Italian version of the IIQ was developed following international guidelines for test translation and adaptation (Gregoire, 2018). The original items were independently translated into Italian by two bilingual researchers with expertise in clinical psychology. The translated version was reviewed by an expert familiar with the construct of illness identity and the Italian clinical context. Minor discrepancies were resolved to ensure conceptual and functional equivalence rather than literal correspondence.

The back-translation was carried out by an independent bilingual researcher not involved in the initial translation process. The back-translated version was compared with the original one, and no substantial discrepancies were identified.

To assess the face validity and comprehensibility of the Italian version (Terwee et al., 2018), the questionnaire was administered to a small pilot sample of 10 participants from the target population (5 M, 5 F; aged 25-55 years). This pilot phase was not intended as a psychometric validation. Following completion of the questionnaire, participants were interviewed regarding item clarity, comprehensibility, and any difficulties in understanding the instructions or response format. Participants were asked to rate the clarity of the items, the comprehensibility of the questionnaire, and the instructions on a 10-point Likert scale. The results indicated good overall face validity, with a mean score of 8.0 (SD = 1.54) for item clarity, 8.4 (SD = .97) for comprehensibility, and 8.2 (SD = 1.23) for ease of understanding the instructions. Feedback from this pilot testing did not indicate major issues, and only minor wording refinements were made to improve clarity and naturalness in Italian.

2.3. Statistical analyses

The factorial structure of the four-factor model was tested using confirmatory factor analysis (CFA). Moreover, in line with the best practices for scale development and validation recommended by Boateng et al. (2018), we tested and compared alternative models excluding items with low factor loadings, as well as a unidimensional (single-factor) model.

As items were rated on a 5-point Likert scale, they were treated as ordinal variables and the model was estimated using a weighted least squares estimator with robust standard errors (DWLS). Sample-size requirements for ordinal CFA cannot be reduced to a single universal threshold, as they depend on several characteristics of the model and data, including model complexity, the number and distribution of response categories, factor-loading magnitude, and the estimation method. Robust DWLS was selected because it is specifically suited to ordinal indicators and is less demanding in terms of sample size than full weighted least squares estimation. Nevertheless, simulation studies indicate that small samples may still affect the accuracy of standard errors, interfactor correlations, and chi-square-based statistics. Accordingly, the present sample size ($N = 132$) was considered sufficient to permit a preliminary evaluation of the hypothesized factorial structure, while the resulting estimates were interpreted cautiously (DiStefano et al., 2019; Li, 2016).

Model fit was evaluated using the scaled chi-square statistic and the chi-square to degrees of freedom ratio (χ^2/df), with values below 3 indicating acceptable fit (Black et al., 2010), together with the Comparative Fit Index (CFI), the Tucker–Lewis Index (TLI), the Root Mean Square Error of Approximation (RMSEA) with 95% confidence intervals, and the Standardized Root Mean Square Residual (SRMR). Internal consistency was assessed using McDonald's ω and Cronbach's α , and preliminary evidence of construct validity was examined through inter-factor correlations. Because no external validation measures were included, convergent, discriminant, and criterion validity were not assessed in the present study.

Exploratory analyses were conducted to examine associations between IIQ subscales and age using Spearman's correlations, given that age was collected in ordinal categories, and to explore potential gender differences using Welch's independent-samples t-tests.

2.3.1. Data screening

No missing responses across items or participants were found. Items descriptives analyses are reported in Supplementary Materials.

3. Results

The CFA based on the original four-factor model (Rejection, Acceptance, Engulfment, and Enrichment) showed a significant chi-square ($\chi^2 = 656$, $df = 269$, $p < .001$), however the χ^2/df ratio was 2.44, below the recommended threshold of 3. The incremental fit indices resulted acceptable (CFI = .89, TLI = .88). RMSEA was .11, 95% CI [.10, .12] and SRMR = .10. Although these values are not optimal, according to Goretzko et al. (2024) they can be considered acceptable, as this is not uncommon in models with a relatively large number of items and a modest sample size. All items loaded significantly on their respective latent factors ($p < .001$), with standardized factor loadings ranging from .41 to .90, supporting the proposed factorial structure (see Table 3).

Table 3

Standardized factor loadings for the original and Italian versions of the IIQ

Factor	Item	Original (CFA)	Italian (25-item)	Italian (24-item)
1.Rejection	i01	.57	.69	.69
	i02	.57	.69	.71
	i03	.73	.90	.90
	i04	.53	.82	.81
	i05	.66	.41	---
2.Acceptance	i06	.54	.60	.60
	i07	.57	.65	.64
	i08	.78	.77	.77
	i09	.89	.89	.89
	i10	.68	.75	.76
3.Engulfment	i11	.77	.82	.82
	i12	.72	.76	.76
	i13	.67	.69	.70
	i14	.80	.84	.84
	i15	.79	.81	.81
	i16	.82	.88	.88
	i17	.64	.88	.88
	i18	.71	.88	.88
4.Enrichment	i19	.69	.68	.68
	i20	.68	.76	.76
	i21	.80	.88	.88
	i22	.81	.83	.83
	i23	.83	.82	.82
	i24	.65	.81	.81
	i25	.76	.70	.70

The majority of items exhibited adequate factor loading ($\geq .50$), supporting the convergent validity of the factors. The Rejection factor showed high and homogeneous loadings items' loading ranged from .41 to .90. Items of the Acceptance scale ranged from 0.6 to .89, Engulfment scale ranged from .69 to .88 and Enrichment displayed solid loading patterns consistent with theoretical expectations .68 and .88 respectively (Oris et al., 2018).

To improve the model fit we tested an alternative 24 item/four-factor model by removing Item 05 from the Rejection factor in light of its lower standardized factor loading ($\beta = .41$). The improvement in fit indices was negligible ($\Delta CFI = +.003$; $\Delta TLI = +.001$), supporting the retention of the Item 05.

The unidimensional model showed a very poor fit to the data ($CFI = .46$, $TLI = .42$, $RMSEA = .23$, $SRMR = .22$), clearly indicating that the model should be rejected according to commonly accepted fit criteria (Schermele-Engel et al., 2003). Fit indices are reported in Table 4.

Table 4

Fit indices for tested CFA models

Model	Items	CFI	TLI	RMSEA (95% CI)	SRMR	χ^2	df	χ^2/df
Four-factor (final)	25	.890	.878	.105 [.095–.115]	.101	656	269	2.44
Four-factor (i05 excluded)	24	.893	.879	.108 [.097–.119]	.100	622	246	2.53
One-factor	25	.464	.415	.229 [.220–.238]	.216	2165	275	7.87

3.1. Reliability

Internal consistency was examined for each IIQ subscale using McDonald's ω and Cronbach's α . Reliability estimates were satisfactory across all dimensions. Specifically, McDonald's ω was .75 for Rejection, .78 for Acceptance, .91 for Engulfment, and .89 for Enrichment, all exceeding the commonly accepted threshold of .70 (Boateng et al., 2018). Cronbach's α showed a comparable pattern, with values of .73 for Rejection, .77 for Acceptance, .91 for Engulfment, and .89 for Enrichment, successfully exceeding the .70 threshold recommended for an acceptable level of internal consistency, with several dimensions reaching good to excellent reliability (Ahmad et al., 2024; Nunnally & Bernstein, 1994). These results indicate adequate to excellent internal consistency for all subscales. Reliability estimates for each IIQ subscale are reported in supplementary materials.

3.2. Preliminary evidence of construct validity

Preliminary evidence of construct validity was evaluated by inspecting correlations among the IIQ latent factors. These analyses were limited to the internal pattern of associations among the IIQ dimensions and did not constitute tests of convergent, discriminant, or criterion validity. As expected, maladaptive illness identity dimensions were positively associated, with Rejection

showing a positive correlation with Engulfment ($r = .38, p < .001$). Acceptance was negatively associated with both Rejection ($r = -.45, p < .001$) and Engulfment ($r = -.45, p < .001$), and positively correlated with Enrichment ($r = .28, p = .003$). Correlations between maladaptive dimensions and Enrichment were small and non-significant. Overall, the pattern of associations was consistent with the theoretical framework of illness identity and with previous findings reported by Oris et al. (2016). Inter-factor correlations are reported in Table 5.

Table 5

Correlations among IIQ latent factors

	1.Rejection	2.Acceptance	3.Engulfment
1.Rejection	—		
2.Acceptance	-.45*** (-.23**)	—	
3.Engulfment	.38*** (.11)	-.45*** (-.39***)	—
4.Enrichment	.06 (.06)	.28** (.20**)	.04 (.11)

Note. Values represent standardized correlations between latent factors. Values in brackets refer to correlations reported in the original study (MSDs sample; Oris et al., 2018). ** $p < .01$, *** $p < .001$.

Exploratory analyses revealed a small-to-moderate positive association between age and Engulfment ($\rho = .33, p < .001$), indicating that older participants tended to report higher levels of illness engulfment. No significant associations emerged between age and the other IIQ dimensions. Exploratory gender comparisons were conducted using Welch's independent-samples t-tests. No significant gender differences emerged for Rejection, Acceptance, or Engulfment. A nominally significant difference was observed for Enrichment, with women reporting higher scores than men, $t(67.4) = 2.32, p = .023, d = .45$. Given the exploratory nature of these analyses and the number of comparisons performed, this finding should be interpreted with caution.

4. Discussion

The present study aimed to test the factorial structure, reliability, and construct validity of the Italian version of the Illness Identity Questionnaire (IIQ) in a sample of adults with chronic illness. Overall, the findings provided support for the psychometric adequacy of the Italian version of the IIQ.

Confirmatory factor analyses supported the hypothesized four-factor structure, consistent with the theoretical model underlying the instrument and with previous validation studies conducted in other cultural contexts (Ingersgaard et al., 2022; Oris et al., 2018; Sematlane et al., 2022). In addition, all IIQ subscales demonstrated satisfactory to excellent internal consistency, supporting the reliability of the Italian version of the questionnaire.

A single exception was observed for item 05 of the Rejection factor, which showed a relatively lower standardized factor loading ($\beta = .41$) compared to the other indicators of the same factor. Unlike the other items, which refer more directly to excluding the illness from one's identity, Item 05 ("I avoid thinking about my illness") may describe the avoidance of illness-related thoughts. Therefore, it may partly capture an avoidant coping process rather than the core identity-based dimension of illness rejection. This conceptual ambiguity may help explain its comparatively weaker association with the Rejection factor. Nevertheless, the removal of Item 05 did not produce a meaningful improvement in model fit. Given the preliminary nature of the present validation, we considered the available evidence insufficient to justify modifying the original composition of the IIQ. The item was therefore retained to preserve comparability with the original instrument and previous adaptations. However, this decision should be regarded as provisional, and the content and psychometric functioning of Item 05 should be examined in larger independent samples, ideally including external measures of avoidant coping.

Although the hypothesized four-factor structure was supported, model fit indices showed a mixed pattern, with acceptable incremental fit indices but suboptimal absolute fit indices. Methodological research has cautioned against relying rigidly on conventional cut-off values, particularly when evaluating ordinal factor models (Marsh et al., 2004; Shi et al., 2020). These considerations provide useful context for interpreting the present findings but do not negate the suboptimal values observed for some fit indices. Therefore, although the factor loadings, theoretical coherence of the model, and comparison with the unidimensional model provide support for the proposed four-factor structure, its factorial validity should be considered preliminary.

Preliminary evidence of construct validity was provided by the pattern of associations among the IIQ dimensions. As theoretically expected (Oris et al., 2016), maladaptive illness identity dimensions were positively associated with each other, whereas adaptive dimensions showed negative associations with maladaptive dimensions and positive associations among themselves. In particular, Acceptance was negatively related to both Rejection and Engulfment and positively associated with Enrichment, reflecting a coherent pattern of relationships consistent with the illness identity framework. Overall, these findings align with previous research and support the conceptual distinction between adaptive and maladaptive forms of illness identity (Ingersgaard et al., 2022; Oris et al., 2018; Sematlane et al., 2022). However, because no external validation measures were included, the present findings should not be interpreted as evidence of convergent, discriminant, or criterion validity.

Exploratory analyses showed a positive association between age and Engulfment, suggesting higher illness-related immersion in older participants. This finding is partially consistent with

previous research, although evidence remains mixed (Oris et al., 2018; Sematlane et al., 2022). No other age-related associations emerged. Regarding gender, no differences were found for Rejection, Acceptance, or Engulfment, consistent with prior IIQ studies reporting no significant gender differences (Oris et al., 2016, 2018; Sematlane et al., 2022). Although women reported higher Enrichment scores, this effect should be interpreted cautiously given its exploratory nature and the lack of consistent supporting evidence. The present findings contribute to the growing literature on illness identity by extending the applicability of the IIQ to an Italian-speaking context. From a theoretical perspective, the results support the multidimensional conceptualization of illness identity and its relevance for understanding psychological adaptation to chronic illness. From a clinical standpoint, the availability of a validated Italian version of the IIQ may facilitate the assessment of identity-related processes in individuals with chronic conditions, providing clinicians with a useful tool to identify maladaptive identity patterns and to tailor psychological interventions aimed at promoting adaptive adjustment and well-being.

5. Limitations

Some limitations should be acknowledged. First, the use of a convenience sample and a relatively modest sample size may limit the generalizability of the findings. Given the complexity of the 25-item four-factor model, the limited sample size may also have affected the stability of the parameter estimates and the observed model fit. Therefore, the present psychometric findings should be considered preliminary and interpreted with caution until they are replicated in larger, independent samples. The sample was also predominantly female, potentially affecting the representativeness of the results. In addition, age was collected using 5-year categorical intervals rather than as a continuous variable, which reduced the statistical precision and flexibility of the exploratory analyses examining associations between age and the IIQ dimensions. Second, the cross-sectional design precludes conclusions regarding the temporal stability of illness identity. Third, evidence of construct validity was limited to internal associations among the IIQ dimensions. Furthermore, the clinical heterogeneity of the sample may also have introduced additional variability related to differences in prognosis, symptom burden, and daily-life impact across chronic conditions, potentially contributing to the observed model fit.

Finally, data were collected via an online survey, which may have excluded individuals without access to digital devices, introducing a potential selection bias.

6. Future directions

Future studies should replicate the present findings in larger, independent samples and aim to recruit more gender-balanced samples. Age should be collected as a continuous variable to improve the precision and flexibility of age-related analyses. Future studies should also examine

convergent and discriminant validity using external measures, assess test–retest reliability, and use longitudinal designs to investigate the temporal stability of illness identity. Further research should explore the functioning of the IIQ across specific diagnostic groups and evaluate measurement invariance across relevant sociodemographic and clinical characteristics. These developments would support the further validation and broader application of the Italian IIQ across diverse clinical populations.

7. Conclusions

The present study provides initial evidence supporting the factorial validity, reliability, and construct validity of the Italian version of the Illness Identity Questionnaire in adults with chronic conditions. The findings supported the original four-factor structure over a unidimensional model, although model fit was acceptable rather than optimal and all four IIQ subscales showed satisfactory to excellent internal consistency. Moreover, the pattern of inter-factor correlations was consistent with the theoretical distinction between adaptive and maladaptive illness identity processes.

From a clinical perspective, the Italian IIQ appears to be a promising instrument for assessing how individuals integrate chronic illness into their sense of self and for identifying identity-related processes that may be relevant to psychological adjustment. Its availability offers new opportunities for the assessment and study of illness identity in Italian-speaking populations. However, given the preliminary nature of the present validation, these findings should be interpreted with caution and confirmed in larger, independent samples.

Ethical approval

The study was approved by the Ethics Committee of Pegaso University (PROT./E 003815, 13 June 2025).

Informed Consent Statement

All participants completed the informed consent form and agreed to take part in the study.

Data Availability Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any potential conflict of interest.

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Authors' Contribution

MGM: Conceptualization; Formal analysis; Methodology; Project administration; Writing - original draft. MDT: Conceptualization; Methodology; Project administration; Resources; Supervision; Writing - review & editing. VS: Investigation; Writing - original draft. DC: Investigation; Writing - original draft. MR: Formal analysis; Visualization; Writing - original draft. AG: Conceptualization; Methodology; Project administration; Resources; Supervision; Writing - review & editing.

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