

Alexithymia in Chronic Pain Patients

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Prior studies of alexithymia in chronic pain patients have used unvalidated alexithymia measures or have not controlled for treatment-seeking status. In this study, we compared 30 patients with chronic pain and patients seeking treatment for two other problems: nicotine dependence ($n = 32$) or moderate obesity ($n = 25$). Alexithymia was assessed with the well-validated Toronto Alexithymia Scale (TAS) and also with the Alexithymia Provoked Response Questionnaire (APRQ). On both alexithymia measures, chronic pain patients were more alexithymic than nicotine-

dependent and obese patients; the latter two groups did not differ. Chronic pain patients had greater psychopathology on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and both alexithymia measures correlated positively with certain types of psychopathology. We conclude that alexithymia is increased among patients with chronic pain, that this relationship is not confounded by a treatment-seeking bias, and that alexithymia may contribute to both chronic pain and psychopathology.

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THE FUNDAMENTAL CHARACTERISTIC of alexithymia is a deficit in the ability to differentiate affective from somatic states, and affective states from each other. As a result, alexithymic patients have difficulty identifying their feelings and communicating these feelings to others. Alexithymic patients also manifest cognitive characteristics including a paucity of fantasy, imagery, or daydreaming, as well as a thought style that is relatively concrete, external, and utilitarian rather than introspective.^{1,2}

Alexithymia was observed first in patients with "psychosomatic" and other somatoform disorders. In particular, early studies suggested that patients with chronic pain problems had increased alexithymia.³⁻⁸ Yet some of these studies failed to use control or comparison groups,^{3,4} and all used poor alexithymia measures such as the Minnesota Multiphasic Personality Inventory (MMPI) alexithymia scale,⁴⁻⁶ which probably is not valid, the Schalling-Sifneos Personality Scale,⁸ which has questionable reliability and validity, and the Archetypal Test with Nine Elements³ or the Rorschach Test,⁷ which are unvalidated or assess only one facet of alexithymia.⁹

Several recent studies of chronic pain have used the construct-derived and well-validated Toronto Alexithymia Scale (TAS)¹⁰ or its recent 20-item revision (TAS-20).¹¹ In a sample of motor vehicle accident survivors with chronic pain¹² and in a sample of heterogeneous chronic pain patients,¹³

alexithymia appeared to be increased; yet the lack of control or comparison groups in these studies limits conclusions about the alexithymia/chronic pain relationship. Three controlled studies compared patients with psychogenic pain disorder,¹⁴ rheumatoid arthritis,¹⁵ or inflammatory bowel disease¹⁶ with matched healthy, nonpatient controls. All of these studies found that pain patients were more alexithymic than healthy controls.

Although comparing chronic pain patients with healthy, nonpatient controls begins to specify the alexithymia/chronic pain relationship, such studies confound the presence of a disorder with the status of being a patient. It is noteworthy that patients who seek treatment for many disorders, including pain^{17,18} and nonpain^{19,20} problems, have greater psychopathology or distress (e.g., anxiety or depression) than controls who have the same disorder of similar severity yet do not seek treatment. Thus, to demonstrate that alexithymia is associated with chronic pain rather than the status of being a patient, it is important to compare pain patients with patients who seek treatment for other problems. To date, no study using a validated alexithymia measure has achieved this.

In this study, we used the TAS and evaluated alexithymia in patients with chronic pain who sought treatment in an outpatient pain/behavioral medicine clinic. To control for treatment-seeking bias and potential differences associated with the type of service or clinic attended (e.g., inpatient or outpatient and mental or somatic health), we compared these patients with two other groups also seeking treatment from the same service: patients with nicotine dependence (cigarette smoking) and patients with moderate obesity. We also assessed psychopathology in the chronic pain and obese samples to determine whether these groups differed

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0010-440X/97/3803-0003\$03.00/0*

in psychiatric disturbance, and whether alexithymia was related to psychopathology. Finally, consistent with the recommendation to use multiple methods to assess alexithymia,²¹ we included the Alexithymia Provoked Response Questionnaire (APRQ),²² an interview-based measure that assesses the emotional-awareness and communication deficits of alexithymia, although not the cognitive facets. The APRQ has not been widely used, and its validity and ability to differentiate chronic pain patients from other groups is unknown; thus, we also compared it against the well-validated TAS.

METHOD

Subjects

Subjects were 87 consecutive adult patients who were recruited when they presented for outpatient pain/behavioral medicine treatment. Patients were primarily white and from urban and suburban areas. They presented with one of three complaints:

(1) *Chronic pain.* Thirty patients (21 women) aged 20 to 61 years (mean, 40.4) sought pain management for heterogeneous, nonmalignant pain problems of at least 6 months' duration. Pain types included back or joint pain, usually secondary to injury ($n = 14$), headaches or facial pain ($n = 9$), myofascial pain ($n = 4$), gastrointestinal pain ($n = 2$), and pelvic pain ($n = 1$).

(2) *Cigarette smoking/nicotine dependence.* Thirty-two patients (17 women) aged 23 to 56 years (mean, 33.5) wanted to quit smoking. Patients smoked eight to 60 cigarettes per day (mean, 24.3) for 3 to 38 years (mean, 16.3).

(3) *Obesity.* Twenty-five patients (22 women) aged 20 to 55 years (mean, 38.4) sought weight-management therapy. Patients ranged in weight from 74.7 kg (166 lbs) to 131.8 kg (293 lbs) (mean, 96.5 kg, or 214.4 lbs). Patients had body mass indices (weight in kilograms divided by height in meters squared) of 26.7 to 49.9 kg/m² (mean, 34.3), consistent with moderate obesity (i.e., approximately 30% to 100% overweight). Patients without obesity (<26 kg/m²) or with morbid obesity (>100% overweight) were excluded, as were patients who reported purging or a history of bulimia.

Procedure and Measures

Patients provided informed consent and completed the following measures during the initial evaluation.

TAS. This 26-item questionnaire has been shown in numerous studies to have acceptable reliability and validity as a measure of alexithymia.^{9,23} TAS items are rated on a scale of 1 to 5 and totaled; scores are continuous and range from 26 to 130—higher scores indicate greater alexithymia. The TAS also has been used to classify patients, and a score of 74 or greater suggests the presence of alexithymia, whereas 62 or less suggests the absence of alexithymia.²⁴

APRQ. In this 17-item structured interview, patients are asked how they would feel in various emotion-provoking circumstances (e.g., "How would you feel if someone pulled a knife on you?", or "... if someone complimented you?").

Consistent with the construct of alexithymia, responses with emotional content are scored as 1 point, whereas responses that lack emotion and describe action, physical states, or situational details are scored as 0. Total scores range from 0 to 17, and lower scores indicate greater alexithymia. The interview was administered by a psychologist, who audiotaped and/or transcribed it verbatim and scored it; a second trained rater also scored 78% of the interviews, and interrater reliability was acceptable ($r = .89$).

MMPI-2. This well-known measure was completed only by the pain and obese patients. Scores were analyzed from the eight clinical scales, which assess a range of psychopathological features.²⁵

RESULTS

Chronic pain patients did not differ significantly from the other two groups in sex distribution. Chronic pain patients were significantly older than the smokers ($P = .008$), but were not significantly different in age from the obese patients. Across the entire sample, the TAS was not related significantly to either age or sex, but increased alexithymia on the APRQ was related to being older ($r = -.25$, $P = .02$) and being male (mean \pm SD, 10.4 ± 3.4 ; female: mean \pm SD, 12.0 ± 2.7 ; $t(85) = 2.3$, $P = .03$). Finally, the two alexithymia measures correlated with each other in the expected direction ($r = -.27$, $P = .01$).

Group Comparisons on Alexithymia Measures

Table 1 presents the means of both alexithymia measures for the three patient groups, as well as the distribution of TAS scores for each group. A one-way analysis of variance (ANOVA) compared the three groups on TAS and APRQ means. For the TAS, there was a significant ANOVA ($F(2, 84) = 3.44$, $P = .037$). Post-hoc contrasts indicated that pain patients were more alexithymic than smokers ($P < .05$) and obese patients ($P = .06$).

Table 1. TAS and APRQ Scores for Patients With Chronic Pain, Smoking, and Moderate Obesity

Measure	Pain ($n = 30$)	Smoking ($n = 32$)	Obesity ($n = 25$)
TAS (mean \pm SD)	67.4 \pm 8.2	60.8 \pm 11.8	62.8 \pm 9.8
≥ 74			
No.	4	4	4
%	13.3	12.5	16.0
63-73			
No.	21	12	7
%	70.0	37.5	28.0
≤ 62			
No.	5	16	14
%	16.7	50.0	56.0
APRQ (mean \pm SD)	10.4 \pm 2.9	11.9 \pm 3.0	12.2 \pm 2.8

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