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ALEXITHYMIA AND RISK OF DEATH IN MIDDLE-AGED MEN

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Abstract—We prospectively examined the association between alexithymia and risk of death over an average follow-up time of nearly 5.5 years in 42- to 60-year-old men ($N=2297$) participating in the Kuopio Ischemic Heart Disease Risk Factor Study (KIHD). Alexithymia, impairment in identification, processing, and verbal expression of inner feelings, was assessed by the validated Toronto Alexithymia Scale (TAS). In age-adjusted survival analyses, men in the highest alexithymia quintile had a twofold greater risk of all-cause death ($p<0.001$) and a threefold greater risk of death from accidents, injury, or violence ($p<0.02$) relative to the men in the three lowest alexithymia quintiles. There was little evidence for confounding by behavioral factors (smoking, alcohol consumption, physical activity), physiological risk factors (LDL, HDL, body mass index, hypertension), socioeconomic status, marital status, perceived health, prior diseases and diagnoses, depressive symptoms or social connections. Consistent and even stronger associations between alexithymia and all-cause death were found in a healthy subgroup ($N=1650$). Why difficulties in dealing with emotions associate with increased mortality remains unclear. Our findings suggest that the association is independent from the effect of well-known behavioral, biological, and psychosocial risk factors. *Copyright © 1996 Elsevier Science Inc.*

Keywords: Alexithymia; Cohort study; Emotions; Epidemiology; Mortality; Population studies.

INTRODUCTION

Previous research has shown that alexithymia, impairment in identification, processing, and verbal expression of inner feelings [1, 2], associates cross-sectionally with many somatic syndromes and disorders, such as hypertension [3], rheumatoid arthritis [4], diabetes [5], chronic pain [6, 7], obesity [8] and various gastrointestinal problems [9, 10]. Todarello and coworkers have observed associations of alexithymia with breast cancer [11] and lymphocytic functions in cervical neoplasia [12] in patients who were unaware of their disease status. Eating disorders [13, 14], as well as substance abuse [15–17] and heavy drinking [18] have also been linked to alexithymic characteristics.

Does alexithymia underline, exacerbate, or even cause somatic health problems? From the epidemiologic point of view, addressing the issues of etiology and causality in a true follow-up setting has not been possible, because previous studies, with

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few exceptions [11, 19, 20], have been cross-sectional and have provided little information on potentially important confounding variables such as smoking, alcohol use, and prior or existing diseases. Another obstacle has been the operationalization of alexithymia; it has been difficult to interpret and compare the results from studies that examine the relationship between alexithymia and health due to the variation in ways of measuring alexithymia. The assessment methods have included the MMPI alexithymia scale [6], the Schalling–Sifneos Personality Scale [3, 8, 10–12, 15], The Beth Israel Questionnaire [4, 7, 10], projective tests [8], and the Toronto Alexithymia Scale [4, 7, 13, 14, 16–18]. The Toronto Alexithymia Scale (TAS) [21, 22] can be viewed as the first psychometrically well validated and reliable method to assess alexithymic characteristics.

The aim of the present study was to examine prospectively the association between alexithymia and risk of death from all causes in a population-based sample of middle-aged Finnish men who have participated in the Kuopio Ischemic Heart Disease Risk Factor Study (KIHD) [23]. The KIHD study is specifically designed to investigate previously unestablished but theoretically promising risk factors of ischemic heart disease and early death. As such, it includes a large number of behavioral, clinical and psychosocial assessments allowing examination of a variety of possible confounders.

METHOD

Study population

The participants in the Kuopio study (KIHD) were randomly selected from the general population in two cohorts [23]. Of 3433 eligible men aged 42, 48, 54, or 60 who resided in the town of Kuopio and surrounding rural communities, 198 were excluded because of death, serious disease, or migration away from the area. The total sample numbered 2682 (participation rate 82.9%). The medical and behavioral baseline examinations were conducted between March 1984 and December 1989. Alexithymic characteristics were assessed via questionnaire in May 1988, or during the baseline examination for those who entered the study later. Sociodemographic and other background characteristics of the sample have been described earlier [23–25]. The present analysis is based on 2297 respondents for whom complete information on both mortality and alexithymia score was available.

Outcome

All-cause mortality, including deaths due to diseases, injuries, suicides, and homicides, were ascertained by linkage to the national death registry. All deaths that occurred between the assessment of alexithymia and December 31, 1993 were included ($N=132$). Of these, 27 were classified as “external deaths” (suicides, homicides, injury deaths, accidental poisonings) based on the ICD-9 codes 800 and above. The average follow-up time for the participants was 5.3 years.

Assessment of alexithymia

The 26-item version of the Toronto Alexithymia Scale (TAS) [21] was used to assess alexithymia. The TAS has been validated both in other general adult populations [26, 27] and in this study population [24, 28, 29]. The original four-factor construct [21] was closely replicated in our previous validation study [24] and the scores were shown to be stable over time [24]. Cross-validation with a clinical interview [24] and other measures [24, 28] further suggested the validity of the measure. The distribution of the TAS was approximately normal with a skewness of -0.018 , a mean of 67.7 (SD 10.9), and a range from 33 to 107. The ranges for the five quintiles each constituting approximately one fifth of the study population were 33–58 (first), 59–64 (second), 65–70 (third), 71–77 (fourth), and 78–107 (fifth quintile). The first three quintiles (60.0% of the study population) were grouped together and defined as “nonalexithymic.” Those men who were in the fourth quintile (20.9%) were considered “moderately alexithymic,” and the men in the highest quintile (19.1%) formed a “highly alexithymic” group. Thus, the highest quintile included men who clearly scored above the cutoff score of 74, which has been widely used as an empirically established cutoff point for identifying alexithymic individuals.

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