Body talk: Sex differences in the influence of alexithymia on physical complaints among psychiatric outpatients

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ABSTRACT

This study investigated the relationship between alexithymia and physical complaints among psychiatric outpatients, and whether sex moderated this relationship. Participants (N = 185) completed measures of physical complaints (bodily symptom burden, pain severity, pain interference), alexithymia, current symptom (depression, anxiety) distress, and somatosensory amplification (i.e., a person's tendency to be bothered by physical sensations). Hierarchical regression analyses were conducted, controlling for the influence of current psychiatric symptom distress and somatosensory amplification. Findings revealed differential relationships between alexithymia and physical complaints (pain interference) for women and men, in addition to main effects for sex and alexithymia. The findings suggest that the negative influence of alexithymia on bodily-related problems may not be universal.

1. Introduction

Physical symptoms and complaints, such as pain, headache, muscle tension, dizziness, and fatigue, are a common manifestation of psychological distress (Simon et al., 1999). Indeed, physical symptoms often present as the chief complaint of psychiatric illnesses across different medical settings (Kapfhammer, 2006). Studies have shown that regardless of medical explanations, as the number of presenting physical symptoms increases, so do the odds that the person will also meet criteria for common psychiatric disorders such as depression and anxiety (Escobar et al., 2010). Psychiatric outpatients whose illness is accompanied by physical complaints appear to have a particularly high burden of illness (Vietri et al., 2015), including greater limitations in daily activities (Emptage et al., 2005), worse health related quality of life (Chung et al., 2012), greater likelihood of being unemployed due to disability (Kassam and Patten, 2006), and increased risk of suicide (Jeon et al., 2016). Typically, their physical symptoms have a tendency to remain medically unexplained, become chronic and disabling, lead to increased health care utilization, and interfere with treatment of their psychiatric illness (Escobar et al., 2010; Ogrodniczuk et al., 2008).

Among the factors that have been investigated to better understand physical complaints among psychiatric outpatients is alexithymia. Current conceptualizations describe alexithymia as a trait deficit in the cognitive processing of emotional experience, entailing an impaired capacity to construct mental representations of emotions, which are needed to cognitively process emotional experiences and to verbally communicate such experiences to others (Taylor et al., 2016). As Smith and Flannery-Schroeder (2013) explain, because of these difficulties with emotion awareness, alexithymic individuals tend to focus on visceral sensations that accompany emotional arousal instead of on the emotions themselves, confusing negative affective states with somatic complaints. Thus, an alexithymic individual's distress tends to be expressed somatically rather than cognitively processed and verbally communicated, leading to increased reporting of physical complaints. Indeed, several studies report strong associations between alexithymia and physical complaints (Lumley et al., 2007).

Alexithymia has been shown to be associated with pain in patients with rheumatoid arthritis, migraine headaches, and systemic lupus erythematosus (Lumley et al., 2005), as well as among healthy adults (Katz et al., 2009; Nyklíček and Vingerhoets, 2000). Similarly, increased physical symptom reporting has been found to be associated with higher alexithymia among patients with major depression (Taycan et al., 2015) and chronic PTSD (Kusevic et al., 2013), and among individuals with histories of childhood traumas (Smith and Flannery-Schroeder, 2013). Elevated levels of alexithymia have been found among people experiencing low back pain (Mehling and Krause, 2007), chronic pain (Shibata et al., 2014), and non-cardiac chest pain (Bozkurt Zincir et al., 2014). Alexithymia has also been shown to predict physical...
impairment in patients with various medical and psychological conditions (Lumley et al., 2002; Shibata et al., 2014). The broad spectrum of illnesses among which alexithymia is associated with physical complaints and impairment suggests that its effect is not limited by diagnosis and that its clinical relevance extends beyond patients with psychological disorders to include populations with clear organic pathology (Hosoi et al., 2010).

Though seemingly robust, the association between alexithymia and physical complaints among psychiatric outpatients may not be as straightforward as it appears. Potentially complicating the matter is the influence of sex. It is frequently reported that alexithymia is higher among men than in women (Mattila et al., 2006; Levant et al., 2009), though there seems to be less evidence for sex differences within clinical samples compared to non-clinical samples (Levant et al., 2009). Furthermore, the relationships between alexithymia and various psychological and medical problems may differ for women and men. For example, Larsen et al. (2006) reported an interaction between sex and alexithymia that reflected an association between alexithymia and disordered eating among men, but not women. Another study demonstrated that alexithymia was associated with elevated blood pressure and risk for hypertension among men only (Jula et al., 1999). White et al. (2011) reported that men with high alexithymia were significantly more likely to develop non-cardiac chest pain and to experience functional impairment related to that ailment. More recently, Luminet et al. (2016) reported sex differences in how alexithymia moderated the relation between depression and craving among alcohol-dependent patients.

Collectively, the findings from these various studies point to the possibility that the influence of alexithymia on physical complaints among psychiatric outpatients may differ between men and women. To our knowledge, no study has explored this possibility. The present study was undertaken to investigate the relationship between alexithymia and physical complaints among psychiatric outpatients, and whether sex moderated this relationship.

2. Methods

2.1. Participants

Participants (N = 185) were consecutively admitted, adult outpatients who sought psychiatric care at clinics of three urban hospitals in Canada. Institutional ethics approval was obtained at each site. Most commonly, outpatients from these clinics experience mood, anxiety, and personality disorders. Formal psychiatric diagnoses were not conducted for this study; treatment services in the study clinics, as in most public mental health clinics in Canada, are not dependent on establishing formal psychiatric diagnoses. No inclusion/exclusion criteria were specified for participation in the study, as we were interested in recruiting a typical clinical sample. To receive treatment in these clinics, individuals had to be at least 18 years of age and able to communicate in English.

2.2. Procedures

Participants completed a survey that included self-report measures of alexithymia, physical complaints, current psychiatric symptom distress, somatosensory amplification, and demographic information. Alexithymia was assessed with the 20-item Toronto Alexithymia Scale (TAS-20; Bagby et al., 1994), which yields a total score with higher scores indicating a great level of alexithymia. The factor structure, internal consistency, and validity of the TAS-20 are well established (Quilty et al., 2017; Watters et al., in press). Physical complaints were assessed using two measures. The first was the 13-item Somatic Symptoms Inventory (SSI; Derogatis et al., 1974), which measures bodily symptom burden, and has satisfactory test-retest reliability, internal consistency, and convergent and external validity (Barsky et al., 1990a; Weinstein et al., 1989). The second measure was the Brief Pain Inventory-Short Form (BPI; Cleeland, 2009), which measures pain severity and pain-related interference (i.e., impact of pain on the patient’s daily functioning). One of the most widely used tools for pain assessment, the BPI has well established reliability and validity and is recommended as a core outcome measure for pain (Dworkin et al., 2005). Current symptom distress was assessed using the depression and anxiety subscales of the Brief Symptom Inventory-18 (BSI-18; Derogatis, 2000), which is widely used and has well-established psychometric properties (Asner-Self et al., 2006; Franke et al., 2017). Somatosensory amplification was assessed using the 10-item Somatosensory Amplification Scale (SSAS; Barsky et al., 1990b), which reflects a person’s tendency toward bodily hypervigilance and to experience physical sensations as intense, noxious, and disturbing. The reliability and validity of the SSAS have been established in a large number of cross-cultural studies (Nakao and Barsky, 2007).

2.3. Statistical analyses

Three hierarchical regression analyses were conducted to examine the moderating influence of sex on the association between alexithymia and physical complaints. The total score from the SSI, and the pain severity and pain interference scores from the BPI served as the dependent variables. The BSI-18 depression and anxiety scores, along with the SSAS score, were entered in Step 1 of each analysis and acted as control variables to account for the influence of current psychiatric symptom distress and a person’s tendency to be bothered by physical sensations. Sex was entered in Step 2, alexithymia was entered in Step 3, and the product term representing the interaction between sex and alexithymia was entered in Step 4.

3. Results

The majority of the 185 participants were female (60.0%), the average age was 38.2 years, nearly half were single (44.9%) and 37.3% were living with a partner, 70.5% were educated beyond high school, and half (49.2%) were employed. Most participants (87.8%) were Caucasian. Many participants (67.2%) reported previous psychiatric treatment, and nearly a quarter (24.0%) reported previous psychiatric hospitalizations. The mean depression score on the BSI-18 was 13.0 (SD = 6.1) and for anxiety it was 11.3 (SD = 5.7), indicating moderate levels of depressive and anxious symptoms. With regard to bodily complaints, the mean scores were 2.7 (SD = 0.8) for the SSI, 3.4 (SD = 2.0) for BPI-severity, and 3.6 (SD = 2.7) for BPI-interference. The average score on the SSAS was 2.1 (SD = 0.8). The mean score for the TAS-20 was 59.2 (SD = 13.7), indicating a high level of alexithymia in the sample, and there was no evidence of a significant difference between men and women (t = 0.593, df = 183, p = 0.554).

Table 1 shows the findings of the regression analyses. In each analysis, anxious symptoms and somatosensory amplification emerged as significant covariates.

For bodily symptom burden (SSI), a main effect of sex was observed, indicating that women had significantly greater physical complaints compared to men. In addition, a main effect for alexithymia was revealed, showing higher levels of bodily symptom burden occurring with higher levels of alexithymia. The interaction between sex and alexithymia failed to achieve statistical significance (p = 0.10).

For pain severity (BPI), there was no indication of significant main effects for sex or alexithymia. Though the interaction between sex and alexithymia pointed to a moderate association between alexithymia and pain severity for women, but minimal association between these variables for men, it did not quite achieve statistical significance (p = 0.06).

For pain interference (BPI), there was not a significant main effect for sex, but there was a significant main effect for alexithymia, demonstrating greater interference from pain being reported with higher
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