

Relationship Between Somatosensory Amplification and Alexithymia in a Japanese Psychosomatic Clinic

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To examine the relationship between somatosensory amplification and three factors of alexithymia (difficulty identifying feelings, difficulty describing feelings, and externally oriented thinking), 48 outpatients attending a Japanese psychosomatic clinic and 33 comparative outpatients completed the Somatosensory Amplification Scale (SSAS), 20-item Toronto Alexithymia Scale (TAS-20), Profile of Mood States (POMS), and other self-rating questionnaires. The scores on the SSAS and the first and second TAS-20 factors were higher (all $P < 0.001$) in the psychosomatic group than in the comparison group. The SSAS was positively associated (both $P < 0.01$) with these two TAS-20 factors, controlling for the effects of age, sex, group, and POMS tension-anxiety and depression. Somatosensory amplification appears to be associated with difficulties identifying and describing feelings, not externally oriented thinking, in Japanese patients.

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Somatosensory amplification refers to the tendency to experience somatic sensation as intense, noxious, and disturbing.¹ The construct of somatosensory amplification is helpful in the assessment of the perceptual style of somatization and in the conceptualization of psychosomatic illness.¹ The Somatosensory Amplification Scale (SSAS) was designed and validated to measure this phenomenon.²

Alexithymia is a personality construct derived from clinical observations of patients with psychosomatic diseases, characterized by difficulty distinguishing between emotions and bodily sensations.³ The Toronto Alexithymia Scale (TAS) and its modified versions, the TAS-R and TAS-20, are among the most common questionnaires to measure this construct.^{4,5}

Evidence has suggested that the tendency to develop functional somatic symptoms is associated with alexithymia.^{6–10} A recent study reported that the SSAS was significantly correlated with the total TAS in the psychiatric sample.¹¹ Some studies, however, have failed to find an association.^{12–14}

One possible reason for the discrepancy of the results might be multiple aspects of alexithymia. One of the major

domains of alexithymia, excessive preoccupation with external events, seems to reflect different aspects as compared with the cognitive inability to accurately perceive and report a full range of affects. A Japanese study¹⁵ indicated that the TAS-20 factor of “externally oriented thinking” was not statistically correlated with the other two TAS-20 factors of “difficulty identifying feelings” and “difficulty describing feelings.” Thus it might be crucial to separate a construct of alexithymia into its composing factors in analysis when the relationship between somatosensory amplification and alexithymia is argued.

We hypothesized that somatosensory amplification is

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Somatosensory Amplification and Alexithymia

primarily associated with difficulties in identifying and describing feelings because inappropriate coping of negative feelings like anxiety and depression is closely linked to the increases in stress responses and bodily sensations.^{16,17} To examine this hypothesis, both the SSAS and TAS-20 were applied to a cohort of patients attending psychosomatic and general medicine clinics in the university setting. Both scale scores were compared between the two groups, and the SSAS was predicted from the TAS-20 subscales, controlling for the effects of age, sex, and mood states.

METHODS

Subjects

The study population included 48 consecutive outpatients (32 women and 16 men) attending the Psychosomatic Clinic at the Branch Hospital of the University of Tokyo. The average age was 36 (SD ± 14). All patients were referred from departments within the hospital or from clinics outside the hospital. Selection criteria were as follows: those who were 1) referred for “psychosomatic illnesses,” 2) were age 15–65 years, 3) were able to visit the clinic during the study period, 4) whose medical conditions were stable without changes of medication for more than 1 month, and 5) did not have major depression or schizophrenia. Concerning criterion 1, the Japanese Society of Psychosomatic Medicine defines “psychosomatic illness” as any physical condition with organic or functional damages affected by psychosocial factors in the process of onset or development of the conditions.¹⁸ Concerning criterion 5, exclusion of psychiatric conditions was based on DSM-IV and done during the first intake interview.¹⁹ The study was approved by a committee of the hospital and conducted with patients’ informed written consent in September 2000.

A total of 52 patients met the criteria, but 4 (8%) did not visit the clinic on the appointed day. The ICD-10 (International Statistical Classification of Diseases and Related Health Problems, Tenth Edition) diagnoses in the psychosomatic group were eating disorders ($n = 12$), autogenic nervous dysfunction ($n = 9$), irritable bowel syndrome ($n = 2$), neurotic gastritis ($n = 2$), spasmodic torticollis ($n = 2$), writer’s cramp ($n = 2$), migraine ($n = 1$), neurocirculatory asthenia ($n = 1$), hyperventilation ($n = 1$), gastric ulcer ($n = 1$), hyperhidrosis ($n = 1$), psychogenic polyuria ($n = 1$), and premenstrual syndrome ($n = 1$). The remaining 12 patients were classified into the ICD-10 symptom codes (category R), including headache ($n = 3$) and chest discom-

fort ($n = 2$) without definite disease diagnoses. Although different from Western medicine, eating disorders are often referred to psychosomatic clinics in Japan.²⁰

A comparison sample ($n = 33$) was randomly selected from outpatients attending the General Internal Medicine Clinic within the hospital during the study period. The total number of outpatients visiting this clinic was estimated to be approximately 1,200 during this period. Major ICD-10 diagnoses in the comparison group were essential hypertension ($n = 13$), diabetes mellitus ($n = 7$), hyperlipidemia ($n = 3$), chronic hepatitis ($n = 3$), iron deficiency anemia ($n = 2$), chronic nephritis ($n = 2$), and others ($n = 3$). The ratio of women to men was 17:16, and the average age was 48 (SD ± 14). Gender was comparable between the two groups ($P > 0.05$, χ^2 test), but the average age was younger in the psychosomatic group than in the comparison group ($P < 0.001$, Student t -test, two-tailed).

Measures

Somatosensory Amplification Scale The SSAS asks the respondent the degree to which 10 statements are “characteristic of you in general,” on an ordinal scale from 1 to 5. In our data the Japanese version of SSAS had good intrascale consistency (Cronbach’s alpha = 0.79) as well as construct and criterion validity in a Japanese psychosomatic medicine sample.²¹

Twenty-Item Toronto Alexithymia Scale The TAS-20 is a self-report questionnaire assessing alexithymic characteristics on a five-point scale. The Cronbach’s alpha of the TAS-20 was 0.74 in the Japanese psychiatric outpatient sample.¹⁵ Three TAS-20 factors reported in the previous studies^{5,15,22} were analyzed in this study. The first factor of “difficulty identifying feelings” included seven items (e.g., “I am often confused about what emotion I am feeling”). The second factor of “difficulty describing feelings” included five items (e.g., “It is difficult for me to find the right words for my feelings”). The third factor of “externally oriented thinking” included the remaining eight items (e.g., “I prefer talking to people about their daily activities rather than their feelings”).

Medical Symptom Checklist and Self-Rated Stress Perception Scale These two questionnaires are clinical tools for evaluation of somatic symptoms and stress perception at the Mind/Body Medicine Clinic, Beth Israel Deaconess Medical Center.^{23,24} The Medical Symptom Checklist was used to assess the following 16 common somatic symp-

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