

# Secondary Alexithymia as a State Reaction in Panic Disorder and Social Phobia

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**In a 6-month follow-up study, a change in alexithymia was examined in two samples of 26 patients with panic disorder and 24 patients with social phobia. Before psychiatric treatment, the prevalence rate of alexithymia, measured by the 20-Item Toronto Alexithymia Scale (TAS-20), was higher for both panic disorder (54%) and social phobia (58%) groups than for healthy persons (15%). After treatment, scores on the alexithymia constructs of difficulty identifying feelings**

**and difficulty describing feelings significantly decreased in panic disorder and social phobia patients. The overall decrease in measures of alexithymia in both groups was significantly related to reduction in anxiety, but not depression. The results suggest that secondary alexithymia related to anxiety exists as a state reaction in patients with panic disorder and social phobia.**

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**S**IFNEOS<sup>1</sup> PROPOSED the term alexithymia in 1973 to describe a cognitive-affective disturbance characterized by difficulty in identifying and describing feelings and in elaborating fantasies. The concept of alexithymia was derived from clinical observations of patients with classic psychosomatic illnesses.<sup>1,2</sup> Freyberger<sup>3</sup> divided alexithymia into two types: (1) primary as a personality trait and (2) secondary as a state reaction, as seen in intensive care unit, critical care unit, dialysis, and transplant patients.<sup>3</sup> Recent studies have shown relatively high rates of alexithymia among psychiatric patients with substance use disorder,<sup>4</sup> eating disorder,<sup>5</sup> posttraumatic stress disorder,<sup>6</sup> and panic disorder.<sup>7-9</sup>

Three studies assessed alexithymia in patients with panic disorder.<sup>7-9</sup> Two<sup>7,8</sup> of the studies demonstrated a high prevalence of alexithymia in patients with panic disorder. The third report focused on alexithymia in panic disorder and social phobia patients,<sup>9</sup> noting the frequency of alexithymia among patients with panic disorder as unstable. These studies were conducted using a cross-sectional design. To our knowledge, a longitudinal follow-up study on alexithymia in panic disorder patients has not been conducted. Therefore, in a 6-month follow-up study, we examined the following three factors: (1) the prevalence rate of alexithymia in patients with panic disorder and social phobia, (2) whether psychiatric treatment of panic disorder or

social phobia affects alexithymic characteristics, and (3) if alexithymic characteristics are affected by treatment, what (if any) psychiatric factors are associated with changes in alexithymia.

## METHOD

Subjects included 26 patients with panic disorder and 24 patients with social phobia who were admitted to the Department of Psychiatry at Tokyo Metropolitan Fuchu Hospital or Kumagaya Psychiatric Clinic of Japan. All patients provided informed consent. The patient group with panic disorder consisted of 12 men and 14 women aged 22 to 49 years, with a mean of 31.7. The patient group with social phobia consisted of nine men and 15 women aged 18 to 47 years, with a mean of 33.7. The mean education in both groups was 13.5 years (range, 10 to 16) and 12.9 years (range, 8 to 16), respectively. For controls, we used 25 subjects recruited from 216 healthy persons living in the Tokyo metropolitan area. The control group contained 10 men and 15 women aged 20 to 48 years, with a mean of 33.0. The mean education in the control group was 13.4 years (range, 11 to 16).

## Procedure

At the time of hospital admission, the Structured Clinical Interview for DSM-III-R (SCID)<sup>10</sup> was administered by a psychiatrist and/or a psychologist to ascertain the presence or absence of a current psychiatric disorder. After the SCID, the interviewers assessed the severity of anxiety and depression using two interviewer-rating scales, the Hamilton Depression Scale (HDS)<sup>11</sup> and Hamilton Anxiety Scale (HAS).<sup>12</sup> If a patient was diagnosed with panic disorder or social phobia (DSM-IV),<sup>13</sup> the Japanese version of the 20-Item Toronto Alexithymia Scale (TAS-20)<sup>14</sup> was administered. Social phobia patients with panic attack were excluded from the study. The TAS-20<sup>15,16</sup> is a self-report questionnaire that assesses alexithymia and has three subscales: difficulty identifying feelings (factor 1), difficulty describing feelings (factor 2), and externally oriented thinking (factor 3). The items are rated on a five-point Likert scale. The reliability and validity of the Japanese version of the TAS-20 were supported by factor analysis, high test-retest correlations, relatively high internal consistency, and high correlations with the Beth Israel Hospital Questionnaire and Minnesota Multiphasic Personality Inventory-2.<sup>14</sup> Internal consistency was supported by adequate  $\alpha$  coefficients. Factor analysis showed

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replicability of the theoretical model of three-factor structures for the Japanese version of the TAS-20. A score of 60 or 61 has been regarded as an acceptable cutoff score for the Japanese version of the TAS-20 (alexithymic when the score is >61).<sup>14</sup> In accordance with techniques described by Beurs et al.,<sup>17</sup> psychological management combined with exposure was used in 12 weekly treatment sessions. Six months after the start of treatment, a second assessment of alexithymia was conducted using the TAS-20.

## RESULTS

To judge whether the two subject groups and the control group were successfully matched with respect to demographic composition, an analysis of variance (ANOVA) for continuous demographic variables, i.e., age and years of education, and a chi-square ( $\chi^2$ ) test for categorical demographic variables, i.e., gender, were performed. A Student *t* test (unpaired, two-tailed) was subsequently applied. All differences were considered significant at *P* less than .05. For statistical analyses, SYSTAT software (version 5.2) for Macintosh was used. The variances were nonsignificant, indicating that the three groups were adequately matched.

Using the cutoff score of the TAS-20, a  $\chi^2$  test was used to check for significant differences in the prevalence rate of alexithymia before and after psychiatric treatment. In a 2 × 2 factorial design, outcome variables were analyzed with ANOVA for two-factor repeated measures using pretest to posttest data on alexithymia in the social phobia and panic disorder groups.

### *Comparison of Patient Groups and Healthy Group*

Before psychiatric treatment, the prevalence rate of alexithymia was 53.8% (14 of 26) and 58.3% (14 of 24) in the panic disorder and social phobia groups, respectively. After treatment, the prevalence rate of alexithymia was 30.8% (eight of 26) and 33.3% (eight of 24) in the panic disorder and social phobia groups, respectively. In 23 of 26 patients with panic disorder (88.5%) and 20 of 24 patients with social phobia (83.3%), scores on the TAS-20 decreased after treatment.

The prevalence rate of alexithymia in the control group was 16.0% (four of 25), with scores (mean ± SD) of 52.1 ± 8.8 (total), 19.6 ± 4.2 (factor 1, difficulty describing feelings), 13.7 ± 4.1 (factor 2, difficulty identifying feelings), and 18.7 ± 4.2 (factor 3, externally oriented thinking).

In a comparison of three groups (two patient and one control) on the prevalence rate of alexithymia

as measured by the TAS-20, significant differences were found ( $\chi^2 = 7.0$ , *P* < .05). The prevalence rate of alexithymia was significantly higher for the panic disorder group versus the control group ( $\chi^2 = 10.2$ , *P* < .01) and for the social phobia group versus the control group ( $\chi^2 = 10.2$ , *P* < .01). After treatment, although the prevalence rate was higher for the two patient groups than for the control group, all significant differences among the three groups were eliminated.

Similar results were noted in a comparison of the groups on the mean score for the TAS-20. A factorial ANOVA found that total TAS scores differed significantly across groups, being highest in the panic disorder group and lowest in the control group (*P* < .01). Post hoc *t* tests after the factorial ANOVA found that before treatment, total TAS scores were significantly higher for the panic disorder group versus the control group ( $t_{49} = 3.91$ , *P* < .001) and for the social phobia group versus the control group ( $t_{47} = 2.56$ , *P* < .05). As for total TAS scores after treatment, all significant differences among the three groups were eliminated.

### *Changes of Alexithymic Characteristics Before and After Psychiatric Treatment in the Patient Groups*

ANOVA for two-factor repeated measures on pretest to posttest data showed that total TAS scores on alexithymia decreased significantly after treatment for both patient groups (*P* < .001; Table 1). Scores on factors 1 and 2 but not factor 3 of the TAS-20 decreased significantly (factor 1, *P* < .001; factor 2, *P* < .001).

### *Relationships of Alexithymia to Depression and Anxiety*

Total TAS scores and scores for factors 1 and 2 but not for factor 3 were significantly and positively correlated with HDS scores on depression before treatment in both panic disorder and social phobia groups (Table 2). After treatment, no significant differences between the TAS-20 and HDS were found in either the panic disorder or social phobia groups. As for the control group, total TAS scores and scores for factors 1 and 2 but not for factor 3 were significantly and positively correlated with HDS scores on depression.

Total TAS scores and scores for factors 1 and 2 but not for factor 3 were significantly and positively correlated with HAS scores on anxiety

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