Alexithymia and self-reflectiveness in bronchial asthma

Alessitimia e auto-riflessione nell’asma bronchiale

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SUMMARY. The aim of the study was to investigate the role of alexithymia in bronchial asthma (BA) patients with low respiratory functioning hypothesizing that it could be used to differentiate a group of patients with clinically significant anxiety and depressive symptoms. We also aimed to investigate whether alexithymia was associated with reduced cognitive insight. Patients (n=153) were administered the State-Trait Anxiety Inventory-State subscale, the Beck Depression Inventory, the Toronto Alexithymia Scale, and the Beck Cognitive Insight Scale (BCIS). Alexithymia could help differentiate a group of patients with low respiratory functioning. Twenty-two percent of patients included in this subsample had airway obstruction, and 51% reported severe alexithymia. Patients with severe airway obstruction and high alexithymia (compared to other patients) also reported higher self-reflectiveness, and more depressive symptoms. Clinicians have to be aware of the presence of a subgroup of asthma patients with low respiratory functioning who report severe alexithymia. These patients often report moderate to severe depression and frequent doubts about one’s own beliefs.

KEY WORDS: asthma, alexithymia, comorbidity, cognitive insight, depression.

INTRODUCTION

It is estimated that up to 44.5% of adult patients with bronchial asthma (BA) will report clinically significant anxiety and up to 24.5% of them will report depression, while severe and persistent BA in childhood is associated with increased odds of future mental health problems. A recent study reported that around 15% of BA patients could have severe alexithymia, a condition due to which the individual experiences difficulty in identifying and describing feelings. Depression, anxiety, and alexithymia have been independently associated with poor asthma control.

Alexithymia has also been indicated as a risk factor for the development of several chronic diseases including asthma. In BA patients alexithymia has been associated with a poorer quality of life, poor compliance, control of the disease, and more frequent near-fatal asthma attacks. The effects of alexithymia on asthma symptoms and severity could also be mediated by different mechanisms.

Recent studies in psychiatric and medical samples have suggested a possible association between alexithymia and reduced insight, which episodically has been associated with worse physical and psychological health in migraine patients. Nevertheless, to date no studies have investigated this topic in BA patients. Thus, the aim of the study was to investigate the role of alexithymia in BA patients with low respiratory functioning hypothesizing that it could be used to differentiate a group of patients with clinically significant anxiety and depressive symptoms. We also aimed to
investigate whether alexithymia was associated with reduced cognitive insight. This paper adds to the existing literature on the role of psychological factors on asthma control and is intended to deepen our knowledge on the relationships among personality, psychopathology, and impairment in BA considering that past studies in psychiatric and medical samples have suggested a possible association among alexithymia, reduced insight, and physical and psychological health.

**METHODS**

**Study design**

This is a cross-sectional study. The sample is composed of adult outpatients admitted to the Asthma Outpatient Clinic of the University Hospital of Parma between December 2010 and November 2012. Patients were included if they were 18 years and above and had a diagnosis of bronchial asthma according to the international guidelines. Exclusion criteria were the presence of any organic comorbidity, and the denial of informed consent. All patients who failed to complete the psychological and respiratory assessments were excluded from the study.

Medical files were inspected by a senior researcher to assess whether the patient satisfied all inclusion and exclusion criteria. The physician in charge approached the eligible patients, informed them of the scope of the study and requested their consent to participate in the study. All patients were approached during the first visit and completed the assessment within the following month. Screening for medical comorbidities was carried out by the physician in charge during a medical history interview with the support of blood pressure and electrocardiogram measurements (e.g., hematological parameters, electrolytes, serum/plasma and urine).

The study protocol was approved by the local ethics committee, and it was conducted in accordance with Good Clinical Practice guidelines and the Declaration of Helsinki and subsequent revisions.

**Participants**

Two hundred twenty-one patients aged 18 and above were recruited. One hundred ninety-one (124 women and 75 men) agreed to participate in the study and completed the assessment (response rate 90%). The age range of patients who agreed to participate in the study was 18-78 years. Those who participated in the study and those who refused informed consent did not differ in terms of sex and age. Thirty-eight patients (27 women and 11 men) failed to complete one or more psychological tests or the spirometry evaluation, so that the final sample was composed of 153 patients (97 women and 56 men). The mean ages of those who completed the assessment and those who did not were 41.24 (SD=14.50) and 47.08 (SD=14.06), respectively. Those who completed the assessment and those who did not complete it did not differ in sex (one-way Fisher exact test $p=0.57$), but they differed in mean age ($t(197)=2.41; p<0.05$). In comparing those who completed the assessment, patients who did not were older, despite the groups did not differ in terms of percentage of people 65 years and above they included (7.9% and 7.0%, respectively, for patients who did not complete the assessment and patients included in the final sample; one-way Fisher exact test $p=0.53$). The groups also did not differ in years with BA (8.50±9.84 years and 10.77±11.12 years, respectively, for patients who did not complete the assessment and patients included in the final sample; $t(197)=1.07; p=0.29$).

**Measures**

All patients were administered the Italian versions of the State-Trait Anxiety Inventory-State subscale (STAI-S) [21], the Beck Depression Inventory (BDI) [22], the Toronto Alexithymia Scale (TAS) [23], and the Beck Cognitive Insight Scale (BCIS) [24]. Socio-demographic and clinical variables were obtained from medical files.

The STAI-form X is a self-rating scale for measuring severity of anxiety and is composed of two 20-item subscales exploring state and trait anxiety. Our sample completed only the subscale measuring state-anxiety, defined as a temporal cross section in a person’s emotional stream of life, consisting of subjective feelings of tension, apprehension, nervousness, worry and activation of the autonomic nervous system. The respondents are asked to rate each item on a four-point Likert type scale ranging from 1 to 4 (1=“Almost Never”, 4=“Almost Always”). The STAI has demonstrated sufficient psychometric properties.

The TAS-20 is composed of 20 items measured on a five-point Likert type scale (from 1: “strongly disagree”, to 5: “strongly agree”). The TAS measures three dimensions of alexithymia: 1) difficulty identifying feelings; 2) difficulty communicating feelings; and 3) externally-oriented thinking. Subjects who obtain a total score ≤50 can be considered non-alexithymic, while a score ≥61 is indicative of severe alexithymia. Scores between 51 and 60 indicate borderline levels of alexithymia. The TAS has demonstrated good psychometric properties, despite some contradictory findings reported in literature.

The BDI is a 21-item self-report scale measuring depression severity. Each item refers to a symptom or an attitude typical of depressed individuals (e.g., sadness, pessimism, sense of failure). The respondents are asked to choose from among four possible statements with increasing intensity (e.g., 0: “I do not feel sad”, 1: “I feel sad”, 2: “I am sad all the time and I can’t snap out of it”, 3: “I am so sad or unhappy that I can’t stand it”). A score of up to 9 indicates minimal depression, between 10 and 18 denotes mild depression, between 19 and 29 suggests moderate depression, and between 30 and 63 indicates severe depression. The BDI has demonstrated good psychometric properties.

Cronbach alpha was 0.86 in the current study.

The BCIS is a 15-item self-report questionnaire measuring cognitive insight. The BCIS was developed to evaluate patients’ self-reflectiveness and overconfidence in the interpretation of one’s own experiences. Each item is rated on a four-point Likert type scale (from 1: “Do not agree at all”, to 4: “Agree completely”). The BCIS measures three dimensions of cognitive insight: 1) accuracy of introspection and willingness to acknowledge fallibility, and 6-item self-certainty dimension (sample item, “At times, I have misunderstood other people’s attitudes towards me”) interpreted as an expression of introspection and willingness to acknowledge fallibility, and 6-item self-certainty dimension (sample item, “My interpretations of my experiences are definitely right”) whose items assess patient’s certainty about beliefs or judgments. The BCIS displayed sufficient convergent validity with the Scale to Assess Unawareness of Mental Disorder (SUMD) but a not entirely satisfactory internal homogeneity.

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Assessment of pulmonary functioning

Pulmonary functioning was assessed during routine outpatient visits. The data collected included forced vital capacity (FVC), forced expiratory volume in the first second (FEV1), FEV1/FVC ratio, and forced expiratory flow rate over the middle 50% of the FVC (FEF25-75). Pulmonary functioning was measured with a flow-sensing spirometer connected to a computer for data analysis (CPFS/D Spirometer, MedGraphics, St. Paul, MN, USA) which met the American Thoracic Society (ATS) standards. FVC, FEV1, and FEF25-75, FEV1/FVC are reported as percentages of predicted values.

Statistical analyses

All analyses were performed with the SPSS 19.0 statistical package for social sciences (IBM, Armonk, NY, USA). In order to reveal groupings of patients with different respiratory functioning and alexithymia (or clusters) within the data set, we used a Two Step Cluster Analysis procedure. To determine which number of clusters is “best”, we let the procedure automatically determine the number of clusters and selected log-likelihood distance measure and the Schwarz’s Bayesian Criterion (BIC) as the clustering criterion. To create groups we included in the analysis three variables: FEV1/FVC ratio, FEF25-75, TAS scores to create clusters. Sociodemographic variables, cognitive insight, and depression and anxiety were used to better characterize groups.

Chi-squared ($\chi^2$) tests and ANOVAs were used to compare differences between groups. Benjamini and Hochberg’s[3] correction was used for multiple testing. When ANOVAs were significant after correction for multi-testing, we used the Tamhane T2 procedure for post-hoc comparisons among groups. Partial eta squared ($\eta^2_p$) and Cramer’s V are reported as measures of effect size. Partial $\eta^2$ is the variance in the dependent variable explained by the independent variables, it is to prefer to $\eta^2$ because it allows a researcher to compare the effect of the same variable in two different studies, which contain different covariates or other factors[2]. When the independent variable is only 1 it is equivalent to the $\eta^2$ statistics. Values around 0.01 denote small effect sizes, around 0.06 medium effect sizes, and values of 0.14 and higher large effect sizes. Cramer’s $V$ varies from 0 (reflecting complete independence) to 1 (reflecting complete association), values of 0.20 and lower indicating weak association, values between 0.20 and 0.40 moderate association, values between 0.40 and 0.60 relatively strong association, and values of 0.60 and higher strong association. Multinominal logistic regression analysis was used to assess multivariate association between variables, while controlling for the effect of other variables. Indices of associations are reported as odds ratios (OR) and their 95% confidence interval (95% CI). As indices of model fit, we reported the likelihood ratio $\chi^2$ test and its p-value. P-values of 0.05 or lower indicate that the model explains the data better than the intercept only model.

Due to the fact that the BCIS was created to be used in psychiatric samples and its use in medical patients is not common, we performed a principal axis factoring analysis to assess its structure, setting the forced extraction factors to extract to two and selecting a varimax orthogonal rotation method to be consistent with the original study of Beck et al. [35].

RESULTS

Characteristics of the sample

Socio-demographic and clinical characteristics of the sample are listed in Table 1. Around 18% of the sample had an FEV1/FVC ratio of less than 70%, denoting the presence of airflow obstruction, and 53.6% of the patients with low FEV1/FVC ratio had FEV1 <80%. Furthermore, 37.3% of the sample had FEF25,75 <65%, denoting small airway obstruction. Only 2.6% of the sample had moderate to severe depression, while 13.7% were alexithymics (Table 1).

A two-step cluster analysis (where we included FEV1/FVC ratio, FEF25,75, TAS scores to create clusters) re-

Table 1. Descriptive statistics (n=153)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Means±SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>41.24±14.50</td>
</tr>
<tr>
<td>Age at onset of asthma</td>
<td>29.99±18.06</td>
</tr>
<tr>
<td>Respiratory functioning</td>
<td></td>
</tr>
<tr>
<td>FVC</td>
<td>103.49±16.75</td>
</tr>
<tr>
<td>FVC ≥80% - %</td>
<td>5.9%</td>
</tr>
<tr>
<td>FEV1</td>
<td>93.13±14.40</td>
</tr>
<tr>
<td>FEV1 &lt;80% - %</td>
<td>16.3%</td>
</tr>
<tr>
<td>FEV1/FVC &lt;70% - %</td>
<td>18.3%</td>
</tr>
<tr>
<td>FEF25,75</td>
<td>73.56±25.47</td>
</tr>
<tr>
<td>FEF25,75 &lt;65% - %</td>
<td>37.3%</td>
</tr>
<tr>
<td>Psychometric measures</td>
<td></td>
</tr>
<tr>
<td>BDI</td>
<td>6.44±4.96</td>
</tr>
<tr>
<td>BDI ≥19 - %</td>
<td>2.6%</td>
</tr>
<tr>
<td>STAI-S</td>
<td>37.77±9.77</td>
</tr>
<tr>
<td>TAS</td>
<td>43.41±14.25</td>
</tr>
<tr>
<td>TAS ≥61</td>
<td>13.7%</td>
</tr>
<tr>
<td>Self-certainty</td>
<td>0.01±0.84</td>
</tr>
<tr>
<td>Self-reflectiveness</td>
<td>-0.01±0.76</td>
</tr>
</tbody>
</table>
revealed the presence of four natural groupings, but one of the clusters was composed only by one subject and was excluded from the analyses. The first cluster had: 1) lower FEV₁/FVC ratio and FEF₂₅-₇₅ values than the third cluster; and 2) higher TAS scores than the other groups (Table 2). The second cluster had: 1) lower FEV₁/FVC ratio and FEF₂₅-₇₅ values than the third cluster; and 2) lower TAS scores than the first cluster. Thus, the first cluster consists of patients with low respiratory functioning (22% had an FEV₁/FVC ratio of less than 70% and 39.0% had FEF₂₅-₇₅ < 65%) and high alexithymia.

### Table 2: Differences among groups

<table>
<thead>
<tr>
<th>Variables entered in the cluster analysis</th>
<th>Cluster 1 – Low respiratory functioning high alexithymia (n = 41)</th>
<th>Cluster 2 – Low respiratory functioning low alexithymia (n = 53)</th>
<th>Cluster 3 – Good respiratory functioning low alexithymia (n = 58)</th>
<th>Tests</th>
<th>p</th>
<th>Partial η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEV₁/FVC</td>
<td>74.00±8.72</td>
<td>70.53±6.97</td>
<td>82.83±6.32</td>
<td>F</td>
<td>(2;149) = 42.26</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>FEV₁/FVC &lt; 70% - %</td>
<td>22.0%</td>
<td>34.0%</td>
<td>1.7%</td>
<td>χ²</td>
<td>2 = 19.62</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>FEF₂₅-₇₅</td>
<td>68.20±23.43</td>
<td>53.77±12.68</td>
<td>95.41±18.10</td>
<td>F</td>
<td>(2;149) = 75.45</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>FEF₂₅-₇₅ &lt; 65% - %</td>
<td>39.0%</td>
<td>77.4%</td>
<td>0.0%</td>
<td>χ²</td>
<td>2 = 70.77</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>TAS</td>
<td>62.29±7.81</td>
<td>37.81±8.20</td>
<td>35.40±9.12</td>
<td>F</td>
<td>(2;149) = 139.51</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>TAS ≥ 61% - %</td>
<td>51.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>χ²</td>
<td>2 = 65.97</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

### Differences among groups

<table>
<thead>
<tr>
<th>Variables</th>
<th>Cluster 1 – Low respiratory functioning high alexithymia (n = 41)</th>
<th>Cluster 2 – Low respiratory functioning low alexithymia (n = 53)</th>
<th>Cluster 3 – Good respiratory functioning low alexithymia (n = 58)</th>
<th>Tests</th>
<th>p</th>
<th>Partial η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women - %</td>
<td>70.7%</td>
<td>58.5%</td>
<td>63.8%</td>
<td>χ²</td>
<td>2 = 1.50</td>
<td>0.47</td>
</tr>
<tr>
<td>Age</td>
<td>43.07±15.30</td>
<td>43.89±13.41</td>
<td>37.46±14.46</td>
<td>F</td>
<td>(2;149) = 3.22</td>
<td>0.05</td>
</tr>
<tr>
<td>Age at onset of asthma</td>
<td>31.21±18.79</td>
<td>31.84±18.67</td>
<td>27.28±17.10</td>
<td>F</td>
<td>(2;149) = 0.95</td>
<td>0.39</td>
</tr>
</tbody>
</table>

### Psychometric measures

<table>
<thead>
<tr>
<th>Variables</th>
<th>Cluster 1 – Low respiratory functioning high alexithymia (n = 41)</th>
<th>Cluster 2 – Low respiratory functioning low alexithymia (n = 53)</th>
<th>Cluster 3 – Good respiratory functioning low alexithymia (n = 58)</th>
<th>Tests</th>
<th>p</th>
<th>Partial η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>10.08±6.35</td>
<td>5.15±3.87</td>
<td>5.04±3.24</td>
<td>F</td>
<td>(2;149) = 18.55</td>
<td>&lt;0.001**</td>
</tr>
<tr>
<td>BDI ≥ 19% - %</td>
<td>9.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>χ²</td>
<td>2 = 11.12</td>
<td>0.01**</td>
</tr>
<tr>
<td>STAI-S</td>
<td>40.93±11.00</td>
<td>37.19±8.94</td>
<td>36.03±9.28</td>
<td>F</td>
<td>(2;149) = 3.23</td>
<td>0.05</td>
</tr>
<tr>
<td>Self-certainty</td>
<td>0.13±0.93</td>
<td>0.04±0.84</td>
<td>-0.12±0.79</td>
<td>F</td>
<td>(2;149) = 1.04</td>
<td>0.36</td>
</tr>
<tr>
<td>Self-reflectiveness</td>
<td>0.27±0.89</td>
<td>-0.02±0.66</td>
<td>-0.22±0.66</td>
<td>F</td>
<td>(2;149) = 5.07</td>
<td>0.01*</td>
</tr>
</tbody>
</table>

Benjamini and Hochberg correction for multi-testing: *p < 0.05; **p < 0.01. Tamhane T2 post-hoc tests. *Cramer’s V; ↑ indicates that the first group of patients considered in the analysis reported higher scores than the second group of patients considered in the analysis.

FEV₁= forced expiratory volume in the first second; FEF₂₅-₇₅= forced expiratory flow rate over the middle 50% of the FVC; BDI= Beck Depression Inventory; STAI-S= State-Trait Anxiety Inventory-State; TAS= Toronto Alexithymia Scale.
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(51.2% of the patients had significant alexithymia), the second cluster consists of patients with low respiratory functioning (34.0% had an FEV1/FVC ratio of less than 70% and 77.4% had FEF25-75 <65%) but low alexithymia (none had significant alexithymia), and the third cluster consists of patients with good respiratory functioning (only 1.7% of the patients had an FEV1/FVC ratio less than 70% and none had FEF25-75 <65%) and low alexithymia (none had significant alexithymia).

Differences among groups

Differences among the three groups are listed in Table 2. Patients with low respiratory functioning and high alexithymia (compared to other groups) had: 1) higher BDI scores; and 2) higher self-reflectiveness. Patients with low respiratory functioning and low alexithymia had: 1) lower BDI scores than the first cluster. Thus, in the first cluster the presence of alexithymia and low respiratory functioning is also associated with higher psychopathology (9.8% had moderate to severe depression) when compared to other clusters. The groups did not differ for self-certainty or state anxiety.

The multinomial logistic regression analysis indicated that the groups could be well discriminated by BDI scores (Table 3). Patients with low respiratory functioning and high alexithymia were 1.3 times more likely to have more severe depressive symptomatology (95% CI: 1.13 / 1.42; p < 0.001) than patients with good respiratory functioning and low alexithymia, while patients with low respiratory functioning and low alexithymia did not differ from patients with good respiratory functioning and low alexithymia. The BCIS self-reflectiveness could not independently differentiates groups.

DISCUSSION

In our sample of BA patients, we differentiated three groups of patients according levels of respiratory functioning and alexithymia. Nearly 44% of the patients with low respiratory functioning were grouped together according to their high levels of alexithymia, one out of 2 patients included in this group reported severe alexithymia. Although clinically significant depression was reported (only 2.6% of the sample reported moderate to severe depression) to a lesser degree in our study than in past studies, all the depressed patients were included in the subsample of patients with low respiratory functioning and high alexithymia, representing almost 10% of all patients included. Significant differences in respiratory functioning and alexithymia were not associated with differences in state anxiety, a variable that is generally associated with symptoms of hyperarousal, including disordered respiratory patterns. These results are consistent with previous studies which suggested that alexithymia could be a risk factor for poorer quality of life, poor compliance, poor control of the disease, and more frequent near-fatal attacks in BA patients. Nevertheless, why alexithymia could affect the presentation of pathology in patients with asthma is not completely clear. For example, due to the fact that alexithymia is a sign of presence of difficulties in emotion regulation these latter could be associated with the use of maladaptive coping strategies while facing life stressors and managing asthma symptoms. However, it is also possible that the effect of alexithymia is mediated through the overreactivity of the sympathetic system which is also implicated in bronchial hyperreactivity. Nevertheless, the objective to understand the ways alexithymia influence health in asthma patients may be very complicated. In fact, alexithymia could represent a complex phenomenon with different etiologies. For example, Freyberger suggested to differentiate two types of alexithymia: primary alexithymia, and secondary alexithymia. The first one attributed to an organic substratum and the latter secondary to psychiatric disorders.

In our study we also evaluated cognitive insight. Indeed, we think that poor cognitive insight, defined as a patient’s current low capacity to correctly evaluate his or her anomalous experiences and atypical interpretations of events could help explain why BA patients with higher alexithymia have difficulties in perceiving asthma symptoms, or why they tend to adopt maladaptive coping strategies, regardless of past experiences. Our results indicate that groups differed for self-reflectiveness but not for self-certainty, although in the multivariate analyses self-reflectiveness was not useful in explaining differences between groups when controlling for depressive symptoms. Patients with low respiratory functioning and high alexithymia reported higher self-reflectiveness than patients with good respiratory functioning, and although not significant the difference with patients with low respiratory functioning and low alexithymia was medium (Cohen’s d = 0.37). Thus, patients with high alexithymia have higher willingness to be introspective and to acknowledge their fallibility. These conterintuitive results are consistent with results from some studies using the BCIS in patients with psychosis which suggested that deficits in self-reflectiveness could be associated with the presence of some specific psychotic symptoms (e.g., delusions) but not others (e.g., hallucinations), while the presence of depressive symptoms could be associated with higher self-reflectiveness. To explain the association between depression and self-reflectiveness, we may see that in the first component of the BCIS

Table 3. Multinominal logistic regression with backward stepwise removal method (reference category: low respiratory functioning low alexithymia)

<table>
<thead>
<tr>
<th>Model statistics: -2 Log Likelihood= 287.68; Likelihood ratio χ²= 31.22; p &lt; 0.001; Nagelkerke R²= 0.22. BDI= Beck Depression Inventory.</th>
<th>95% Confidence Interval for Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
</tr>
<tr>
<td>Low respiratory functioning high alexithymia</td>
<td>BDI</td>
</tr>
<tr>
<td>Self-reflectiveness</td>
<td>0.34</td>
</tr>
<tr>
<td>Low respiratory functioning low alexithymia</td>
<td>BDI</td>
</tr>
<tr>
<td>Self-reflectiveness</td>
<td>0.22</td>
</tr>
</tbody>
</table>

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In conclusions, clinicians have to be aware of the presence of a subgroup of asthma patients with low respiratory functioning who report clinically significant depression and severe alexithymia, and of the need to differentiate them from other patients who have low respiratory functioning but low alexithymia. In this group of patients with more severe respiratory limitations, alexithymia is associated with more doubting about one’s own beliefs and depression. In these patients interventions able to ameliorate alexithymia and insight could improve the perception of asthma control, reduce the risk of exacerbation of asthma and help the individual in using more adaptive coping strategies to cope with the illness. However, we need prospective studies to investigate the role of cognitive insight in the course of the asthmatic illness.

Acknowledgements

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Conflicts of interest

The authors have no competing interests to report.

REFERENCES

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