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Commentary on the paper “Is alexithymia a risk factor for major depression, personality disorder, or alcohol use disorders? A prospective population-based study”

The main aim of the study conducted by Honkalampi et al. [1] was to examine whether alexithymia (and depression) scores at three different times predict major depression, personality disorder, and alcohol use disorders 7 years after the first data collection in a population-based sample. The key issue was thus to assess the ability of the constructs to predict new cases of psychiatric disorders in the future. This data set tested whether, in a large group of healthy people, alexithymia is a predisposing or vulnerability factor that influences the onset or course of psychiatric disorders.

Results showed that while BDI scores significantly predicted major depressive disorder, personality disorder, and alcohol use disorder, TAS-20 total scores did not. This could suggest that for the general population, alexithymia is not a vulnerability factor. Such conclusion is probably premature, however, due to some limitations in the present study that are developed below. Thus, other studies involving some specific conditions that are later specified need to be conducted in order to fully examine the vulnerability hypothesis.

In their conclusions, Honkalampi et al. suggest that alexithymia might act as an indirect predictor of long-term mental health as about one third of the variation in depression was accounted for by alexithymia sum scores. This raises the question of the relationship between depression and alexithymia, which will also be addressed.

Strengths and limitations of the study

The study is innovative and strong as it involves a very long follow-up period (7 years). The baseline sample is also screened to include only healthy people (i.e., without major depression, personality disorder, and alcohol use disorders). This is a very important condition for a truly valid investigation of the vulnerability hypothesis. The sample is also large and includes an extended age range and variability for sociodemographic variables.

There were also some limitations that preclude a full examination of the vulnerability hypothesis. First, all the analyses were based on a categorical approach of alexithymia that only included two levels (with vs. without alexithymia). One problem is that predictors were based on the cumulative scores for the first three times of measurement, which means that very slight differences in TAS-20 scores could result in change in category. Recent data using taxometric analyses revealed that alexithymia is best conceptualized as a dimensional rather than as a categorical construct, especially when examining its association with symptom severity [2]. Other limitations include that health was assessed as the participants’ present, subjective experience of their health. Objective measures of health need to be included in future studies. Also, psychiatric diagnoses at baseline were not assessed, which opened the possibility that some people with mental disorders were included at baseline. Finally, the multidimensional aspect of vulnerability was not considered in this study. Vulnerability does not only involve the prediction of the onset of a disorder but also the prediction of its maintenance and the probability of relapse.

What does this paper tell us about future research on the vulnerability hypothesis of alexithymia?

The importance of prospective studies

Many transversal studies already showed a higher prevalence of alexithymia in psychiatric disorders (alcohol dependence [3], posttraumatic stress disorders [4,5], panic disorder [6], somatoform disorders [7], and eating disorders [8–10]), but also for somatic disorders (essential hypertension [11,12], functional gastrointestinal disorders [13], or inflammatory bowel disease [14]). The transversal status of these studies precluded, however, any causal interpretation. Moving to prospective studies is thus an important step for
future research, and the present paper represents an important attempt in this direction. In a prospective study, the level of alexithymia is evaluated before the onset of psychological distress, thus making it possible to determine whether alexithymia represents a cause, an effect, or a simple covariate of psychological distress.

Only one prospective study [15] has been conducted that examined the influence of alexithymia (and social support) on future mental health (i.e., depression). A group of chronically ill patients with hemodialysis were examined prospectively 6 months after baseline measures. Multivariate logistic analysis showed that patients who were depressed at baseline were 17.7 times and alexithymics 5.3 times more likely to be depressed at the follow-up. Also, analyses of the prognostic values of alexithymia and social support on the deterioration of depressive symptoms during the 6 months revealed that both initial alexithymia and low social support (number of available persons whom the subject feels that he/she can turn to when he/she needs to) showed independent associations with increased risks of deterioration of depression. This study thus shows the impact of alexithymia on future mental health. But one limitation was that participants had already a deteriorated physical condition at baseline.

The conditions for performing future prospective studies evaluating the vulnerability hypothesis of alexithymia should include the following aspects: (1) a large initial sample, representative of the general population; (2) a potential for variation in the initial alexithymia score; (3) participants still in good health when included in the first data collection; (4) several follow-up measures every 3 to 6 months; (5) a simultaneous assessment of mental and physical health, both at the subjective and at the objective level.

Better understanding of the relationship between depression and alexithymia

In the present study, the BDI scores at T1 to T3 explained 24.4% of the variation in TAS-20 scores in T4. This is congruent with previous studies. For instance, Luminet et al. [16] found such relationship both at baseline and at follow-up in a group of women with breast cancer, and for both total and factor scores. This association between depression and alexithymia has been found both in normal populations (e.g., Refs. [17,18]) and in clinical populations such as those with alcohol dependence (e.g., Refs. [19,20]) or eating disorders (e.g., Refs. [21,22]). Overall, these results show that depression and alexithymia are not overlapping dimensions, as they never share more than around one third of the common variance. Also, factor analyses showed that there is no overlap between items measuring both constructs in clinical and in normal adult samples [23,24]. Other studies (e.g., Ref. [25]) have also shown that alexithymia is not merely equivalent to the construct of neuroticism but is rather represented by a cluster of traits across the dimensions of the five-factor model.

Differences in the magnitude of the relationship between depression and alexithymia are observed, however, depending on the factor considered [16]. This is likely to have an impact in the assessment of the vulnerability hypothesis. If the common variance shared by the predictors is high, this leaves less room for alexithymia to predict future outcomes. Thus one can assume that “difficulty describing feelings” and “externally oriented thinking” have more chances to become significant predictors of the psychiatric outcomes examined in this study as they have a lower common variance with initial depression. Another issue is that the item content of the depression scale (BDI) is more likely to share a higher proportion of variance with items assessing major depressive disorder at follow-up than with the items of the alexithymia scale (TAS-20). This is reflected in the highest OR found for the relationship initial depression—major depressive disorder (OR=1.08), while the OR for the two other dependent variables was smaller (OR=1.04).

Total alexithymia vs. factor scores

The relation observed between total alexithymia scores and depression is mainly due to the factor “difficulty identifying feelings.” It would have been useful to conduct separate analyses for each factor as previous studies point out that while “difficulty identifying feelings” is partially related to mood variations, this is not or much less the case for “difficulty describing feelings” and “externally oriented thinking.” For instance, de Timary et al. [26] showed absolute changes for “difficulty identifying feelings,” but absolute stability for “difficulty describing feelings” and “externally oriented thinking” in a group of alcohol-dependent patients.

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