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Predictive value of alexithymia in patients with eating disorders: A 3-year prospective study

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Abstract

Objective: Several cross-sectional studies have reported high levels of alexithymia in populations with eating disorders. However, only few studies, fraught with multiple methodological biases, have assessed the prognostic value of alexithymic features in these disorders. The aim of the present study was to investigate the long-term prognostic value of alexithymic features in a sample of patients with eating disorders. **Methods:** Within the framework of a European research project on eating disorders (INSERM Network No. 494013), we conducted a 3-year longitudinal study exploring a sample of 102 *DSM-IV* eating disorder patients using the Toronto Alexithymia Scale (TAS-20) and the Beck Depression Inventory. **Results:** At the 3-year assessment, 74% (n=76) of the sample still presented a syndromal or subsyndromal eating disorder (unfavorable outcome: score of ≥3 on the Psychiatric Status Rating Scale for anorexia nervosa or bulimia nervosa). In logistic and hierarchical regression analyses, the Difficulty Identifying Feelings factor of the TAS-20 emerged as a significant predictor of treatment outcome, independent of depressive symptoms and eating disorder severity. **Conclusions:** The results of this study indicate that difficulty in identifying feelings can act as a negative prognostic factor of the long-term outcome of patients with eating disorders. Professionals should carefully monitor emotional identification and expression in patients with eating disorders and develop specific strategies to encourage labeling and sharing of emotions.

Keywords: Alexithymia; Depression; Eating disorders; Longitudinal study; Outcome predictors

Introduction

The identification of variables that predict treatment outcome in patients with eating disorders is critical if we are to increase the degree of sophistication with which we treat these disorders. Understanding predictors of outcome could theoretically facilitate matching treatments to individuals based on their clinical profile at presentation. Dirks et al. [1] have coined the term "psychic maintenance" to describe the chronic outcome of an illness due to psychological reasons. Among the several psychological features that have been proposed to predict treatment outcome in patients with eating disorders, alexithymia has attracted special interest. Alexithymia is a personality construct characterized by a difficulty in identifying and describing feelings, a diminution of fantasy, and a concrete and externally oriented thinking style [2]. Several arguments, namely, factor analyses and longitudinal studies, have supported the view that alexithymia is a stable personality trait rather than a state-dependent phenomenon linked to depression or to clinical status [3,4]. Several studies have reported high levels of alexithymia in patients with eating disorders, especially in individuals with anorexia nervosa [5–8]. There are several reasons to believe that this construct could play a

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major role in the illness course of eating disorders: due to their cognitive limitations in emotion regulation, alexithymic individuals with eating disorders may resort to maladaptive self-stimulatory behaviors such as starving, bingeing, or drug misuse to self-regulate disruptive emotions [9]. The lack of insight and the externally oriented thinking style of alexithymic subjects may also interfere with their capacity to benefit from psychotherapeutic interventions. However, in spite of the clinical relevance of this issue, clear data on the prognostic value of alexithymic features in eating disorders are still lacking. Two studies conducted on individuals with bulimia have failed to demonstrate a specific impact of alexithymia on the outcome of these patients. However, these studies presented some methodological limitations: samples were relatively small; the longitudinal time period was too short (10 weeks); both studies used an earlier version of the Toronto scale to assess alexithymic features; and finally, the outcome measures did not account for the degree of clinical change between baseline and follow-up [6,10].

The aim of the present study was to investigate the long-term prognostic value of alexithymic features in a large sample of patients with eating disorders, taking into account the limitations of previous studies.

Method

Participants and procedures

The subjects of this study were derived from a multicenter research project investigating the psychopathological features of eating disorders (Inserm Network No. 494013). The overall design of the Network was a cross-sectional investigation, with only a subset of research centers involved in a prospective follow-up study. The recruitment centers were academic psychiatric hospitals specialized in adolescents and young adults (age range of reception: 15–30 years). For this study, only female participants who had requested care for a disorder of eating behavior were screened for inclusion. At the first assessment and 3 years later, patients included in the sample completed a research protocol, which consisted of a clinical interview (for sociodemographic and diagnostic data) and a self-report questionnaire eliciting psychopathological features (namely, alexithymia and depression). Eating disorder diagnoses, whether of anorexia nervosa or bulimia nervosa, were made by a psychiatrist or a clinical psychologist specialized in the field of eating disorders using *DSM-IV* diagnostic criteria [11]. Diagnostic assessment was made using the Mini International Neuropsychiatric Interview, which is a structured, validated diagnostic instrument that explores each criterion necessary for the establishment of current and lifetime *DSM-IV* Axis I main diagnoses (anxiety and depressive disorders, substance-related disorders) [12,13]. In relation to the main purpose of the study, which was to investigate the predictive power of alexithymia in eating disorders, we excluded patients presenting a comorbid diagnosis of current major depressive episode (MDE) (n=11) and patients presenting a current alcohol or drug dependency (n=6). MDEs were excluded to raise the chance of detecting a significant relationship between alexithymia and outcome, which would have been reduced by an excessive overlap between alexithymic and depressive scores. Alcohol and drug dependencies were excluded because of very few cases, thus creating a more homogeneous sample of eating disorders.

Patients were invited to participate in the follow-up study 3 years later. At 18 months, a reminder letter was sent to all participants. A second letter was sent just before contacting them by phone to plan the second assessment. The protocol was approved by the local ethics committee (Paris Cochin Hospital). After all the necessary information was provided, all subjects gave written consent for participation in the study.

Measures

Alexithymia was rated using the French translation of the revised Toronto Alexithymia Scale (TAS-20) [14–16], which is a self-report scale with 20 items rated on a five-point Likert scale. The items of the TAS are clustered into three factors: Difficulty Identifying Feelings (DIF), Difficulty Describing Feelings (DDF), and Externally Oriented Thinking (EOT) [17].

Depression severity was measured with the French translation of the abridged version of the Beck Depression Inventory (BDI-13) [18]. The BDI-13 has been developed by Beck and Beck [19] as a specific tool for epidemiological studies by selecting within all the items showing a high correlation (>.90) with the total score of the BDI-21.

The severity of the illness was assessed by the "severity of illness" item of the Clinical Global Impression (CGI). The CGI requires the clinician to rate on a 7-point scale (1=*normal* to 7=*extremely ill*) the severity of the patient's illness at the time of assessment, relative to the clinician's past experience and training with patients with the same diagnosis.

Outcome criteria

The clinical outcome at 3 years was approached by two complementary perspectives: categorically, according to the presence or absence of eating symptoms, and dimensionally, according to the degree of clinical improvement between baseline and follow-up. For the categorical approach, eating disorder symptoms were assessed by the Psychiatric Status Rating Scale (PSRS) for anorexia nervosa or bulimia nervosa [20,21]. The PSRS, which is part of the diagnostic assessment LIFE Eat II, is based on *DSM-IV* diagnostic criteria for eating disorders. It defines six levels of severity according to the presence and the degree of clinical