Alexithymia, Gender, and Responses to Depressive Symptoms

Kelly M. Carpenter and Michael E. Addis

Clark University

Difficulty in labeling and communicating emotions (commonly known as alexithymia) may play a role in how women and men respond to a depressed mood. In the current study, we hypothesized that alexithymia would be associated with a lower probability of seeking support from close others or health care professionals. We also tested the hypothesis that gender differences in response to depressive symptoms could be accounted for by alexithymia. One hundred and seventy-two employees of a small urban university completed the Toronto Alexithymia Scale-20, the Beck Depression Inventory, and a Responses to Depression Analogue Questionnaire. This sample was 67% women, 90% Caucasian, and was highly educated overall. Difficulties in communicating emotion were associated with a lower self-reported probability of seeking social support from friends or family, or thinking about the reasons for problems. No relationship was found between alexithymia and the probability of seeking help from a professional. Partial support was found for alexithymia as a mediator of gender differences in response to depressive symptoms. Overall, the results are consistent with the idea that the abilities to recognize, label, and communicate affective experiences are related to the ways in which people cope with depression, and that these relationships differ according to gender.

INTRODUCTION

Individual differences in response to emotional distress may determine whether and how a person seeks help. For example, although major depression is the most common psychiatric disorder in the United States (Kessler,
McGonagle, Zhao, & Nelson, 1994), a recent large-scale epidemiological survey found that only 29% of individuals diagnosed as depressed had received treatment in the previous year (Howard et al., 1996). This was true despite the fact that a number of treatment options, both psychosocial and pharmacological, have been empirically tested and found to be effective treatments for depression (e.g., Dobson, 1989; Elkin et al., 1989). In order to increase the percentage of people receiving effective treatment, researchers must begin to identify variables that influence how a person responds to the experience of depressive symptoms.

Gender

A number of studies have found gender differences in patterns of mental health service utilization and responses to depressed mood. For example, men are less likely to use mental-health related services than women are (e.g., Greenley & Mechanic, 1976; Kessler, Brown, & Bromá, 1981). This appears to be true from childhood (Garland & Zigler, 1994) to old age (Husaini, Moore, & Cain, 1994), and includes mental health practitioners themselves (Norman & Rosvall, 1994). These findings support the common assumption that help-seeking is inconsistent with the male gender role (e.g., Sabo & Gordon, 1995).

Other studies suggest a particular style of responding to depression that is more likely in women. Nolen-Hoeksema (1987; Nolen-Hoeksema, Parker, & Larson, 1994) found that women are more likely than men to report that they had responded to depression by ruminating and focusing on the possible causes of their symptoms. Similarly, Ingram, Cuet, Johnson, and Wisnicki (1988) found that when depressed mood was induced, women responded with higher levels of self-focus and negative affect than did men. What remains unclear from these studies is precisely why women are both more likely to seek mental health services and to think about their reasons for being depressed. Although it is typically assumed that thinking about one's feelings and consulting a psychotherapist do not coincide with traditional male gender roles, the precise psychological mechanisms are unclear.

Alexithymia

The term alexithymia (from the Greek, a = without, lexi = word, thymos = emotion) was coined by Sifneos (1972) to describe a cluster of symptoms including a decreased ability to label and communicate affect, confusion of affective and somatic symptoms, and externally-oriented thinking
Alexithymia and Gender

(Taylor & Taylor, 1997). A growing body of research has linked alexithymia to a variety of both psychological and physical disorders including depression (e.g., Bagby, Taylor, & Ryan, 1986; Wise, Mann, & Hill, 1990).

To our knowledge, few studies have attempted to examine how the presence of alexithymic personality traits affects an individual’s response to psychological distress. Parker, Taylor, and Bagby (1998) examined the relationship between alexithymic traits and general coping styles. College students with higher alexithymia scores were more likely to indicate a preference for distraction and emotion-oriented coping strategies (i.e., becoming preoccupied with bodily symptoms, self-blaming, worrying about what to do). The authors suggest that these results reflect alexithymic individuals’ lower capacity to constructively think about their problems and devise cognitive strategies to soothe their affective distress. One goal of the present study was to examine how alexithymia is related to responses to depressive symptoms. Rather than asking individuals about typical ways of coping with stress (as in Parker et al., 1998), we were interested in how likely people thought they would be to respond in specific ways to depressive symptoms.

One study (Lumley & Norman, 1996) has examined the relationship between alexithymic characteristics and health care utilization in college students. Lumley and Norman found that the identifying feelings component of alexithymia was related to increased use of outpatient medical treatment whereas the externally-oriented thinking component predicted decreased use of outpatient medical treatment and of psychotherapy services. This finding supports our central assumption that the ability to identify and describe emotional experiences will influence how likely a person is to share their experience with others, to think about the causes of a problem, and to seek professional help.

Gender and Alexithymia

Facility with emotion talk is often described as a central part of male and female gender roles (Bem, 1974). The evidence regarding gender differences in alexithymia, however, is equivocal with some studies finding that men tend to be more alexithymic than women do, and others finding no gender differences (see Parker, Bagby, Taylor, Endler, & Schmitz, 1993). A related line of research on gender role conflict describes a constellation of negative effects from socialized gender roles for males (O’Neill, Good, & Holmes, 1995; O’Neil, Helms, Gable, David, & Wrightsman, 1986). One of these negative effects of male gender role socialization is “restrictive emotionality.” Restrictive emotionality refers to difficulty with and fears
about expressing emotions. Restrictive emotionality has been found to be associated with a lower likelihood of men's willingness to seek psychological help (e.g., Wisch, Mahalik, Hayes, & Nutt, 1995), as well as decreased psychological well-being (Blazina & Watkins, 1996). However, no research to date has examined the possibility that emotional awareness and expression capabilities may be related to help-seeking and other responses to depression in women.

In addition to overall gender differences, it is possible that alexithymia and gender have additive or interactive effects on responses to depression. For example, if men in general are less likely to seek help for problems, then difficulty in identifying and communicating emotions may make a particular man even less likely to do so. Alternatively, gender may lose its predictive power when alexithymia is considered because deficits in emotional awareness may underlie gender differences in responses to depression. Thus, an additional goal of this study was to examine the possible interactions between gender and alexithymia and their joint influence on responses to depressive symptoms.

The Present Study

In the present study we evaluated the relationships among alexithymia, gender, and responses to depressive symptoms, using an analogue methodology. We predicted that alexithymia would be associated with a lower estimated probability of (a) seeking help from a psychotherapist or counselor, (b) talking about problems with friends and family members, or (c) thinking about the causes of depressive symptoms. Our rationale for these hypotheses was that the ability to verbally share feelings with others (or with oneself) depends on the ability to identify and describe emotional experiences (the opposite of alexithymia). Additionally, we hypothesized that alexithymia would be associated with a higher estimated probability of (a) seeking help from a medical doctor, (b) distracting oneself from a situation, and (c) keeping depressive symptoms to oneself. Our rationale for these hypotheses was that the inability to verbally describe emotional experiences may lead one to focus on physical symptoms, to cope by distracting, or to keep to oneself. We hypothesized that women in general would be more likely than men to state that they would seek help from a therapist or medical doctor, and more likely to think about the reasons for their depressive symptoms. Finally, we hypothesized that alexithymia would mediate the relationship between gender and responses to depressive symptoms. In other words, gender differences in response to depressive symptoms could be accounted for by differences in the ability to identify and describe emotional experiences.
Alexithymia and Gender

METHOD

Participants

One hundred seventy-two faculty and staff members of a small urban university in New England participated in the study. They ranged in age from 22 to 67 years ($M = 41, SD = 10.96$), and 67% were female ($n = 116$). In terms of education, 7% reported some high school or graduated from high school, 18.6% reported some college, 28.5% had graduated from a 4-year college, and 45.9% had a graduate degree. This higher than average educational level was due to the university setting of the study. Ninety percent of the sample were Caucasian. Twenty-five percent of the sample had never been married, 48.3% were in their first marriage, and 26.1% had been divorced. The 172 participants came from the larger sample of 650 university employees who were mailed the survey. This larger group consisted of 50% women, and their ethnicity was 4% Asian, 3% African American, 4% Hispanic, and 89% Caucasian. Thus, more women responded to the survey than men did and the number of ethnic minorities was similar to that of the population surveyed.

Procedure

Questionnaires were mailed to all faculty and staff through campus mail. The study was introduced as a study on “coping styles.” Each packet that was mailed was assigned an identification number. Participation was encouraged by offering a random drawing for a gift certificate to a popular local restaurant. Participants’ identity was never matched with their identification number except to privately notify the winner of the gift certificate. One hundred and seventy-two (27%) of the 650 questionnaires were completed and returned.

Measures

The 20-Item Toronto Alexithymia Scale (TAS-20; Bagby, Parker, & Taylor, 1994) is a self-report measure of alexithymia. Respondents use a 5-point Likert scale ranging from strongly disagree to strongly agree to rate themselves on statements describing alexithymic traits. Possible scores on the TAS-20 range from 20 to 100. Scores below 51 are considered nonalexithymic whereas scores above 60 are considered alexithymic. The TAS-20 has demonstrated good internal consistency (Cronbach’s $\alpha = .81$) and test-retest
reliability ($r = .77$). Three factors have been identified in the TAS-20: (a) difficulty identifying feelings and distinguishing them from bodily sensations; (b) difficulty describing feelings to others; and (c) externally-oriented thinking. This factor structure has been replicated with Canadian and German samples in both clinical and nonclinical populations and shows good stability and reliability (Parker et al., 1993).

The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a 21-item self-report measure of current symptoms of depression. Respondents identify which of four statements best describes how they felt over the past week. The four statements range from symptom absent (0) to severe (3). Scores on the BDI range from 0 to 63, with scores less than 10 thought to reflect an absence of clinical depression, 10–20 mild depression, 20–30 moderate, and greater than 30 severe. The BDI is widely used and has excellent internal consistency and high content validity and has been shown to be a valid method of differentiating between depressed and nondepressed research participants (Beck, Steer, & Garbin, 1988; see Richter, Werner, Heerlein, Kraus, & Sauer, 1998, for a meta-analysis). Its primary purpose in this study was to control for the effects of current depression symptoms when examining the relationship between other variables and predictions of responses to future episodes of depression.

The Responses to Depression Analogue Questionnaire (RDAQ) was developed for the current study. This self-report measure consists of a short description of the phenomenology and symptoms of an episode of depression. Respondents are asked to imagine that they are experiencing the symptoms in the description, and then to rate the likelihood of responding in six different ways on a 5-point Likert scale (highly unlikely to highly likely). The six items on the RDAQ are as follows: (1) discuss my feelings or problems with a friend or family member, (2) seek help from a therapist or other type of counselor, (3) think about how I feel to try to figure out the reasons for my problems, (4) seek help from a medical doctor, (5) try to do things to take my mind off the situation, and (6) keep my situation to myself so other people don’t know about my problems. These six items were chosen because of their theoretical relationship to alexithymia and gender. Difficulty in identifying and describing affect should make one less likely to discuss feelings with a friend or family member, introspect about the causes of emotional distress, or seek help from a psychotherapist. The same difficulty may make one more likely to use distraction as a coping technique, be reserved in discussing one’s feelings, or seek help from a medical doctor. The six items were intended to reflect six different behavioral responses to depressed mood and not to reflect an underlying construct of “help-seeking.” Accordingly, the correlations among the items were all .30 or less with the exception of Items 2 and 4.
Alexithymia and Gender

(seek help from a therapist or counselor and seek help from a medical doctor, respectively), which had a correlation of .40. These low correlations among items indicate the relative independence of these behavioral responses to depression.

The RDAQ's criterion validity was measured by correlations between the professional help-seeking items and questions asked in the demographics questionnaire regarding past professional help-seeking. The correlation of number of visits to a medical doctor in the past year with RDAQ Item 4 (seek help from a medical doctor) was .37, \( p < .000 \). The correlation between the number of visits to a therapist or counselor in the past year and RDAQ Item 2 (seek help from a therapist or counselor) was .57, \( p < .000 \).

RESULTS

Participants had a mean BDI score of 6.79 (\( SD = 6.06 \), Range = 0–29) suggesting, as expected, that the sample as a whole was not experiencing symptoms related to depression. Twenty percent (\( N = 34 \)) of participants had scores between 10 and 20 suggesting mild symptoms of depression, and 3.5% (\( N = 6 \)) had scores from 20 to 29 suggesting moderate levels of depression (Beck et al., 1988). Consistent with previous research, TAS-20 and BDI scores were significantly correlated, \( r = .44, p < .001 \). BDI scores were subsequently partialled out of analyses involving predictors of response to depression. Our primary interest was in the specific relationships between alexithymia, gender, and participants' predictions of what they would do if they were depressed.

Gender comparisons revealed that males scored significantly higher than females on the TAS-20, \( t(169) = 2.27, p = .03 \), were significantly older, \( t(162) = 2.23, p = .03 \), and significantly more educated, \( t(169) = 3.05, p = .003 \). There was also a small but significant negative correlation between education and TAS-20 scores, \( r = -.19, p = .013 \).

Age and education were partialled or covared out of subsequent analyses relating alexithymia to gender and responses to depression.

Alexithymia and Responses to Depressive Symptoms

Table 1 shows partial correlations between the TAS-20 and RDAQ items controlling for age, education, and BDI scores. Correlations are broken down by gender, and presented separately for the three TAS-20 factors: difficulty identifying feelings, difficulty describing feelings, and externally-oriented thinking. Looking between columns on Table 1 shows that difficulty
Table 1. Correlations Between TAS-20 Factor Scores and RDAQ Items by Gender

<table>
<thead>
<tr>
<th>RDAQ Item</th>
<th>Difficulty Identifying</th>
<th>Difficulty Describing</th>
<th>Externally Oriented</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>1</td>
<td>-.07</td>
<td>-.15</td>
<td>-.32**</td>
<td>-.40**</td>
</tr>
<tr>
<td>2</td>
<td>.21</td>
<td>.13</td>
<td>-.11</td>
<td>-.22**</td>
</tr>
<tr>
<td>3</td>
<td>-.14</td>
<td>-.14</td>
<td>-.25**</td>
<td>-.13</td>
</tr>
<tr>
<td>4</td>
<td>.16</td>
<td>.22*</td>
<td>-.10</td>
<td>-.18*</td>
</tr>
<tr>
<td>5</td>
<td>.07</td>
<td>-.05</td>
<td>.01</td>
<td>.04</td>
</tr>
<tr>
<td>6</td>
<td>.14</td>
<td>.11</td>
<td>.18</td>
<td>.52**</td>
</tr>
</tbody>
</table>

Note: Depression scores, education, and age have been partialled out of these analyses. RDAQ items are (1) discuss my feelings or problems with a friend or family member, (2) seek help from a therapist or other type of counselor, (3) think about how I feel to try to figure out the reasons for my problems, (4) seek help from a medical doctor, (5) try to do things to take my mind off the situation, and (6) keep my situation to myself so other people don’t know about my problems. *p < .05, **p < .01.

describing feelings and externally-oriented thinking were more reliably associated with responses to the RDAQ than did difficulty identifying feelings. This pattern emerged for both men and women. However, differences in sample size yielded differences in power for males and females resulting in fewer significant correlations for males than for females.

Looking between rows on Table 1 reveals that TAS-20 scores were primarily associated with responses to RDAQ Items 1 and 3. In general, both men and women scoring higher on the TAS-20 reported a lesser likelihood of discussing their feelings with friends or family members (Item 1), or thinking about how they feel and trying to figure out the reasons for problems (Item 3). Contrary to what we had predicted, there were few relationships between the TAS-20 and the likelihood of seeking help from a therapist (Item 2) or a medical doctor (Item 4). An exception was that women who reported difficulty describing feelings were less likely to seek help from a therapist or medical doctor.

Gender and Responses to Depressive Symptoms

Table II shows the mean scores on the RDAQ items for men and women. We performed a series of analyses of covariance examining gender differences while controlling for participants’ age, education, and BDI scores. Men reported a significantly lower probability than women of discussing their feelings with a friend or family member (Item 1), seeking help from a therapist (Item 2) or medical doctor (Item 4), or thinking about their feelings and trying to figure out the reasons for problems (Item 3).
Alexithymia and Gender

Table II. Analysis of Covariance of RDAQ Items by Gender

<table>
<thead>
<tr>
<th>RDAQ Item</th>
<th>Males</th>
<th>Females</th>
<th>F (df)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>1</td>
<td>4.18</td>
<td>1.17</td>
<td>4.42</td>
<td>.95</td>
</tr>
<tr>
<td>2</td>
<td>2.13</td>
<td>1.21</td>
<td>2.71</td>
<td>1.47</td>
</tr>
<tr>
<td>3</td>
<td>4.42</td>
<td>1.13</td>
<td>4.71</td>
<td>.53</td>
</tr>
<tr>
<td>4</td>
<td>2.12</td>
<td>1.20</td>
<td>2.67</td>
<td>1.46</td>
</tr>
<tr>
<td>5</td>
<td>3.94</td>
<td>.89</td>
<td>3.91</td>
<td>.94</td>
</tr>
<tr>
<td>6</td>
<td>2.85</td>
<td>1.39</td>
<td>2.67</td>
<td>1.34</td>
</tr>
</tbody>
</table>

Note: Depression scores, education, and age have been covaried out of these analyses. RDAQ items are (1) discuss my feelings or problems with a friend or family member, (2) seek help from a therapist or other type of counselor, (3) think about how I feel to try to figure out the reasons for my problems, (4) seek help from a medical doctor, (5) try to do things to take my mind off the situation, and (6) keep my situation to myself so other people don’t know about my problems. *p < .05. **p < .01.

We were particularly interested in whether alexithymia might mediate some of the gender differences found on the RDAQ. If this were the case, then entering TAS-20 scores into a regression equation, with gender as a predictor and RDAQ items as criteria, should remove or reduce the size of the gender effect (Baron & Kenny, 1986). Accordingly, we conducted a series of hierarchical regression equations in which the four RDAQ items in which we found gender differences served as criteria. In each equation, gender was entered first along with age, education, and BDI scores. TAS-20 scores were entered next. The statistic of interest was the difference between the initial beta weight for gender and the same beta weight when TAS-20 scores were included in the equation. The results of these analyses are presented in Table III.

When TAS-20 scores were entered into the equation, the size and significance of the beta weights for gender were reduced for Items 1 (discuss...
my feelings or problems with a friend or family member) and 3 (think about how I feel to try and figure out the reasons for my problems). In other words, TAS-20 scores accounted for the gender differences on these items. Gender made significant and independent contributions in predicting responses to Items 2 (seek help from a therapist or other type of counselor), and 4 (seek help from a medical doctor), when TAS-20 scores were entered into the equations. Thus, TAS-20 scores did not account for gender differences in response to these two items.

DISCUSSION

This study examined the relationships among gender, alexithymia, and self-reported patterns of responding to depressive symptoms. The results suggest that both alexithymia and gender are related to variations in how individuals respond to depressive symptoms. Difficulties in communicating emotion and an externally-oriented thinking style were associated with a lesser likelihood of talking with others or thinking about the causes of depressive symptoms. This was true for both men and women. We also found partial support for the premise that gender differences in response to depressive symptoms are mediated by alexithymic difficulties.

Our results suggest that alexithymia is associated with patterns of responding to depressive symptoms. Both men and women who score higher on a measure of alexithymia report a lower likelihood of seeking help from friends and thinking about the reasons for one's problems. Women with alexithymic characteristics also report a lower likelihood of seeking support from a mental health counselor or medical doctor. Because of our smaller sample of men, we are unable to make similar claims regarding alexithymia's relationship to help-seeking from professionals for men. Our results also suggest that, for both men and women, the relationship between alexithymia and responses to depressive symptoms is specific to difficulty describing feelings, rather than difficulty identifying them. This distinction is important and could suggest either a specific behavioral deficit (e.g., skill with emotion language) or a discomfort or reluctance to entertain awareness of negative affect. Either a skills deficit or discomfort with awareness of negative affect may be addressed with ameliorative interventions.

Our original hypotheses regarding professional help-seeking behavior differentiated between seeking help from a medical doctor and seeking help from a mental health professional. Our results did not support this distinction. Responses to the two items were virtually identical for both men and women. Our initial reasoning was that alexithymic patients would find it easier to discuss physical symptoms with medical doctors than to discuss
Alexithymia and Gender

emotional symptoms with mental health professionals. There are strong similarities between the processes involved in the two types of help-seeking, however, that may account for our findings. Both types of professional help-seeking involve speaking to a professional (most likely a stranger), describing symptoms and difficulties, and asking for help. These processes may be difficult for individuals with alexithymic traits regardless of from whom they are seeking help.

Although the overall pattern of relationships between alexithymia and responses to depressive symptoms is similar for men and women, two of our findings indicate that alexithymia has stronger relationships to thinking about the causes of the depressive symptoms for men than for women. First, men’s (but not women’s) ability to express emotion is related to their preference for thinking about possible reasons for their moods when depressed. Second, externally-oriented thinking is a significantly stronger predictor of not thinking about reasons for men than for women. That is, men who have difficulty thinking or talking about internal states are far less likely to report that they would think about their feelings and reasons for their mood than women with similar difficulties would. Thus, men’s lesser likelihood of introspecting about emotional issues may be due to a difficulty with emotion-related language.

Consistent with previous studies, we found that women reported a higher likelihood than men of seeking help for depressive symptoms, or sharing feelings with friends or family members (Greenley & Mechanic, 1976; Kessler et al., 1981). We also found partial support for the hypothesis that alexithymic difficulties can account for observed gender differences in response to depressive symptoms. This was true for sharing problems with others and thinking about the reasons for problems. However, gender differences in seeking help from professionals were not accounted for by alexithymia. Thus, deficits in being able to talk about emotion and other internal states do not appear to be the reason that men don’t seek professional help, at least in the present sample. It is also important to recognize a variety of types of masculinity rather than generalizing about men per se. It appears likely that help-seeking is difficult for different men for a variety of reasons. In our highly educated sample, for example, difficulty expressing emotion was not related to the likelihood of professional help-seeking. Although the most common theory for why men don’t seek professional help is reluctance or inability to self-disclose emotion (e.g., Ritter & Cole, 1992), other gender-role issues such as power and dependence may come into play depending on the particular type of masculinity operating (Sabo & Frederick Gordon, 1995). Even when some men are able to talk about emotion, they may have difficulty seeking help because it requires them to give up power and control to someone else, leaving them in an uncomfortable
position of dependence. Furthermore, it should be noted that although the gender differences in help-seeking were statistically significant in some cases, the actual means were quite similar and quite high (e.g., 4.2 for men and 4.4 for women on the social sharing measure). The clinical significance of these gender differences is unclear.

Alexithymia, and the ability to express emotion in particular, does appear to be related to women’s likelihood of seeking help from professionals. Although women, in general, do seek professional help more often than men do, the present findings indicate that alexithymic women may be less likely to get the help they need when they are depressed (or otherwise distressed). It may therefore be helpful to extend to women with alexithymic characteristics the efforts to increase help-seeking that are typically aimed at men.

The present study suggests that alexithymia is associated with a decreased likelihood of discussing problems with friends and family members for both men and women. Pennebaker and colleagues have shown that failing to discuss life events or stressors can have long-lasting negative effects on physical and psychological health. Furthermore, participants who were encouraged to disclose negative events in the laboratory had long-term positive consequences on several health indicators (e.g., Pennebaker & Beall, 1986; Pennebaker & O’Heern, 1984; see Smyth, 1998, for a meta-analysis). Disclosing problems to friends, family members, or a professional also diminishes the likelihood of using cognitive, behavioral, and affective avoidance as coping strategies. Thus, for both men and women, difficulty identifying and describing feelings may play a role in the well-established link between social support and physical and mental health (Hegelson, 1995).

By definition, alexithymic individuals are less able to verbalize emotional distress. Our findings suggest that alexithymic individuals are not only less likely to discuss emotion with others, but are also less likely to think about the causes of depressive symptoms privately. The empirical evidence is equivocal in terms of the adaptive or maladaptive consequences of thinking about the reasons for a problem. Some have argued that thinking about the reasons for current problems may provide benefits (e.g., Horowitz, 1986; Martin & Tesser, 1989). For example, thinking about the problem may enable one to find meaning in negative life events by developing an understanding of these events. Rumination, however, has been found to increase the intensity of negative affect; to prolong negative mood; and to interfere with attention, concentration, and the initiation of problem-solving behavior (Morrow & Nolen-Hoeksema, 1990). At the other extreme from rumination, avoiding thinking about problems is related to increased stress and health problems (Pennebaker and Beall, 1986). It may be that thinking about a problem is adaptive when it is action-oriented (e.g., leads to cognitive or behavioral
Alexithymia and Gender
coping), but harmful when it is state-oriented (e.g., dwelling on a problem’s negative aspects; Paez, Basabe, Valdosed, Velasco, & Iraurgi, 1996), action-prohibiting, or inflexible (Strauss, Muday, NcNall, & Wong, 1997).

The present results also contribute to broader research on correlates of alexithymia for both men and women. The observed relationship between alexithymia and responses to depressive symptoms may partly account for the well-documented relationship between alexithymia and various psychiatric problems. Avoiding thinking about the reasons for a problem, keeping problems to oneself, and not seeking professional help may lead to the development of problems associated with maladaptive coping (e.g., substance abuse: Fukunishi et al., 1992; Haviland, Hendryx, Shaw, & Henry, 1994; eating disorders: Cochran, Brewerton, Wilson, & Hodges, 1993; Legorreta, Bull, & Kiely, 1988; Schmidt, Jiwany, & Treasure, 1993), or exacerbate existing symptoms. It may also be that alexithymic tendencies leave some people with fewer of the skills that are needed to develop close relationships. Self-disclosure and the discussion of emotion have been found not only to have emotional and physical benefits (Pennebaker & Beall, 1986), but are linked to the development of close relationships as well. It is possible that alexithymic individuals are unable to reap the benefits of social support because they have difficulty talking about their emotions and, therefore, cannot develop close relationships with others. The present results suggest that difficulties connecting with others due to alexithymic traits may be more common in women than in men, perhaps because discussing emotional issues directly is typically not considered as central a part of male–male friendships. Future studies should examine more closely the relationship between alexithymia and specific components of social support for both men and women.

Finally, we would like to address some methodological issues. This study was a preliminary investigation. Before the results can be generalized to a depressed population, the study should be replicated using a sample of depressed individuals who report their actual help-seeking behavior. It is also important to note that our conclusions about gender differences were based on self-reported sex, not gender role. It is possible that our findings would have been different if we had assessed gender role. Our sample was, on average, highly educated. Although we partialled out the variance attributable to education from the pertinent analyses, this sample cannot be considered representative of the general public. In particular, it is possible that the men in this sample, by virtue of their education and employment in a university setting, held more favorable attitudes toward seeking professional help. However, it should be noted that men, on average, reported a low likelihood of seeking help from a therapist or medical doctor. Thus, our results do not suggest an unusual sampling bias with regard to patterns of help-seeking. Nonetheless, it would certainly be appropriate to replicate the findings with
a more diverse sample before drawing strong conclusions based on these results. The measure used to assess predicted help-seeking behavior (the RDAQ) is a set of six single-item measures developed for the present study. Single-item measures are somewhat controversial and are sometimes viewed as less psychometrically sound than multiple-item measures are. However, several recent investigations found strong correlations between single-item measures and their multiple-item counterparts (e.g., Gardner, Cummings, Dunham, & Pierce, 1998; McKenzie & Marks, 1999). These studies suggest that in situations, such as the present study, where there is a strong need to keep the assessment battery brief, single-item measures represent a viable option. Finally, the present study used an analogue design and is thus a study of predicted responses to depressed mood. Recent research has shown that attitudes about help-seeking do have predictive power. For example, Cramer (1999) found that individuals’ attitudes about mental health treatment did predict the likelihood of undergraduates seeking psychological help. However, we do not claim that our participants were likely to be perfect predictors of their own responses to depressed mood. Further research looking at the relationship among gender, alexithymia, and actual help-seeking behavior is certainly warranted.

REFERENCES


Alexithymia and Gender


Carpenter and Addis


