SUPPLEMENTAL TABLE

	Aim of the Study	Number of Patients/Mean Age/Mean Disease Duration	Assessment Methods	Main Findings
			TBI	
Williams et al. 2001	To investigate alexithymia in a TBI population	135 patients	TBIQ TAS–20	49% of patients had a history of head injury. 18% of these were alexithymic
Becerra et al. 2002	To investigate alexithymia in a patient with TBI	Case report, 1 M, age 21 (diffuse TBI, mostly parietal and frontal damage bilaterally)	Complete neuropsychological test battery TAS–20 BDI	Impaired verbal and nonverbal learning and memory. TAS–20 score: 71 post TBI, 41 pre TBI Moderate depression
Koponen et al. 2005	To evaluate the prevalence of alexithymia in TBI patients. To evaluate how the severity of TBI, the MRI findings, and the presence of axis I and II psychiatric disorders may modify the prevalence of alexithymia after TBI	54 TBI patients /58.8 (44–80)/29.7 (26–47) years. 54 HC	TAS–20 BDI SCAN SCID II MRI	Alexithymia was significantly higher in patients with TBI (31.5% versus 14.8%; OR 2.64, 95% CI 1.03– 6.80) Severity of TBI, the presence, laterality, or location of contusions on MRI, were not associated with the TAS–20 total score 15/17 alexithymic patients had a psychiatric disorder; significant associations were observed on both axis I and axis II: axis I disorder or anxiety disorder was associated with significantly higher TAS–20 total scores; axis II disorder, personality disorder or organic personality syndrome had significantly higher TAS–20 total scores
Henry et a 2006	To evaluate the prevalence of alexithymia in TBI, to evaluate whether alexithymia was related to deficits in executive functions and its relationship with anxiety, depression and quality of life	28 TBI (MRI in 18: 10 bilateral lesions, 8 focal unilateral lesions: 3 right and 5 left hemisphere) 31 HC	TAS–20 Verbal fluency (phonemic, semantic and alternating fluency task) HADS LEIPAD (quality of life)	Patients showed greater levels of alexithymia in total TAS–20 score than HC (32.1% versus 12.9%) TBI patients were more depressed but not more anxious. DIE subscore of TAS–20 was associated with poorer quality of life, even after controlling for depression and anxiety. DIE subscore was inversely correlated with executive function deficits (semantic and alternating fluency)
Wood et al. 2007	To examine the prevalence of alexithymia in a TBI population, and its relationship to injury severity, neuropsychological ability and affective disorder.	121 TBI patients 52 orthopedic patients as controls	Neuropsychological evaluation (test battery) TAS–20	The TBI cohort (57.9%) recorded a significantly higher prevalence rate of alexithymia than orthopedic controls (15.4%). A significant between group difference was only evident for the cognitive domains “Verbal Ability” (Vocabulary, Similarities, Comprehension), and “Sequencing” (Digit Span, Letter-Number Sequencing, Spatial Span).

			BDI	In both domains, higher scores on the TAS–20 were associated with poorer cognitive performance.
			BAI	Regression analyses: alexithymia, depression, and anxiety should be considered distinct, but overlapping constructs.
Wood et al. 2009	To evaluate the relationship between alexithymia, affective distress and somatization in a TBI sample	83 TBI patients	TAS–20	63.9% TBI patients were alexithymic
			SCL–90-R and its 3 dimensions: anxiety, depression and somatization	Alexithymic patients reported greater somatization rating, more anxiety and more depression
				Regression analysis: after correcting for anxiety and depression only subscale DIE make a significant unique contribution to explaining somatization rating.
Wood et al. 2013	To examine the influence of 2 personality constructs: alexithymia and anxiety sensitivity on level of psychological distress and PC symptoms in the acute recovery stage of mild TBI	61 mTBI	TAS–20	mTBI shower >anxiety sensitivity and alexithymia, psychosocial distress (BDI-II) and PC symptoms
		61 HC	Rivermead PC questionnaire	Regression analyses indicated that anxiety sensitivity score were significant predictors of PC symptoms and levels of psychological distress.
			Anxiety sensitivity index	mTBI alexithymic group reported higher PC symptoms and psychological distress.
			STAI	Regression analysis showed that TAS to score predicted a significant amount of variance in PC symptoms and psychological distress. Only TAS–20 subscale DIE and DDE had large significant positive correlation with PC symptoms.
			BDI	Regression analyses (do anxiety sensitivity, alexithymia, psychological distress predict PC symptoms?): anxiety sensitivity and depression account for 52.6% of the variance, alexithymia failed to make a significant contribution.
Wood et al. 2010	To evaluate the frequency of suicide ideation following TBI and its relationship with alexithymia, depression, hopelessness and worthlessness in a TBI sample	105 TBI patients	TAS–20	TBI had higher frequency of suicide ideation (33%), hopelessness (84.8%) and worthlessness (61%) on the BDI; higher rating of depression in the suicide ideation group of patients (74.3%).
		74 HC	BDI and its subscale of suicidal thoughts or wishes and of hopelessness and worthlessness (to assess suicide ideation)	Patients reporting suicide ideation had higher TAS–20 (DIF subscale only)
				Logistic regression analyses found that worthlessness was the strongest predictor of suicide ideation after TBI.
Wood et al. 2013	To examine the relations among coping styles, alexithymia, and psychological distress following TBI.	71 TBI patients	TAS–20	The participants with TBI exhibited significantly higher rates of alexithymia and psychological distress and lower levels of task-oriented coping than healthy controls.
		54 HC	Estonian COPE-D	Levels of avoidance coping and psychological distress were significantly higher in a subgroup of

				TBI patients with alexithymia than in a nonalexithymic TBI subsample.
			BDI	There were significant relations among alexithymia, avoidance coping, and levels of psychological distress.
			DAI	Regression analysis revealed that difficulty identifying feelings was a significant predictor for psychological distress.
Williams et al. 2010	To evaluate the presence of alexithymia and low emotional empathy following TBI and to examine the relationship between alexithymia and emotional empathy.	64 TBI	TAS–20	Alexithymia in TBI patients (60.9%) was higher than in HC (10.9%) .
		64 HC	BEES	TBI patients (64.1%) had lower emotional empathy than HC (34.4%)
			Wechsler Adult Intelligence Scale	Regression analysis: 72% of alexithymic TBI had a low emotional empathy (moderate negative correlation between TAS–20 and BEES)
				No significant correlations between alexithymia, emotional empathy, injury severity, and time since injury.
Williams et al. 2013	To evaluate the relationship quality and satisfaction in couples after TBI of one partner and to explore the impact of alexithymia on it.	47 TBI and their	TAS–20	TBI reported significantly fewer relationship problems than their partners (IMS total $p \geq 0.01$; DAS tot $p \geq 0.05$ and satisfaction subscore $p \geq 0.05$)
		47 partners	IMS	Significant positive relations between length of relationship and partner rated DAS consensus and affectional expression; positive correlation between number of relationship problems IMS and time since injury and presence of children.
			DAS and its subscales (satisfaction, consensus, cohesion, affection expression)	Partners of TBI alexithymic patients reported poorer DAS scores than partners of non alexithymic ones.
Neumann et al. 2013	To compare the differences in alexithymia, empathy and affect recognition in TBI patients compared with HC	60 TBI	TAS–20	30% of TBI had alexithymia and 3.3% of HC
	To determine the amount of affect recognition and empathy variance explained by alexithymia	60 HC	DANVAS–2	TBI: lower score at TAS–20 ($p \leq 0.005$) and empathy ($p \leq 0.005$)
				TBI had more difficulties in facial and vocal affect recognition.
				Facial and vocal affect recognition variances were significantly explained by alexithymia (12% and 8%, respectively) but the majority of variance was accounted for EOT subscale of TAS–20.
				Affect recognition and alexithymia significantly accounted for cognitive empathy (16%).
Ho et al. 2013	To illustrate possible neural underpinnings of alexithymia resulting from occipital lobe damage	Case report: 1 F, age 46 survivor of a severe childhood TBI (damage at	Complete neuropsychological test battery	Normal Neuropsychological profile except for an attentional dysfunction (digit vigilance test).

		primary visual cortex)		
		Visual deficit: hemianopsia	Eyes test	High alexithymia score (TAS–20: 63) and low empathy (EQ 16)
			Faux pas test	All other scales scores are in the normative range
			TAS–20 and Bermond-Vorst alexithymia questionnaire	
			Interpersonal reactivity index	
			EQ 16	
			Visual Imagery task	
			HADS	
		STROKE		
Spalletta et al.. 2001	To confirm the hypothesis that RBD contributes to the development of alexithymia in stroke patients. To detect which dimension of alexithymia is associated with the laterality of the brain damage.	48 stroke patients/ 21 RBD: 68.6±12.1; 27 LBD: 61.6±13.6/RBD: 143.5±178.6; LBD: 145.0±169.1	SCID	RBD patients had more alexithymic features than LBD patients (48% versus 22%) on DIE and DDF but not in EOT (even after controlling for general cognitive level, anxiety, and depression).
	To evaluate the influence of gender on alexithymic features.	days.	STAI-S	Significant effect of gender on TAS–20 in RBD and LBD patients (male with RBD had higher score at TAS–20 than male with LBD)
			BDI	No differences in terms of lesion location between the two groups.
			TAS–20	
			Barthel index	
			Neuroimaging (location and size of the lesion)	
Spalletta et al. 2007	To investigate the relationship among anosognosia, neglect, alexithymia, and cognition in stroke patients	50 patients with Right hemisphere stroke/68.5±10.	TAS–20	26% patients showed anosognosia of motor impairment, 52% alexithymia, 52% unilateral spatial neglect, 20% major depression
		6 patients with anosognosia; 66.1±14.4 without anosognosia/44.	Anosognosia scale (Bisiach et al.)	Higher alexithymia in patients with anosognosia than patients without it, DDE subscore F2 was the only significantly different in the two groups.
		4±26.5 days in patients with anosognosia; 37.6±19.9	Neglect: line crossing, letter cancellation, figure and shape copying, line bisection	Anosognosia and alexithymia rates were not statistically associated.
		patients without anosognosia.	General NPS evaluation	Regression analysis: presence of neglect and more difficulty in describing feelings (TAS–20 F2 subscore) were the only predictors of anosognosia.
			SCID	Anosognosics with alexithymia performed worst in frontal task than pure anosognosics (verbal fluency and verbal span forward task)
			HADS	
			Barthel index	
Cravello et al. 2009	To evaluate the effect of SSRI venlafaxine and fluoxetine on alexithymia severity in patients with poststroke depression	50 patients with first-event stroke and post stroke depression were	SCID-P	Patients of both groups improved in depression.
			HAM-D	Patients treated with venlafaxine, both those alexithymic at baseline and those not alexithymic had a greater
			TAS–20	
			MMSE	

		included in an open label randomized study: 25 patients were treated with fluoxetine (20–40 mg/die) and 25 patients with venlafaxine (75–150 mg/die)	All assessment at: baseline and 1,2,4,6,8 weeks after starting the treatment.	improvement on alexithymia severity than patients treated with fluoxetine even when using a covariate baseline HAM-D score.
Wang et al. 2011	To evaluate the relationship of alexithymia with PTSD and psychiatric comorbidity following stroke.	90 patients with stoke/75.23±10.25/ 47.09±25.99 days	At 1 month (T1) and 3 months (T2) after stroke occurrence:	30% of the patients were diagnosed with full PTSD at T1, at T2 23.1%
		87% ischemic, 13% hemorrhagic, (67% right-sided lesion)	MMSE	At T1 no change in severity of PTSD symptoms but significant reduction of psychiatric comorbidity.
			TAS–20	At T1: Alexithymia was associated with severity of poststroke PTSD and psychiatric comorbidity. DIF had the strongest correlation.
			Post-traumatic stress diagnostic scale General health questionnaire Barthel index	At T2: After adjusting for PTSD, psychiatric comorbidity, physical disability and time from the stroke occurrence, there was no significance association between alexithymia and severity of poststroke PTSD and psychiatric comorbidity 3 months poststroke.
		EPILEPSY		
Tojek et al. 2000	To compare patients with PNES and patients with epilepsy on stressful life events and psychosocial risk factors for somatization as well as on alexithymia	25 patients with PNES and 33 patients with epilepsy/43.56+13.23 versus 39.60+9.03/NA	Life events checklist	PNES had >stress life events, higher rating of stressfulness of the events, total stress score, greater somatic symptoms, greater anxiety and depression, more hypertension and ulcers than epileptic patients
			Brief symptoms inventory Illness worry scale Private body consciousness scale TAS–20	No difference in psychotic symptoms, in illness worry or alexithymia. Both groups had higher alexithymia than community norms (approx. 30% in both groups)
Bewley et al. 2007	To investigate whether alexithymia might distinguish patients with psychogenic non epileptic seizures from those with epilepsy and nonpatient controls	21 patients with PNES, 21 patients with epilepsy, 21 healthy controls	TAS 20 BDI-II BAI	Overall TAS–20 scores did not differentiate the three groups after controlling for anxiety and depression, but scores on certain subscales of the TAS–20 differed significantly between the patient groups and the controls
Kalinin et al.. 2010	To evaluate the effect of seizure lateralization, handedness, and alexithymia on psychopathology in patients with temporal lobe epilepsy	105 temporal lobe epilepsy patients (40 symptomatic, 53 cryptogenetic, 12 idiopathic)	ICD–10 criteria for a psychiatric assessment	25 patients had high alexithymia
		L side focus in	HAM-D	Alexithymia score itself does not

		52; R sided focus in 53		depend on handedness and focus laterality.
			HAM-A	Alexithymic patients had higher SCL–90 and HAM-D scores than nonalexithymic.
			SCL–90	Left-handed and right handed patients significantly differ on: somatization, depression and SCL–90 score (right-handed had higher score)
			TAS–26	Alexithymia has maximal effect on psychopathological variables, and maximal scores of SCL–90 were reported in patients with alexithymia/left-handedness and alexithymia/right-sided seizure focus combinations.
			Annett's scale for handedness	
Kaplan et al. 2013	To compare PNES and ES in terms of alexithymia, early childhood trauma and immature defensive styles.	94 PNES (41.06+12.81)	Childhood trauma questionnaire	38/94 PNES and 21/81 ES scored >60 at TAS–20: a significant difference of 14% in the prevalence of alexithymia.
		81 ES (39.15+12.98)	TAS–20	Significant difference in TAS–20 total score and subscale DIE (PNES more alexithymic)
			REM–71	
Hingray et al. 2011	To assess psychiatric comorbidity, alexithymia and dissociation in patients with PNES.	31 PNES: according to the presence or absence of trauma antecedents: 19 with trauma (28 years/ 5 years, values as median); 6 without trauma (35/1.5 years).	Childhood trauma questionnaire	Alexithymia was high in both groups (no percentage given, only median scores)). The trauma group scored higher on DDE (p=0.033)
			Clinical interview	
			Clinical and semistructured psychiatric interview	
			Montgomery depression rating scale	
			HAM-A	
			TAS–20	
			Dissociative experience scale	
Chung et al. 2013	To evaluate the incidence of postepileptic seizure PTSD and psychiatric comorbidity in patients with ES and	71 epileptic patients (39.12+12.86/2 1.39+13.89)	Post-Traumatic Stress Diagnostic Scale	81% of patients met the criteria for PTSD (51% for full PTSD; 30% partial PTSD)
	the relationship between alexithymia traits and the severity of them.	71 healthy controls (30.29+9.67)	HADS	Epileptic more depressed and anxious than controls
			TAS–20	41% of epileptic high level of alexithymia (no control group, the13% median level was used)
				Regression analysis: DI consistently predicted postepileptic seizure PTSD and psychiatric comorbidity, it was correlated with elevated post epileptic seizures PTSD and depression, it was negatively correlated with anxiety.
Chung et al. 2013	To evaluate the incidence of postepileptic seizure PTSD and psychiatric comorbidity in patients with ES and the relationship between alexithymia traits, self-efficacy and multiple traumas and the severity of them.	Same populations of Chung et al. 2013 (above)	As above	As above
			+	+
			Generalized self-efficacy scale	Self-efficacy was significantly and negatively correlated with alexithymia and with postepileptic seizure PTSD. Alexithymia was also significantly and positively correlated with postepileptic seizure PTSD and psychiatric comorbidities.

Brown et al. 2013	To study emotional dysregulation, alexithymia, attachment and psychopathology in patients with PNES and ES	43 PNES (42–27 years, age) 24 ES (43.5–26 years, age)	Difficulties in Emotion Regulation Scale TAS–20 Relationship scales questionnaire Generalized anxiety disorder–7 Patient health questionnaire 9 Somatoform dissociation questionnaire–20	PNES higher score at TAS–20 total and subscores but did not reach statistical significance. Cluster analyses: Cluster 1 (N=11 patients with PNES) high level of emotional dysregulation and alexithymia, more anxiety, depression and somatization compared with cluster 2 PNES and ES.
Myer et al. 2013	To assess coping strategies employed by patients with PNES and determine whether these approaches were associated with other maladaptive psychological features.	82 patients with PNES (39.7 years[16–67])	Coping Strategy for Stressful-Situations State Trait Anger expression scale–2 TAS–20 TSI-II MMPI 2-RF Test for Memory Malingery Wechsler Abbreviated Scale of Intelligence	60.9% of patients endorsed using at least one coping strategy that was 1.5 SD away from normal adult mean. 30% used the less effective Emotion-oriented coping strategy (Emotion-Focus coping strategy); 25% underused the most effective one (Task oriented coping strategy). Alexithymia (TAS–20 score) significantly correlated with Emotion-Focused coping strategy. Task-Oriented strategies were significantly associated to low alexithymia scores.
Myers et al. 2013	To determine the prevalence rate of alexithymia in patients with psychogenic nonepileptic seizures and epileptic seizures. To identify the predictors of alexithymia in patients with PNES.	66 consecutive patients with PNES and 35 patients with ES	TAS–20 TSI-II MMPI 2-RF MS	Prevalence of alexithymia in PNES and ES of 36.9% and 28.6%, respectively (not a significant difference). In PNES patients: a significant correlation between alexithymia and anxious arousal, intrusive experiences, dissociation, and defensive avoidance from the TSI-II
Bondini et al. 2008	To assess alexithymia in a group of patients with relapsing-remitting MS and its role as a factor contributing to the presence and severity of fatigue and depression.	58 Relapsing-remitting MS patients/34.8±9.3/9.1±5.5	Expanded disability status scale (EDSS) TAS–20	EDSS 1.5. Alexithymia prevalence 13.8%. No significant differences in demographic and clinical characteristics in relation to alexithymic features, except for higher levels of fatigue (FSS, Alexithymic: 5.3±1.0, Nonalexithymic 3.9±1.0; p<0.002) and depression (BDI, Alexithymic: 18.0±12.3, Nonalexithymic: 7.1±7.8; p<0.007). Among the alexithymic group (8 patients in total), 7 (87.5%) were fatigued and 6 (75%) were depressed, whereas in the nonalexithymic group (37 patients in total) 18 (52.9%) were fatigued and7 (20.6%) depressed (p=0.06 for fatigue and p=0.02 for depression). There was a significant correlation between alexithymia and

				fatigue (rho=0.5; p<0.001) and between alexithymia and depression (rho=0.37; p<0.004).
			Fatigue severity scale (FSS) BDI	
Gay et al. 2010	To clarify the relationship between depression and the factors associated with it (among them alexithymia).	115 MS patients/47.22± 10.83/15.30 ± 10.5	EDSS	EDSS: 4.75±2.45. Depression prevalence 25.9% (20.5% moderate, 5.4% severe); anxiety prevalence 36.3%; alexithymia 23.2%.
			Depression self-rating scale	Depressive symptoms were strongly associated with trait anxiety, state anxiety, alexithymia and emotion-centered coping.
			STAI TAS–20 Self-esteem inventory Social Support Questionnaire Coping about Health Injuries and Problems	The depressive symptoms were moderately and negatively associated with self-esteem, social support. They were moderately and positively associated with EDSS.
Prochnow et al. 2011	To examine the level of emotion processing in MS patients evaluating the performance in test of facial affect recognition and alexithymia.	35 MS patients 48.2±10.2/9.2± 8.4 61 healthy control subjects 33.5±11.5	EDSS	EDSS:6
			BDI	MS patients were significantly more depressed compared with healthy controls (MS 17.1% depressed and 28.6 moderately depressed) versus HC 21.3% moderately depressed.
			TAS–20	Alexithymia: MS 25.7% versus HC 16.4%
			Benton facial recognition test Faces symbol test Ekman–60-Faces test Perceptual Competence of Facial Affect Recognition (PCFAE)	The MS patients made significantly more mistakes in both facial affect recognition tasks (PCFAE and Ekman–60-Faces test). In detail, MS patients performed less accurately than healthy controls on the PCFAE emotions fear, surprise, anger, and sadness, while they did not differ from healthy controls on disgust and happiness.
Chahraoui et al. 2014	To investigate the course of alexithymia and its relation with anxiety and depression in patients with MS, over a period of 5 years.	Baseline: 62 patients/41.37 ± 10.86/10.92± 8.66 At 5 years follow-up: 44 patients	EDSS	Prevalence of alexithymia of 30.6% at T1 and 29.5% at T2(not a significant difference).
			TAS–20	Anxiety 19.4% at T1 and 20.5%at T2; moderate depression 32.3%at T1 and 22% at T2; severe depression 8.1% at T1 and 4.9% at T2.
			BDI	Increase in EDSS score at T2 showed a slight progression of the level of handicap (+0.76)
			STAI	No significant correlation was observed between alexithymia and any of the demographic or clinical variables recorded. Alexithymia scores were mainly positively correlated with anxiety and depression at T1 and T. Multiple regression: anxiety and the number of relapses as being significantly related to the presence of

				alexithymia at T2.
			PD	
Costa et al. 2006	To investigate the relationship between alexithymia and depression in PD	58 PD patients: 3 groups: major depression patients: N=12/70.2+5.2/ 9.5+4.6; minor depression patients: N=20/65.3+8.8/ 8.0+4.9; nondepressed patients: N=23/63.8/10.6 /4.4+2.3	SCID I BDI TAS–20 UPDRS H&Y	Depression: 20.7% had a major depression (MD) 34.5% had a minor depression (miD) 39.6% no depression (ND) Alexithymia: 20.7% alexithymic; 22.4% borderlines. Depression/alexithymia: MD more alexithimic than ND (0.01) MD more alexithymic than MiD (0.06) MiD versus ND: no differences Regression analysis: Higher BDI score predicts higher alexithymia
Costa et al. 2007	To investigate the neuropsychological correlates of alexithymia	70 PD and 70 orthopedic disease or peripheral nervous system pathologies/64. 3+9.8/7.3+5.0 years	TAS–20 Test assessing: verbal episodic memory, executive functions, abstract reasoning, and visual-spatial and language abilities	Alexithymic PD performed worse than controls with or without alexithymia on tasks requiring visual-spatial processing. Regression analyses: in PD patients, but not in controls, poor performance on a constructional praxis task predicted high scores on the TAS–20 subscale (F1)
Costa et al. 2010	To investigate alexithymia in PD	70 PD patients and 70 HC	TAS–20	21.4% of PD and 10% of HC are alexithymic. Univariate analyses: PD differ only in the subscale “difficulty describing and communicating feelings”
Poletti et al. 2011	To investigate the prevalence of alexithymia in de novo PD patients and its relationship with depression	42 de novo PD/64.97+7.87 30 HC	TAS–20 GDS–15 MMSE UPDRS-II, III	In de novo patients alexithymia has a prevalence of 23.8%; in HC 16.6% No difference in alexithymia frequency between PD and HC. Both alexithymic PD and HC were more depressed than non alexythimic.
Poletti et al. 2011	To investigate how alexithymia might influence decision making in de novo PD	24 de novo PD/65.04+6.23	IGT TAS–20 GDS–15 MMSE/FAB	De novo PD versus HC: no differences in alexithymia, depression and decision making Alexithymic outperformed the non alexithymic only in the central IGT block No difference between depressed PD and no depressed PD Correlation analyses: TAS–20 and GDS–15 correlate with age and MMS/FAB. TAS–20 F1 correlates positively with second block of IGT[21–39,59] and negatively with last 2 blocks (61–100)
Poletti et al. 2011	To investigate the association between alexithymia and clinical motor subtypes in de novo PD	42 de novo PD/64.97+7.87	TAS–20 GDS–15 MMSE UPDRS II-III PD were classified in PIGD	23.80% were alexithymic PIGD-PD reported higher score than MIX-PD in GDS–15 (<0.05), TAS–20 total score and subscores (<0.05) PIGD had higher scores than TD in TAS–20 F2 (difficulty describing feelings)

			TR	
			MIX	
Assogna et al. 2012	To investigate whether alexithymia in PD is primarily linked to the disease process or to depressive symptoms or other sociodemographic and clinic characteristics	100 PD patients (71.7+5/6.2+6 years)	TAS–20	Twice as many PD as control patients had categorical alexithymia (11% controls, 22% PD)
		100 geriatric patients (control group) (72.7+4.4)	MMSE BDI HADS SCID according to DSM-IV	PD was mainly associated with DIF After adjusting for sociodemographic factors, antidepressant use and BDI score PD had 4 times higher odds of having categorical alexithymia than controls.
Goerlich-Dobre et al. 2013	To investigate whether alexithymia is an independent risk factor for ICDs in PD (contributing independently from impulsivity, anxiety and depression to ICD).	91 PD/62.3+8.8/8.5+5.7 years	QUIP-RS TAS–20 BIS–11 BIS-BAS Emotion regulation questionnaire BDI-II BAI	52/91 PD (57.1%) had at least 1 ICD 16/91 (18%) were alexithymic Alexithymia correlates with ICDs (q=0.381, p≤0.001) especially DIE and DDE. ICDs positively correlate with impulsivity (q: 0.194, p≤0.05) with anxiety (q=0.316, p≤0.01) and depression (q=0.348, p≤0.01). They negatively correlate with behavioral inhibition (q=–20.31, p≤0.01) and behavioral approach (q=–0.20, p≤0.05)
			CD	
Gudel 2004	To investigate the autonomic and motor reactivity to an emotional and a cognitive stressor in high- versus low-alexithymic cervical dystonia patients	10 CD patients with high alexithymia and 10 with low alexithymia score.	VAMS	HR, SCL and NS.SCF were lowest during the baseline and the intertask relaxation periods, but they clearly increased during the Stroop Test and the Stress Interview.
		Stress inducing cognitive and emotional tasks (Relaxation 1, Stroop Test, Relaxation 2, Stress Interview)	ROM of spinal cord Tonic and phasic electrodermal activity: (SCL, NS.SCF) HR ST	
			HD	
Tinkler Iris et al.	To clarify if HD patients have deficit in expressing emotions and understanding their feeling	13 HD patients and 13 controls matched for age and education	cognition test (Ekman test) expression (patients emotion facial expressions were video recorded and rated by external raters) TAS–20 Empathy: IRI, BEES MRI (for caudate atrophy evaluation) UHDRS	No difference in alexithymia and empathy between HD patients and HC (p=0.98). Both recognition and expression were impaired across different emotions in HD compared with controls and recognition and expression scores were correlated.

BAI: Beck Anxiety Inventory; BDI: Beck Depression Inventory; BEES: Balanced Emotional Empathy Scale; BIS-BAS: Behavioral Inhibition/Approach Scale; CD: cervical dystonia; DAS: Dyadic Adjustment Scale; DDE: difficulty describing emotions; DIE: difficulty identifying emotions; EDSS: Expanded disability status scale; EOT: externally orientated thinking; EQ–16: Empathy Quotient; ES: epileptic seizures; F: female; FAB: Fullerton Advanced Balance Scale; GDS–15: Geriatric Depression Scale Short Form; H&Y: Hoehn and Yahr Scale; HADS: Hospital Anxiety and Depression Scale; HAM-D: Hamilton Rating Scale for Depression; HAM-

A: Hamilton Rating Scale for Anxiety; HC: healthy controls; HD: Huntington's Disease; HR: heart rate; ICD: impulse control disorders; ICD–10: International Classification for Diseases; IGT: Iowa Gambling Task; IMS: Index of Marital Status; IRI: Interpersonal Reactivity Index; L: left; LBD: left brain damage; M: male; MMSE: Mini Mental State Examination; MIX: mixed motor subtype; MMPI 2-RF: Minnesota Multiphasic Personality Inventory–2-RF; mTBI: mild traumatic brain injury; NPS: neuropsychological; NS.SCF: nonspecific skin conductance fluctuations; PD: Parkinson's Disease; PC: postconcussional; PIGD: postural instability gait difficulty motor subtype; PNES: psychogenic nonepileptic seizures; PTSD: posttraumatic stress disorder; QUIP-RS: Questionnaire for Impulsive-Compulsive Disorders; R: right; RBD: right brain damage; REM–71: Response Evaluation Measure; ROM: range of motion; SCAN: Schedules for Clinical Assessment in Neuropsychiatry; SCID II: Structured Clinical Interview for DSM-III-R Personality Disorders; SCL: skin conductance level; SCL–90-R: Symptoms Check List; ST: skin temperature; STAI: State Trait Anxiety Inventory; SSRI: selective serotonin reuptake inhibitors; TAS–20: Toronto Alexithymia scale; TBI: traumatic brain injury; TBIQ: Traumatic Brain Injury Questionnaire; TR: tremor dominant subtype; TSI-II: Trauma Symptoms Inventory II; UPDRS: Unified Parkinson's Disease Rating Scale; VAMS: Visual Analog Visual Scale.