

# The relationship between alexithymia and perinatal depressive symptomatology<sup>☆</sup>

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## Abstract

**Objective:** The purpose of this study was to examine the relationship between alexithymia and perinatal depressive symptoms and the stability of the alexithymia construct in a sample of low-income, predominantly Latina women during pregnancy and the early postpartum period. **Methods:** Seventy-seven pregnant women completed self-report questionnaires and were classified as “high risk” or “low risk” for developing a major depressive episode based on a history of depression and/or current high depressive symptom scores. Measures included the Toronto Alexithymia Scale, the Center for Epidemiological Studies Depression Scale, and the Maternal Mood Screener, and were completed during pregnancy and at postpartum month 2. **Results:** Alexithymia was positively associated

with depressive symptoms during pregnancy and early postpartum. Women at high risk for depression had significantly higher alexithymia levels than low-risk women during pregnancy but not during postpartum. Alexithymia and depressive symptoms were independently and strongly correlated across the ante- and postpartum periods. Hierarchical regression analyses indicate that alexithymia scores at postpartum were predicted by alexithymia scores during pregnancy, above and beyond the variance explained by the depressive symptom scores during pregnancy and postpartum.

**Conclusion:** Alexithymia is positively correlated with depressive symptoms during the perinatal period and is a stable phenomenon.

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## Introduction

Alexithymia is a multidimensional personality construct characterized by three core features: (a) difficulty identifying emotions and distinguishing between emotions and bodily sensations, (b) difficulty describing or communicating emotions to others, and (c) an externally oriented style of thinking [1–3]. Multiple etiologies, from biological to psychological, have been proposed for the development of alexithymia [3–5]. Recent research supports a social learning

model of alexithymia in which parents who have difficulties regulating their own emotions (i.e., high levels of alexithymia) also have more difficulty attending to and interpreting their children’s emotions, thus not being able to teach their children how to regulate their own emotions [6–8].

Another area of research has documented that mothers who are depressed, at either the subsyndromal or clinical level, also have difficulty regulating their children’s emotions [9–11]. However, to date, minimal research has focused on the relationship between depression and alexithymia in mothers, who are the primary caregivers in most families. This is surprising given that alexithymia and depression have been found to be positively and strongly associated in various psychiatric [12] and nonpsychiatric populations [13,14]. In examining this association, there is an ongoing debate as to whether alexithymia is a trait (i.e., a stable personality factor) or state (i.e., changes in

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alexithymia depend on the course or onset of other disorders). Researchers [5,15,16] have advocated for an examination of the absolute and relative stability of alexithymia over time to address this issue. Luminet et al. [15] reported that although alexithymia scores changed pre- to post-treatment for major depression, there was also evidence for its relative stability because alexithymia scores correlated significantly with changes in depression scores; the authors concluded that alexithymia is relatively stable and best conceptualized as a stable personality trait. Saarijärvi et al. [16] recently conducted a study examining the relationship between alexithymia and depression in a sample of outpatients with major depression over a 5-year period and found that alexithymia was both a stable personality trait and a state. In particular, there were differences in the three factors of alexithymia: difficulty identifying and communicating emotions were state dependent (i.e., associated with decreased depressive symptoms), whereas externally oriented thinking showed absolute stability over time.

Ten to fifteen percent of new mothers experience postpartum depression [17]. Yet only one study, conducted in Finland, has examined the relationship between alexithymia and perinatal depression [18]. It examined the relationship between women's social conditions during pregnancy and their children's level of alexithymia 31 years later. Results from this study indicate that pregnant women who had an unwanted pregnancy, a child born into a family with four or more children, and/or lived in rural areas were more likely to have children who reported having higher levels of alexithymia. In addition, depression during pregnancy was associated with higher levels of alexithymia in children of urban-dwelling women. Depression was reported as a dichotomous variable ("normal/depressed" or "very depressed"), which was derived from mothers' mood (normal, depressed, or very depressed). However, this definition does not differentiate between "depression" defined as scores on symptom scales and "depression" meeting current diagnostic criteria for major depressive episodes (MDEs). In addition, no study to date has examined the relationship between alexithymia and depression in the early postpartum period (i.e., within the first 6 months). This period is important because the effect of maternal depression can be observed in infants as young as 3 months [19,20] and because it is critical in the formation of mother–infant attachment relationships [21]. Therefore, the perinatal period (from pregnancy to the early postpartum) provides a particularly important time to examine the relationship between alexithymia and depressive symptoms.

The present study examined the relationship between perinatal depressive symptomatology and alexithymia in a sample of low-income, urban, predominantly Latina pregnant women. We tested three hypotheses: first, whether alexithymia would be positively associated with depressive symptoms during pregnancy and the early postpartum period; second, whether women at high risk for MDEs

had higher levels of alexithymia than women at low risk for MDEs; and third, whether alexithymia would be stable across time in this population.

## Method

### Participants

Participants in this study were part of a larger longitudinal study aimed at identifying high-risk status for MDEs and related health outcomes. Eligibility criteria included women who were (a) 15 to 30 years old, (b) English or Spanish speaking, (c) in their second trimester of pregnancy, and (d) receiving prenatal services from an obstetrics clinic in a public-sector hospital in Northern California. Exclusion criteria included (a) being currently psychotic, (b) actively using psychoactive substances during pregnancy, and/or (c) having severe medical complications (i.e., high-risk pregnancy). Data were collected between 1997 and 2000.

Eighty out of 100 women in the original longitudinal study completed questionnaires on both alexithymia and depression and composed the sample for the current analysis. The larger longitudinal study followed a sample of pregnant women to test whether those at high risk for developing MDEs during the following year could be identified. Therefore, women who already met criteria for MDEs at the onset of the study were excluded. Of the 80 participants, 3 (3.8%) met criteria for current major depression at the initial screening interview and were excluded from subsequent analyses, resulting in a sample of 77.<sup>1</sup>

Of the 77 participants, 63 (81.8%) were Latina. The remaining included 7 African Americans, 5 Asian Americans, and 2 European Americans. For all participants, the interviews were conducted in the same language throughout the study. All of the non-Latina participants completed the questionnaires in English. For the Latina participants, the majority of the interviews were conducted in Spanish. Within the Latina sample, the majority (87.3%) reported Spanish as the primary language, 11.1% as English, and the remaining (1.6%) stated they were bilingual. Most interviews (85.7%) with the Latina group were conducted in Spanish, per participant preference. A total of 23 participants were interviewed in English, and 54 in Spanish (see Table 1). Compared to the Spanish-speaking group, the English-speaking group were younger, had more years of education, and higher gestational weeks. In addition, those who completed interviews in Spanish were more likely to be born outside the United States, whereas those born in the

<sup>1</sup> Yonkers et al. [22] found that the prevalence of major depressive disorder during 3–5 weeks postpartum was between 6.5% to 8.5%, with one fourth of the sample developing this during pregnancy, for a sample of predominantly Latina and African American women. The rate for Hispanic women was lower (4.8–7.4%). Thus, the rate observed here, 3.8%, is slightly lower than that of previous research.

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