

## Age is strongly associated with alexithymia in the general population

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Received 23 January 2006; received in revised form 10 April 2006; accepted 25 April 2006

### Abstract

**Objective:** We studied the prevalence of alexithymia, its distribution in different age groups in a wide age range, its association with sociodemographic and health-related variables, and its co-occurrence with depression. **Methods:** The study forms part of the Health 2000 Study. The original sample comprised 8028 subjects representing the general adult population of Finland. Alexithymia was measured with the 20-item Toronto Alexithymia Scale (TAS-20), and depression was measured with the 21-item Beck Depression Inventory. Altogether, 5454 participants filled in

TAS-20 in their mother tongue. **Results:** The prevalence of alexithymia was 9.9%. Men (11.9%) were more commonly alexithymic than women (8.1%). Alexithymia was associated with male gender, increasing age, low educational level, poor perceived health, and depression. **Conclusions:** The findings were in line with earlier population studies. For the first time, it was possible to analyze the prevalence of alexithymia in a wide age range (30–97 years). International comparative studies are needed.

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**Keywords:** Alexithymia; Epidemiology; General population; Personality; Prevalence; Sociodemographic variables

### Introduction

In the early 1970s, Sifneos [1] coined the term *alexithymia*. Alexithymia means “no words for feelings” and refers to a personality construct characterized by impoverishment of fantasy, poor capacity for symbolic thought, and inability to experience and verbalize emotions. Increasing evidence shows that alexithymia is associated with several medical conditions and various psychopathological syndromes [2] and mental disorders [3,4]. It is thought to reflect a deficit in the cognitive processing of emotion, and alexithymics are thought to lack the capacity for the mental representation of emotions [5–7]. These

deficiencies are believed to cause an inability to regulate emotions and affect, and therefore to predispose alexithymic individuals to both psychological and somatic symptoms. According to previous studies, since alexithymia is more prevalent among depressed individuals and since alexithymia scores decrease as depression is alleviated, it has been claimed that alexithymia is associated with level of depression and may be a state-dependent phenomenon [8–10]. On the other hand, several studies have yielded evidence on both the absolute stability and the relative stability of alexithymia, suggesting that alexithymia is a personality trait [4,11–15].

It is quite surprising that the epidemiology of alexithymia has been the subject of only a handful of papers. Three research groups have studied the epidemiology of alexithymia in different kinds of samples of working-age populations, all of them in Finland [16–18]. Two studies have focused on elderly people [19,20]. Lane et al. [21] studied both working-age and elderly people. Alexithymia was

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associated with male gender in four earlier epidemiological studies [16–18,21], with low educational level in four studies [16–18,21], with low social status in four studies [16–18,21], with psychological problems in three studies [17,19,20], and with singleness in one study [18]. The prevalence figures for alexithymia were quite similar across studies on working-age populations, with the prevalence being 9–17% among men and 5–10% among women. In elderly populations, the prevalence of alexithymia was notably higher.

All studies mentioned above differ from each other on several aspects. Disparities in size, age range, and stratification of the samples make it difficult to generalize the findings to adult general populations. The aim of our study was to determine the prevalence of alexithymia and its distribution in different age groups, the sociodemographic and health-related factors associated with it, and its co-occurrence with depression in a representative sample of the whole Finnish adult population.

## Method

### Sample

Our study is a part of the Health 2000 Study. The gathering of data took place in Finland in 2000–2001 [22]. A large national network coordinated by the National Public Health Institute was responsible for the planning and execution of this multidisciplinary epidemiological survey. It was designed according to the concept of a two-stage stratified cluster sampling and comprised adults aged 30 years and above. The age limit was set at 30 years because the prevalence of somatic diseases is low in younger age groups. The study design has been described in detail elsewhere [22,23]. The strata included all five Finnish university hospital districts, each containing approximately 1 million inhabitants. Altogether, 80 health center districts, 16 from each university hospital region, were selected for participation in the study by systematic sampling, thus forming 80 clusters. From each area, a random sample of subjects was drawn from the national population register. The nationally representative sample comprised 8028 persons. Of these, 6770 participated in a health examination after an interview. The interview was used to gather basic background and sociodemographic information, and information on health-related factors. After the health examination, the participants were given a questionnaire, the 20-item Toronto Alexithymia Scale (TAS-20). Those 5454 subjects who received it in their mother tongue and returned it completed were included in our substudy.

### Measures

Alexithymia was assessed using the Finnish or the Swedish (the two official languages of Finland) version of

TAS-20, depending on the mother tongue of the subjects. Among the different methods for measuring alexithymia, TAS-20 is most widely used and is presumably the most carefully validated. Its internal consistency, test–retest reliability, and convergent, discriminant, and concurrent validity have been demonstrated to be good [24–27]. The psychometric properties of both the Finnish version [28] and the Swedish version [29] of TAS-20 have proven to be satisfactory. In accordance with the recommendation of the developers, the cut point for alexithymia was also used: subjects scoring >60 were defined as alexithymic cases [30]. In addition, TAS-20 consists of three subscales, which reflect the three main facets of the alexithymia construct: the DIF subscale assesses difficulties in identifying feelings, the DDF subscale concerns difficulty in describing feelings, and the EOT subscale reflects concrete externally oriented thinking or preoccupation with details of external events.

To assess the level of depression, the Finnish or the Swedish version of the 21-item Beck Depression Inventory (BDI) was used. A BDI score of <10 was considered to indicate cases without depression, while total scores of 10–18 and >18 were taken to indicate mild depression and moderate/severe depression, respectively [31].

Age was categorized into a six-class variable: 30–44, 45–54, 55–64, 65–74, 75–84, and 84–97 years. A three-class variable describing level of education was combined from two variables containing information on basic education and information on vocational education. No vocational training beyond a vocational course or an on-the-job training with no matriculation examination was classified as “basic education.” Completing vocational school and passing the matriculation examination but having no vocational training beyond a vocational course or on-the-job training was defined as “secondary education” regardless of basic education. “Higher education” comprised degrees from higher vocational institutions, polytechnics, and universities. Total years of education was used as a continuous variable. The financial situation of the subjects was assessed by inquiring about the monthly income of the household in which they lived. The variable was divided into three categories: ≤10,000 FIM, 10,001–20,000 FIM, and >20,000 FIM (≤1680.7, 1680.8–3361.3, and >3361.3 €), with the categories being roughly of the same size. As part of the interview, the subjects were asked to assess their subjective health on a five-class scale ranging from *good* to *poor*. For statistical purposes, the classes *good* and *fairly good* and the classes *fairly poor* and *poor* were combined, thus yielding a three-class variable. Self-reported data on any chronic illness, handicap, or other ailment that had reduced the participants’ working or functional capacity for at least 3 months were also gathered in the interview. The answer was rated *yes* or *no* regardless of the number of illnesses. In the same way, the interviewees were asked whether they had ever had a psychiatric disorder diagnosed by a physician.

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