RE-Alexithymia – State and Trait

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Taylor and his colleagues refer to the ‘frequently observed’ characteristic of alexithymics i.e. a difficulty in employing self-solacing strategies implying that the results of our study are more or less old hat. In fact, the present study [1], coupled with the results of the first, formal, controlled study of solacing or comforting object usage by alexithymics [2] suggests an important diagnostic distinction: Whereas the severely personality disordered typically use no solacing or ‘transitional objects’ [3, 4], the alexithymic does use solacers but significantly fewer than normal controls. Also, we bring into focus the qualitative use of solacing objects by alexithymics – the alexithymic’s solacers, unlike the majority of normals, do not include memories. It appears that alexithymics may attempt to soothe themselves but in mainly vigorous, physical, motoric ways with little reliance on psychological solacers. This observation, when made at the 1992 Annual Meeting of the American Psychiatric Association, prompted Sifneos to recommend that we add a ‘future-planning’ item to our core symptom questionnaire [5]; this is an excellent suggestion and we believe that it will prove to be very discriminating.

Regarding the ‘state’ versus ‘trait’ issue, we defined ‘state’ simply and straight-forwardly as a ‘condition’ or ‘disorder’ such as might be caused by a neurophysio-logical deficit. This is compatible

with the conventional definition of state as a ‘mode or condition of being’ [6]. It corresponds to ‘primary’ alexithymia described in psychosomatic [7] and commissurotomy [8] patients. As such, it is a diagnosis. The original studies on which the alexithymia concept is based provide, in our opinion, excellent evidence for the validity of the concept and we wonder why Taylor et al. [10] keep claiming that ‘... there is little empirical evidence that would establish the validity of the construct’.

The problem for Taylor and his colleagues is not so much with the distinction between ‘state’ and ‘trait’ as with the fact that alexithymia can be a diagnosis at all. They appear to have fallen into a conceptual trap caused by their misuse of the notion ‘hypothetical construct’. For them, those who see alexithymia as a condition, state or diagnosis are ‘failing to realize that constructs do not exist in the sense that material things do but represent hypotheses which behavioral scientists rely on to explore human thought and behavior’ [9]. However, to label alexithymia as a hypothetical construct is to denote the possibility of a diagnosable condition. As MacCorquodale and Meehl [11] stated in their original, pivotal and classic article, ‘hypothetical constructs ... assert the existence of entities ... it is the business of a hypothetical construct to be “true” ‘.In their denial of its probable existen-

tial status as a diagnosable entity, Taylor and colleagues actually mean to refer to alexithymia as an 'intervening variable' rather than as a 'hypothetical construct'.

Though it is the prerogative of Taylor and colleagues to regard the word alexithymia as a mere provisional, short-hand notation for a set of empirical relationships – an 'intervening variable' in the correct terminology – they may want to bear in mind MacCorquodale and Meehl's [11] famous caveat to psychologists: 'But for those theorists who do not confine themselves to intervening variables in the strict sense, neurology will some day become relevant'. Obviously, with their emphasis on the intervening variable character of alexithymia, Taylor and colleagues do not foresee a connection with the medical sciences. For Sifneos [7], Hoppe [8] and several others who have made special contributions to the recognition of alexithymia as a diagnostic entity, neurology was, from the outset, relevant to the alexithymia construct.

Regarding trait, we use it in both the conventional and traditional psychiatric senses.

Conventionally, trait means, a touch or trace [6]. According to this definition, a person can have a 'little' alexithymia as in, 'Most adolescents are a little alexithymic', or, 'Most people are kinda alexithymic – at least some of the time'. Trait, in this very loose sense, was in the

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original DSM [12] where, for example, 'neurotic trait' referred to a 'transitory situational response'. Also, 'personality trait disturbance' was separated from 'personality pattern disturbance'. The latter, like primary alexithymia, was conceptualized as a condition – or state – in which 'functioning may be improved by prolonged therapy, but basic change is seldom accomplished ... In some, "constitutional" features are marked and obvious'. In DSM-III, 'traits' were described as 'enduring patterns' but the word, trait, was to be replaced with 'disorder' when the condition was 'inflexible and maladaptive...' [13].

Two-thirds of our large sample consisted of 16- and 17-year olds; this age group was included in Taylor et al's [9] original validation study of undergraduates with an age range of 16–61 and a mean age of 23.8 years. About the cutoff scores Taylor and Bagby [14] state: '... the cut-off scores we have established provide the sensitivity and specificity that are required for an instrument used for research pur-

poses'. Moreover, the Toronto group has claimed 'Using previously established TAS cut-off scores > 74 for identifying alexithymic subjects... 18.8% of the sample was found to fall within the alexithymic range. A virtually identical proportion of alexithymic subjects would be found if the same cut-off levels were to be applied to a normative group of college students originally reported by Parker et al. [15]'. Twenty-six percent of our sixteen and seventeen year olds were TAS positive for alexithymia. As noted, Parker et al. [15] report that 18.8% of a 'normal adult sample' as well as college students are TAS-positive. Why they should be so offended at our reporting pretty much the same findings i.e. that an incredibly large percentage of 'normals' are found to be TAS-alexithymic is puzzling.

Appositely, one of us (P.H.) has reported [5] on a survey of consecutive outpatients in a general psychiatric practice which showed that more than 50% were TAS-positive despite the fact that the over-

whelming majority of these positive patients readily described dreams and fantasies and were in no sense – other than on the TAS -alexithymic. To be added to this is the observation that it took

one of us (P.H.) 2 years to collect just 13 cases of well-defined alexithymia from the patient pool of a large, full-time general psychiatric practice [5]. That this experience is not unique is testified to by the following comment, which was received by one of us (P.H.) when he asked an alexithymia researcher to validate the Solacing-Methods-Questionnaire on his own patients: 'I regret that I have been unable to administer your questionnaire to any alexithymic patients. It is proving difficult to obtain a sufficient number of alexithymic subjects for validating our own self-report alexithymia scale'. If nearly 20% of 'normals' are 'alexithymic', why is it so difficult to find alexithymics for validation studies? In any case, we have found the TAS to be virtually useless for identifying clinically significant alexithymia.

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