

Are alexithymia, depression, and anxiety distinct constructs in affective disorders?

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Abstract

Objective: the present study was undertaken to gain a better insight into the relationship between alexithymia, anxiety, and depression. Two hypotheses were tested: (1) whether a depressive or anxiety disorder is associated with an elevation of one or more dimensions of alexithymia; and (2) whether alexithymia is an independent construct from depression and anxiety in patients with depressive or anxiety disorders. **Method:** a total of 113 patients with depressive or anxiety disorders (DSM-IV) and 113 control subjects completed the 20-item version of the Toronto alexithymia scale (TAS-20) and the hospital anxiety and depression scale (HADS). **Results:** the TAS-20 total score was higher in depressed

and anxious patients than in controls. This finding mainly depended on an increased score for “difficulty identifying feelings” (DIF), and (only in depressed patients) on an increased score for “difficulty communicating feelings” (DCF). The factor analysis of the TAS-20 and HADS items showed that depression is a construct different from alexithymia, whereas some overlap exists between anxiety and DIF dimension. **Conclusion:** our results suggest that in depressive and anxiety disorders, alexithymia and depression are separate constructs that may be closely related; in contrast, there are some overlaps between the DIF dimension and anxiety. © 2000 Elsevier Science Inc. All rights reserved.

Keywords: Alexithymia; Anxiety; Depression; Depressive disorders; Anxiety disorders

Introduction

The alexithymic construct is defined as (1) a difficulty in identifying feelings (DIF); (2) a difficulty in describing feelings to other people (DCF); (3) a paucity of fantasy life; and (4) a tendency to focus on the concrete details of external events (“externally oriented thinking”, EOT) [1]. Alexithymic subjects, amplifying normal bodily sensations and misinterpreting the somatic symptoms of emotional arousal, tend to communicate emotional distress through bodily complaints and to seek treatment for physical symptoms [2].

Some investigators have suggested that alexithymia is a personality trait [3] that predisposes people to suffer from depressive disorders [4], anxiety disorders (particularly panic disorder [5,6]), or other mental disorders [7,8]. In contrast, alexithymia is, for others, merely a

state reaction, which mitigates painful affects in patients with psychiatric and somatic illness [9,10]. Moreover, many studies have reported an association between alexithymia, depression [2,9,11–16], and anxiety [5,6,15,17], raising the controversy as to whether alexithymia, depression, and anxiety are distinct or overlapping constructs [11,17].

The present study was undertaken to gain a better insight into the relationship between alexithymia, anxiety, and depression. Two hypotheses were tested: (1) whether the presence of a depressive or anxiety disorder in patients admitted to an emergency department (ED) ward for physical complaints is associated with an elevation of one or more dimensions of alexithymia, as assessed by the 20-item Toronto alexithymia scale (TAS-20) [18]; and (2) whether alexithymia in patients with depressive or anxiety disorders is an independent construct from depression and anxiety.

We chose to study patients admitted to an ED ward, because many depressed and anxious patients believe that their illness is of physical origin [19,20] and seek treatment for somatic symptoms at an ED [21–24], because it is the

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one medical facility where self-referral is sufficient to obtain prompt clinical attention [25].

To test the first hypothesis, we compared the results of the TAS-20 obtained in patients with depressive and anxiety disorders with those found in subjects with normal psychological conditions. The effect of confounding variables, such as age, gender, level of education, severity of physical illness, and functional disability (known to be related to alexithymia) [8,10,26,27], was taken into account.

To test whether alexithymia, depression, and anxiety are independent constructs in patients with depressive and anxiety disorders, we used multiple regression and factor analysis.

Method

Sample

The patients included in the study were selected among subjects who had been consecutively admitted, during a 120-day period, to the ED ward of the University Hospital of Parma, Italy.

After providing informed consent, patients were included in the study if (1) their age was within 18–65 years; (2) they were affected by depressive or anxiety disorders, according to the DSM-IV criteria [28]; and (3) they completed the diagnostic interview and the psychopathological evaluations.

Patients with comorbid depressive and anxiety disorders were excluded from the study.

Moreover, age-matched patients, consecutively admitted to the ED ward and without any mental disorders according to the DSM-IV criteria, served as the control group.

Assessment

All subjects underwent the following interview or rating scales (all validated in Italian): (1) the Italian version [29] of the Mini International Neuropsychiatric Interview [30] (MINI-IV) to diagnose mental disorders according to the DSM-IV criteria; (2) the TAS-20 [31] and the hospital anxiety and depression scale (HADS) [32] for the assessment of the severity of depressive and anxious symptoms; and (3) the Brief Disability Questionnaire (BDQ) [33] for the evaluation of the severity of the functional disability (impairment of daily living activities and days spent in bed) in the month before the admission to the ED ward. Functional disability was evaluated because it can be associated with the elevation of the TAS-20 score [10].

The TAS-20 was composed of 20 items with a three-factor structure theoretically congruent with the alexithymia construct: DIF (the inability to recognize one's own affects and to distinguish between feelings and bodily sensations of emotional arousal); DCF (the inability to communicate feelings to other people); and EOT (a cognitive style that

shows a preference for the external details of everyday life rather than thought content related to feeling, fantasies, and other aspects of a person's inner experience).

The HADS is a reliable instrument to evaluate significant anxiety and depression from a clinical point of view in non-psychiatric hospital departments. The items of the depression subscale were largely based on the anhedonic state; in fact, five of the seven depression subscale items are related to the loss of pleasure. The anxiety subscale items were chosen from the psychic manifestations of anxiety, according to the Present State Examination [34] and the revision of the Hamilton Anxiety Scale [35]. In our sample, the sensitivity, specificity, and positive predictive value of the HADS depression subscale (score >7) in detecting patients with depressive disorders were 69.4%, 87.2%, and 61.8%, respectively, whereas the sensitivity, specificity, and positive predictive value of the HADS anxiety subscale (score >7) in detecting patients with anxiety disorders were 84.4%, 64.4%, and 50.5%, respectively.

In all patients, the severity of the physical illness was assessed by ED physicians with the Duke Severity of Illness (DUSOI) instrument [36]. The severity of the physical illness was controlled because it can be associated with an elevation of the TAS-20 score [8].

Statistics

In the statistical analyses, we evaluated three groups of subjects: patients with depressive disorders; patients with anxiety disorders; and controls.

Comparisons between groups were made with the chi-square test for categorical variables, the two-tailed Student's *t*-test, and one-way analysis of variance with the Scheffé post-hoc analysis for continuous variables, as appropriate.

Analysis of covariance was used to calculate the effect of diagnostic groups on the score of the TAS-20 and of its three subscales, after excluding the effect of the confounding variables such as age, gender, level of education, severity of the physical illnesses, and functional disability.

In all subjects, multiple regression analysis was used to evaluate the relationship between the score of TAS-20 and of its three subscales and the HADS anxiety and depression scores, after excluding the effect of the aforementioned confounding variables. We used the hierarchical multiple regressions in which the five control variables were entered first as a set; we then tested the HADS anxiety and depression scores, separately from each other. Only the significant standardized coefficients of regression (full model) are reported.

In the total sample, a factor analysis (principal components with the varimax rotation) was performed using 20 items of the TAS-20 and 14 items of the HADS. If alexithymia, depression, and anxiety are distinct constructs, the factor analysis of the TAS-20 and HADS items should produce separate factors corresponding to their respective construct.

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