

Alexithymia and Somatosensory Amplification in Functional Dyspepsia

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Somatosensory amplification is the tendency to report somatic sensations as intense and disturbing. Alexithymia is a personality construct characterized by difficulty recognizing emotions and a tendency to focus on external events and bodily sensations. The association of somatosensory amplification and alexithymia with functional symptoms was assessed in 111 patients with functional dyspepsia and 53 healthy comparison subjects. The subjects completed several assessment instruments, including the Somatosensory Amplification Scale and the 20-Item Toronto Alexithymia Scale. The patients with dyspepsia had modestly higher scores on measures of alexithymia (especially difficulty identifying feelings) and somatosensory amplification. Alexithymia and somatosensory amplification may play important roles in symptom generation and perception in a subset of patients with functional dyspepsia, but the importance of these constructs in this patient population appears less than previously reported. (Psychosomatics 2004; 45:508–516)

Somatization has been frequently described in association with functional dyspepsia,^{1–4} yet in the clinical practice of gastroenterology, somatization remains a misunderstood and often mismanaged concept. In its broadest definition, somatization is the articulation of psychosocial and emotional distress through physical symptoms.^{5,6} Although a minority of patients may seek the sick role without truly feeling unwell (i.e., malingering), most patients with somatization truly perceive themselves as ill.

Somatization is a complex construct and is linked to a variety of patient factors. Somatosensory amplification refers to the tendency to experience somatic sensations as intense, noxious, and disturbing.⁷ Somatosensory amplifi-

cation is a useful construct in assessing the perceptual styles of patients with psychosomatic illness. Alexithymia is a personality construct that is useful in the assessment of patients with psychosomatic disorders. Alexithymia refers to difficulty describing one's own emotions in words and the tendency to instead focus on the details of external events at the expense of articulating one's true emotional distress.⁸ As somatosensory amplification and alexithymia both address facets of somatization, some investigators have reported a positive correlation between the two constructs.^{9,10}

Several studies have demonstrated somatosensory amplification and alexithymia in patients with chronic pain, patients with somatoform disorders, and poorly characterized patients with functional gastrointestinal disorders. To our knowledge, no study has evaluated these constructs in a well-defined group of patients with functional dyspepsia. The aim of this study was to assess the severity of alexithymia and somatosensory amplification in patients with functional dyspepsia (as defined by the Rome II criteria), compared with healthy subjects.

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METHOD

Adult patients with functional dyspepsia were consecutively enrolled from the Gastrointestinal Physiology Laboratory after being referred from the outpatient gastroenterology clinic at Northwestern University. Although enrollment from the physiology laboratory was consecutive, it was not possible to know the total pool of patients with dyspepsia from which these subjects were selected. Functional dyspepsia was defined by using Rome II criteria.¹¹ Briefly, functional dyspepsia is defined as pain or discomfort centered in the upper abdomen. Discomfort may be characterized by or associated with upper abdominal fullness, early satiety, bloating, or nausea. Symptoms were required to be present for >12 weeks in the past 12 months. All subjects were required to have normal results on an upper gastrointestinal endoscopy with further evaluation performed as indicated by the evaluating gastroenterologist. Patients were excluded if they had dominant complaints of heartburn, had prior digestive surgery other than cholecystectomy or appendectomy, or were taking medications known to alter or suspected of altering digestive motility. Subjects were also excluded if they were infected with *H. pylori*. *H. pylori* status was determined either by biopsy for histology or by rapid urease testing, whole blood serology, or ¹³C urea breath testing. For purposes of this study, patients were considered infected if any test for the presence of *H. pylori* was positive.

Patients with functional dyspepsia were further categorized according to Rome II guidelines as having ulcer-like dyspepsia or dysmotility-like dyspepsia. Patients were considered to have ulcer-like dyspepsia if the predominant symptom was pain centered in the upper abdomen. Patients were considered to have dysmotility-like dyspepsia if their predominant symptom was a nonpainful sensation characterized or associated with upper abdominal fullness, early satiety, bloating, or nausea.

The healthy comparison subjects were recruited by advertisement and consisted largely of hospital staff, house staff, and patients' family members. The comparison subjects were free of digestive complaints and were taking no medication to treat digestive disorders. Comparison subjects were excluded if they had a prior history of abdominal surgery other than cholecystectomy or appendectomy.

The protocol was approved by the Northwestern University Institutional Review Board. Informed consent was obtained from all study participants.

Questionnaires

Subjects were asked to complete several self-report measures pertaining to symptoms, quality of life, and psychologic traits. Dyspepsia severity was evaluated with the Nepean Dyspepsia Index,^{12,13} a validated, disease-specific measure for assessment of symptoms and disease-specific quality of life over the 2 weeks before administration. Respondents are asked to rate the frequency, intensity, and intrusiveness of 15 common dyspeptic symptoms on a Likert-type scale. The scores are summed for each symptom to give a total symptom score that could range from 0 to 13. Raw Nepean Dyspepsia Index scores are expressed as the percentage of the maximal possible score for comparative purposes. Higher scores indicate greater symptom severity and poorer quality of life.

General quality of life was assessed with the Medical Outcomes Study 36-Item Short-Form Health Survey.¹⁴⁻¹⁶ The 36-Item Short-Form Health Survey is a well-studied, valid instrument that has been used to determine general quality of life in a variety of clinical contexts, including in patients with functional gastrointestinal disorders. This measure assesses eight health concepts: 1) limitations in physical activities because of health problems, 2) limitations in social activities because of physical or emotional problems, 3) limitations in usual role activities because of physical health problems, 4) bodily pain, 5) general mental health (psychological distress and well-being), 6) limitations in usual role activities because of emotional problems, 7) vitality (energy and fatigue), and 8) general health perceptions. These scales can be grouped into mental and physical composite scores. Lower scores indicate poorer quality of life.

Psychiatric distress was measured with the SCL-90-R, a self-report, clinical symptom rating scale consisting of 90 questions.¹⁷ Responses indicate the presence of symptoms associated with nine psychiatric constructs: somatization, obsessive-compulsive behavior, feelings of inadequacy or inferiority (interpersonal sensitivity), depression, anger/hostility, phobic anxiety, paranoid ideation, and psychoticism. Raw scores were converted into t scores by using published values for healthy outpatients. In addition, a global severity index was calculated; scores >63 are associated with significant psychological distress.

Alexithymia was measured with the 20-Item Toronto Alexithymia Scale.¹⁸⁻²¹ This self-report measure assesses a variety of alexithymia characteristics with 5-point Likert-type scales. In addition to a total score, the measure includes subscale scores for "difficulty identifying feelings,"

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