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Finding words for feelings: The relationship between personality disorders and alexithymia

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ABSTRACT

This study examined whether personality disorders (PDs) are associated with alexithymic features at varying levels of comorbid psychopathology distress. 167 psychiatric outpatients completed the Toronto Alexithymia Scale (TAS) and the General Severity Index (GSI) of the SCL90-revised. Bootstrapping analyses were performed to test whether the PD/alexithymia relationship was moderated by psychopathology distress (GSI). The overall number of PD criteria was associated with cognitive aspects of alexithymia (i.e., Externally Oriented Thinking, EOT) only at low/moderate levels of distress. Borderline criteria predicted EOT only when distress was low, while avoidant and dependent criteria were independently related with EOT. No association was found between other PDs and alexithymia facets. Thus, within clinical samples the alexithymia/PD association is mainly explained by comorbid psychopathology; however, individuals with avoidant, dependent and borderline features might have a specific difficulty with focusing on internal reality, even when their current symptom distress is low.

1. Introduction

Alexithymia refers to an altered processing of emotions that results in difficulty identifying/communicating one's own feelings and in a concrete style of relating to others (Taylor, Bagby, & Parker, 1997). These affective (i.e., impaired emotional awareness and expression) and cognitive (i.e., externally oriented thinking) components of alexithymia prevent from understanding and representing the affects and mental states of both the self and the other, thereby interfering with successful mentalization (Choi-Kain & Gunderson, 2008; Di Maggio et al., 2013; Grynberg, Luminet, Corneille, Grèzes, & Berthoz, 2010; Moriguchi et al., 2007; Taylor et al., 1997).

Given the clinical relevance of emotional and mentalizing dysfunctions among patients with personality disorders (PDs), several studies investigated the relationship between alexithymia and PDs. However, results are mixed both in terms of which specific PDs show increased alexithymia, and of the nature of the alexithymic difficulties eventually endorsed by PD patients. Alexithymia has been associated with the presence of personality disturbances in general (Berenbaum, 1996; De Panfilis et al., 2008; Grabe, Spitzer, & Freyberger, 2001), with Cluster A or C PD only (Bach, de Zwaan, Ackard, Nutzinger, & Mitchell, 1994; Coolidge, Estey, Segal, & Marle, 2013; Nicolò et al., 2011; Sexton, Sunday, Hurt, & Halmi, 1998), or with borderline personality disorder (BPD) (Domes, Grabe, Czieschnek, Heinrichs, & Herpertz, 2011; Guttman & Laporte, 2002; Joyce, Fujiwara, Cristall, Ruddy, & Ogrodniczuk, 2013; New et al., 2012). In addition, PDs have been linked with affective components of alexithymia only (Di Maggio et al., 2013), with both affective and cognitive alexithymia (Domes et al., 2011; New et al., 2012), or with increased alexithymia in general (Coolidge et al., 2013; Honkalampi, Hintikka, Antikainen, Lehtonen, & Viinamaki, 2001; Nicolò et al., 2011).

A potential reason for these discrepancies may rely on the different ways used to control for comorbid psychopathology when examining the PD/alexithymia relationship, which is a necessary step given the well-known association between "affective" alexithymic deficits (i.e., difficulty recognizing and expressing feelings) and current psychiatric disorders (e.g. Eating, Substance Use, Anxiety and Mood Disorders) (Marchesi, Bertoni, Cantoni, & Maggini, 2008; Marchesi, Brusamonti, & Maggini, 2000; Marchesi, Fontò, Balista, Cimmino, & Maggini, 2005; Marchesi, Ossola, Tonna, & De

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Panfilis, 2014; Saarijavi, Salminen, & Toikka, 2001; Taylor et al., 1997). While most studies employing clinical populations did not control for the severity of concurrent psychiatric symptoms (De Panfilis et al., 2008; Domes et al., 2011; Joyce et al., 2013), other studies deal with such issue by including non-clinical samples only (Coolidge et al., 2013) or selected PD samples with no current comorbidity (New et al., 2012), which, however, limits the generalizability of the findings to 'real world' PD patients.

Importantly, after controlling for current psychopathology severity, overall alexithymia was unrelated with total PD criteria among treatment-seeking psychiatric outpatients (Di Maggio et al., 2013), suggesting that PD patients' alexithymic deficits are accounted for by the emotional distress arising from their comorbid symptoms. However, since most patients with PD are driven to seek treatment by their concurrent psychological distress, within clinical samples the robust link between alexithymia and current psychopathology might also disguise any correlation between alexithymia and PD. For instance, Honkalampi et al. (2001) found that whereas alexithymia was unrelated with Cluster C PD among patients with active major depression, Cluster C comorbidity was nonetheless associated with lesser alexithymia decrease over a 6-month follow-up than pure major depression only. This suggests that the specific relationship between alexithymia and PD was disguised, during the acute depressive episode, by the stronger correlation between symptom severity and increasing alexithymia features. Thus, although some PD could be characterized by specific alexithymic difficulties, such association could be obscured by the presence of severe concurrent symptom distress, and can become apparent only at milder levels of psychopathology.

Investigating whether (and which) alexithymic features are associated with PDs at varying levels of symptom severity has important treatment implications. If no association between PD and alexithymia is detected at any degree of current psychopathology distress, it would mean that PD patients are impaired in their ability to recognize/communicate/analyze emotions only because of their comorbid psychopathology; thus, such social-cognitive difficulties could be reduced by more vigorous efforts at decreasing their distress. Conversely, if alexithymia is specifically associated with PD at low levels of psychopathology, treatment should directly address PD patients' difficulty to accurately process their own affects.

Therefore, this exploratory study examined whether (and which) PDs are associated with overall alexithymia and its affective and cognitive components depending on different levels of current psychopathology severity. Based on previous research, we expected that for patients with high symptom distress alexithymia (and, particularly, its affective component) might not be related with PD features, but only with the current state of symptom severity; however, for individuals with low psychopathology distress, a specific relationship between some PDs and definite components of alexithymia could emerge.

2. Methods

2.1. Sample

The study included 167 outpatients consecutively seeking treatment at an Italian public Psychiatry Unit. Exclusion criteria were: (1) younger than 18 and older than 65 years old; (2) cognitive impairment or language barriers interfering with the capacity to understand interviews or questionnaires; (3) a diagnosis of schizophrenia, other psychotic disorders (except brief psychotic episodes) or psychotic mood episodes due to their impact on cognitive and affective processing; (4) current substance intoxication or withdrawal. After giving informed consent all patients were evaluated by a trained psychiatrist.

2.2. Measures

2.2.1. Personality pathology

PD were evaluated using the Structured Interview for DSM-IV Personality (SIDP-IV) (Pfohl, Blum, & Zimmerman, 1997). The SIDP-IV assesses each of the criteria for all personality disorders (PD) with one or more questions, which are then rated on a 4-point scale. In this study the number of criteria met (i.e., score $\geqslant 2$) were used as a dimensional measure of overall personality pathology (total number of PD criteria), Cluster A, B and C pathology, and definite PDs. During the enrolment time period of the study the raters ($n = 4$) met regularly with the first/last author to discuss the scored protocols; uncertainties were discussed until a consensus was reached. Independent ratings on ten conjoint interviews from the four raters were used to evaluate inter-rater reliabilities for PD criteria count. Intraclass correlations varied from 0.68 (for Schizoid and Narcissistic PD) to 0.92 (for Borderline PD).

2.2.2. General psychopathology

Current psychiatric disorders were assessed with the Structured Clinical Interview for DSM-IV-TR Axis I disorders Research Version (SCID-I/P-RV) (First, Spitzer, Gibbon, & Williams, 2002). Current psychopathology severity was assessed by means of the General Severity Index (GSI) of the Symptom Checklist 90-revised (Derogatis, 1994; Prunas, Sarno, Preti, Madeddu, & Perugini, 2011), a 90-item self-report inventory assessing nine primary symptom dimensions. The GSI is a global index of psychopathology that combines information concerning the number of symptoms reported with the intensity of perceived distress, thereby representing the best indicator of the current level or depth of an individual's disorder. The GSI internal consistency in this sample was .94.

2.2.3. Alexithymia

All subjects completed the Italian version of the twenty-item Toronto Alexithymia Scale (TAS-20), which showed good validity in both healthy and psychiatric subjects, irrespectively of gender (Bagby, Parker, & Taylor, 1994; Bressi et al., 1996). The TAS-20 has a three-factor solution (i.e., Difficulty identifying feelings and bodily sensations, DIF; Difficulty describing feelings, DDF; Externally oriented thinking, EOT), which allows assessing both affect-related (DIF, DDF) and cognitive (EOT) features of alexithymia. A total score is calculated by summing all items, after reversing scores for designated items; higher score reflects greater alexithymia. In this sample, the internal consistency was $\alpha = .84$ for TAS total and $\alpha = .77$, $\alpha = .63$ and $\alpha = .74$ for DIF, DDF and EOT.

2.3. Statistical analysis

Student's *t*-test for independent samples was applied to detect differences in TAS scores between genders, and Pearson's correlations were performed to examine their association with years of education, age, number and type of PD criteria, and GSI.

We next evaluated whether PD features interacted with current psychopathology severity (GSI) in predicting TAS scores using Hayes' (2013) bootstrapping procedure for conditional effects (SPSS-PROCESS macro, Model #1). A series of moderation analyses were performed to evaluate whether any PD criteria (independent variables: overall PD criteria, Cluster A, B and C criteria) predicted alexithymic features (dependent variables: TAS total, DIF, DDF and EOT) depending on different levels of psychopathology severity (GSI: proposed moderator; low severity = GSI scores 1SD below the mean; moderate severity = mean GSI scores; high severity = GSI scores 1SD above the mean). In order to facilitate the interpretation of the results, both the independent variables and the proposed moderator were mean centered prior to the analyses: