



NEUROTICISM, ALEXITHYMIA AND MEDICALLY UNEXPLAINED SYMPTOMS

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(Received 28 May 1996)

Summary—The contribution that alexithymia can make to the understanding of medically unexplained physical symptoms (MUS) was studied in 244 subjects drawn from a range of medical and non-medical situations. People's histories of MUS—also called somatisation—were assessed using physical symptom lists derived from the DSM-III-R somatisation criteria. Two subscales from the Toronto Alexithymia Scale-20 had significant correlations with reported MUS, but also with neuroticism, negative emotion health coping, anxiety, depression, general psychological distress and dysphoric mood. Despite there being a large general latent trait (negative affectivity) underlying most of the measured variables, the best model of the data in men and women was a two-factor model that emphasised that alexithymia could make a contribution to MUS variance beyond that made by negative affectivity. It is suggested that, for the purposes of studying MUS, alexithymia might be reconstructed as a single component construct, related to a confusion among feelings and between feelings and bodily symptoms, rather than its present three-component structure. A two parameter model for the occurrence of medically unexplained physical symptoms is proposed in which negative affectivity acts as a threshold factor (influencing symptom detection) and alexithymia acts as an interference factor (influencing symptom discrimination/recognition). © 1997 Elsevier Science Ltd. All rights reserved.

INTRODUCTION

The purpose of this study was to examine whether the concept of alexithymia, as measured by the Toronto Alexithymia Scale (TAS and its newer form, the TAS-20; Bagby, Parker & Taylor, 1994a; Bagby, Taylor & Parker, 1994b; Taylor, Bagby, Ryan & Parker, 1990) could add to our understanding of the phenomenon of medically unexplained symptoms (MUS). We sought to discover whether TAS-20 scores accounted for variance in MUS that is independent of other psychological constructs, such as neuroticism and coping styles. The experience of physical symptoms that do not result from organic disease is very common and is time-consuming and costly to health services (Kroenke, 1992; Mayou, Bass & Sharpe, 1995). Up to 20% of general practice consultations in the U.K. relate to physical complaints for which no physical reason will be found (Bridges & Goldberg, 1985), and such problems are among the commonest source of referrals to hospital outpatient clinics in the U.K. (Bradlow, Coulter & Brookes, 1992).

The medical phenomenon described above has attracted a number of names. These include hysteria, somatisation, somatoform disorders, psychosomatic symptoms (and/or syndromes), functional somatic symptoms and MUS. In preferring the term MUS, we are emphasising that there is no recognised theory of the generation of these symptom reports. Other terms are employed in this report where the investigators themselves have used the particular label, such as 'psychosomatic symptoms' and 'functional somatic symptoms'. Therefore, the literature survey that we offer must be read with the forewarning that the symptoms discussed would not always meet today's accepted categories of MUS (Mayou *et al.*, 1995).

The term alexithymia was first introduced by Sifneos (1973). The concept has since attracted many researchers and clinicians, resulting in a plethora of studies. These studies include: attempts to explain the aetiology of alexithymia, its relationships with other personality traits, the influence of alexithymia on therapeutic processes and the construction of a variety of measures to assess the construct (see Bagby *et al.*, 1994a; Lesser, 1981; Norton, 1989; and Taylor, Bagby, Ryan & Parker,

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1990 for discussions of these topics). Despite over 20 years of research it appears that only the broad definition of the concept has been agreed upon, and alexithymia is generally accepted as consisting of the following dimensions: difficulty identifying and describing feelings, difficulty in distinguishing between feelings and the bodily sensations of emotional arousal, constricted imaginative fantasy life, and the tendency to focus on the concrete details of external events ('*pensee operateire*') (Lesser, 1981; Nemiah, Freyberger & Sifneos, 1976; Taylor, 1984).

The idea that patients with a 'psychosomatic' disorder may be psychologically different from those without one has long been discussed in the literature (Freedman & Sweet, 1954; Marty & de M'Uzan, 1963; Reusch, 1948). Indeed, the very concept of alexithymia rose from clinical observations that many patients with psychosomatic disorders had difficulty talking about feelings and fantasies when assessed in psychodynamically oriented interviews. However, investigation of the relationship between alexithymia and psychosomatic disorders has been hampered by the lack of a valid and reliable measure. Moreover, medical disorders that were originally termed psychosomatic, such as rheumatoid arthritis, would not be included today under the banner of MUS or functional somatic disorders. A number of measures has been devised to assess the concept of alexithymia, including: the Beth Israel Hospital Psychosomatic Questionnaire (BIQ; Sifneos, 1973), a semi-standardised clinical interview; the Schalling-Sifneos Personality Scale (SSPS; Apfel & Sifneos, 1979), a self-report measure based on the BIQ; and an alexithymia score derived from the Minnesota Multiphasic Personality Inventory (MMPI-A; Kleiger & Kinsman, 1980), another self-report scale. Finally, there are two projective tests of alexithymia: the SAT9 test (Cohen, Auld, Demers & Catchlove, 1985), and the Rorschach Alexithymia Index (Acklin & Bernat, 1987).

Several authors have identified significant flaws with all of the above measures including unacceptably low inter-rater reliability coefficients for the BIQ (Taylor, Doody & Newman, 1981). Also, initial findings of a high level of agreement between SSPS and BIQ scores have not been replicated in subsequent studies (Demers-Desrosiers, Cohen, Catchlove & Ramsay, 1983; Federman & Mohns, 1984). Results from a study examining and comparing the psychometric properties of the SSPS, the MMPI-A and the SAT9 found that the SSPS and MMPI-A scales has dissimilar factor structures and therefore assess different domains, and that the inter-rater reliability of the SAT9 was so low that it raised serious doubts as to its measurement accuracy (Norton, 1989). Because of the lack of an adequate alexithymia measure, Taylor and colleagues constructed the Toronto Alexithymia Scale (TAS), initially a 26-item self-report scale but more recently a 20-item scale (TAS-20), using a measurement-based approach to validate the construct (Taylor, Ryan & Bagby, 1985). Results from a series of studies showed that especially the TAS-20 demonstrated internal consistency, good test-retest reliability, and a stable factor structure theoretically congruent with the alexithymia construct (Bagby *et al.*, 1994a, 1994b; Taylor *et al.*, 1990).

A study of 30 patients with a DSM-III diagnosis of psychogenic pain disorder found that in comparison to 30 age- and sex-matched controls the psychogenic pain patients had significantly higher scores on both the Toronto Alexithymia Scale (26-item version) and the Beth Israel Hospital Questionnaire (Sriram, Chaturvedi, Gopinath & Shanmugam, 1987). Another study of 207 patients, referred to an out-patient behavioural medicine service with a diagnosis of pain found that 36% of the sample scored in the 'alexithymic' range of the MMPI-A scale (Papciak, Feuerstein, Belar & Pistone, 1986-1987). A heterogeneous group of 107 psychosomatic patients was significantly more alexithymic, as measured by the BIQ, than a control group of patients with somatic complaints (Keltikangas-Jarvinen, 1985). Scores on the TAS were found to correlate more highly with functional somatic symptoms than did scores on the Schalling-Sifneos Personality Scale or the MMPI-Alexithymia Scale (Bagby, Taylor & Atkinson, 1988). Cohen, Auld and Brooker (1994) found an association between alexithymic features and a tendency to report physical signs and symptoms, although a small study by Bach, Bach, Bohmer and Nutzinger (1994a) found no more somatisation (based on responses to the Symptom Checklist 90) in a group of alexithymics. As recently as 1994, Wise and Mann stated that the relationship between alexithymia and somatosensory amplification remained unknown.

While psychosomatic patients appear to demonstrate greater levels of alexithymia than controls or patients with somatic disease, patients with psychiatric disorder have levels just as high (Lesser, Ford & Friedman, 1979) or greater (Rubino, Grasso, Sonnino & Pezzarossa, 1991) than psychosomatic patients. Other studies have also reported alexithymic traits in individuals with substance

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