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Alexithymia as an Adjunct to Cognitive Behaviour Therapy for Depression

Abstract

Alexithymia refers to the deficits in identifying and describing the felt emotions, and an externally oriented thinking style which has been identified as a personality trait present significantly more in patients of a range of psychiatric disorders. Alexithymia has been recorded to play a pivotal role in the outcome of psychotherapeutic interventions. The present paper reports the efficacy of incorporating specific interventions for alexithymia as adjunct to the cognitive behavior therapy for depression across genders using six case studies. The cases were assessed for their levels of depression and alexithymia using Beck Depression Inventory –II and Toronto Alexithymia Scale, respectively, in a pre-post research design. The paper highlights the significance of the role of alexithymia treatment as an integral component of cognitive behavior therapy for enhanced therapeutic outcome.

Keywords: Alexithymia, Cognitive Behavior Therapy, Depression.

Introduction

Alexithymia refers to cognitive-affective styles that result in specific disturbances in the expression and processing of emotions. Ruesch(1948) described certain individuals as “infantile personalities”, and they have been labeled as ‘triune brain’ (maclean,1949) or as ‘Emotional illiterate’ (Freedman & Sweet,1954), which later got to be recognized as Alexithymic individuals. Alexithymia as a term has its roots in Greek where it means “lack of words for emotions”. Originally the concept was extensively studied in psychosomatic patients, who exhibited four characteristics, namely a lack of emotional awareness, difficulty identifying and describing emotions, a poverty of a fantasy life, and an excessive externally-oriented occupation with physical symptoms and external events (Nemiah & Sifneos, 1970). The concept has, however, now been established as a personality feature found across various psychiatric diagnostic categories with prevalence estimates of 14-19% in general adult population and 30-40% among psychiatric out-patients (Todarello, Taylor, Parker, & Fanelli, 1995). This personality construct has been conceptualized to comprise multiple facets including: 1) difficulty identifying and distinguishing emotions from bodily sensations; 2) difficulty describing and verbalizing emotions; 3) poverty of fantasy life; 4) externally oriented thinking style; and 5) poor empathizing. Review of 1507 empirical articles reported alexithymia as unfavorable characteristic for disease control and health promotion (Kojima,2012). It has been reported to be more in individuals with psychiatric distress (McGillivray, Becerra, & Harms, 2017). In the Indian context alexithymia has been reported to be significantly present in patients with psychogenic pain (Sriram, Chaturvedi, Gopinath & Shanmugam(1987),with somatoform & depressive disorder (Duddu, Isaac,& Chaturvedi(2003), with multiple somatic symptoms (Sarkar & Chandra(2003), in somatoform & dissociative patients (Irrpati, Avasthi, & Sharan(2006), and in irritable bowel syndrome (Arun, 1998). In the Indian population, it has been found to be significantly related to obesity in females (Kaur & Kaur, 2012), and correlated with anger in young adults (Kaur & Jindal,2013). It has been recorded in Indian adolescent/ children as well; for example in relation to social anxiety (Kaur & Kaur , 2012) , Dissociative Disorders (Kaur & Mishra, 2010) and Anxiety (Kaur & Sachdev , 2012). These findings empirically validate Taylors conclusion (1984) that ‘alexithymia appears not to be a substantive feature of any of these syndromes, but instead a related, co-morbid condition’.

Further, gender differentiation in alexithymia continues to be inconclusive. While in an obese sample females were reported significantly higher on factors 1, 2 & total scores on alexithymia, in their matched healthy controls, the males were found to be significantly higher on factor 3

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(Kaur & Kaur, 2007). Kaur & Sachdev (2011) reported no significant differences in alexithymia in a sample of healthy adolescents. In another study on relationship of alexithymia with social anxiety in an adolescent population females were reported to be significantly higher on factors 1, 2 & total scores of alexithymia (Kaur & Kaur, 2014). The same trends were reported in Somatoform adolescents (Kaur & Sachdev, 2015). However, in non-Indian samples Lane, Sechrest, Reidel, Weldon, Kaszniak, and Schwartz (1996) have reported higher alexithymia in males in the community sample. Similarly, in a Psychiatric OPD Salien, Saarijarvi, Aarela and Tamminen (1994), found it higher in males. Kirmayer and Robbins (1993) failed to find any gender differences in a sample of family medicine patients. Wester et al. (2002) thus concluded that 'empirical research on the verbal expression of emotions in general and alexithymia specifically, do not demonstrate a consistent gender-based pattern of results'.

Based on the above review, it can safely be concluded that alexithymia as a personality feature occupies a significant place in an individual's life space, particularly in those individuals who acquire maladaptive set patterns to be labeled as one or the other psychiatric disorders. Some indications of gender based variations are also present but are still debatable.

The next natural transition is to evaluate the role of therapeutic interventions specifically directed towards management of the alexithymic features. Alexithymic personality features may influence the symptom presentation, the course of illness, prevalence, and the response to treatment.

Alexithymia Dynamics within Cognitive Behavior Therapy

Traditionally Cognitive Behaviour Therapy has a primary focus on the Negative Cognitive Triad using cognitive restructuring as the main tool for treatment. Socratic questioning helps to deal with Cognitive Distortions / Irrational thoughts, while the Behavioral Experiments help in challenging the dysfunctional basic assumptions. Rational Emotive Behaviour Therapy has incorporated the emotional components related to the cognitive dysfunctional assumptions, but the basic deficits in emotional abilities in the form of alexithymic traits need specific inputs. No doubt the efficacy of CBT for depression has been established beyond doubt, yet it has been reported that many times the results fail to reach the expected levels.

Cognitive behavior therapy (CBT) basically aims to identify, monitor, and analyze the negative affects & the subtle fleeting cognitions which are leading an individual to maladaptive behaviors whereby biological, psychological and social functioning is impaired. CBT helps the patients to have good access to their internal world and challenge the irrationalities and dysfunctional biases so that the cognitive processing styles may be modified. In the process the related emotional reactions also move from the uncontrolled negative ones to a whole range of optimum emotional

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expressivity. However, the individuals who have alexithymia have marked deficits in identifying and describing emotions and an excessively externally-oriented thinking; and which are bound to be a hindrance in the optimum utilization of inputs provided during therapeutic interventions. Yet, as reviewed earlier, it has been established beyond doubt that the patient population has markedly higher levels of alexithymia.

Adverse Mediation effect on therapist responses due to alexithymia in patients have also been reported (Ogrodniczuk, Piper & Joyce, 2005). Negative impact of alexithymia on response to CBT for cocaine addicts (Carroll, 2004) has also been recorded. Rufer et al (2006) have found significance of alexithymia in the outcome of CBT for OCD.

Thorberg et al (2009) have found significant potential of the alexithymic features in the patients to interfere with treatment outcome for therapy for alcohol use. Similarly, alexithymia has been found to be associated with poor outcome in traditional psychodynamic & supportive psychotherapy (Ogrodniczuk, Piper & Joyce, 2011). In a recent study by McGillivray, Becerra, & Harms, (2018) it was concluded in group cognitive therapy that "it may advantageous for clinicians to treat alexithymia in order to enhance therapeutic intervention".

Objective of the Study

The current paper aims to discuss the role of specific inputs towards handling alexithymia in patients suffering from depression, both males and females, across different ages. The cases provide a window to the significance of incorporating specific goals within the realm of CBT to enhance the individuals' emotional expressivity and processing of emotions so that the alexithymia may decrease and the individual can sustain the gains made during psychological interventions.

Procedure

The cases sought psychotherapeutic help at a Community Counselling Centre providing at the Department of Psychology, Punjabi University, Patiala; where the author, a trained clinical psychologist renders volunteer services for the same. After the initial case work, patients' informed consent for psychotherapy was obtained and wherever needed a behavioral contract against suicide was also made. The primary caretaker within the family was provided a session of psycho-education wherein misconceptions about the illness and its course and treatment were particularly discussed. Their role in the treatment process was also clarified.

For the depressive negative automatic thoughts, the related cognitive distortions, and the dysfunctional assumptions, Cognitive Behaviour Therapy based on Beck's model was provided. The negative triad and the Negative self schemas were addressed. At the same time the alexithymic features of being unable to adequately identify and describe their emotional upheavals, and of concretizing the day to day experiences was brought out to them. For the latter the therapy focused on four stages.

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Stage 1

Making the patient an observer of his inner states and their nonverbal cues.

Stage 2

Developing affect tolerance, and hence decreasing the perceived frightening nature of affect.

Stage 3

Recognizing the emotions as signals that are self-limited in duration and controllability.

Stage 4

Beginning to verbalize the emotional states with the therapist as teacher / guide, providing feedback and enhancing self esteem and consequently self reliance and independence in thought and action.

Emotion cards, role plays, emotions diary writing, emotional interpretations from television serials, emotional revisiting of challenging life events, emotions communication with significant others, were some of the major tools used to take the patients through these four stages. These were done in the sessions as well as through home work assignments. The therapist provided a preparatory phase before monitoring of high-risk situations & skills training. Special efforts were made to prevent patients from being overwhelmed by the emotional matters. A slow transition was then made to identifying feelings and affect states along with restructuring thoughts. As the patients gained proficiency, they were made to move through the four stages described above.

The patients were assessed on Toronto Alexithymia Scale and on Beck Depression Inventory to obtain the pre-therapy scores. The patients were then provided CBT for depressive cognitions along with specific inputs for managing their alexithymic features. Post therapy assessment was done on TAS as well as BDI-II to measure the changes in depressive and alexithymic severity.

Tools

Two scales were used to measure the efficacy of the interventions provided by administering

them on the patients before and after the therapy. The two are described below.

Toronto Alexithymia Scale(TAS)

(Bagby, Parker, and Taylor, 1994). TAS is a 20-item measure of alexithymia providing a total score along with scores on three factors , namely,

1. Difficulty Describing Feelings
2. Difficulty Identifying Feelings, and
3. Externally-Oriented Thinking

The TAS-20 scores of 52 to 60 indicate possible alexithymia, while scores equal to or greater than 61 indicate alexithymia. The non-alexithymic individuals score less than 52. It has been found to be stable and replicable across clinical as well as nonclinical populations. It's a reliable and a valid tool for assessment of alexithymia (Craparo, Faraci, & Gori, 2015).

Beck Depression Inventory –II (BDI-II)

1996 revision of the Beck Depression Inventory was used to measure the severity of depression. It is a 21-item self-report multiple-choice inventory aimed to assess the degree of various symptoms of depression including suicidal ideation, hopelessness, sadness of mood, guilt, and fatigue. The BDI-II scores up to 13 indicate minimal depression, while scores of 14–19 are taken as mild depression. Scores of 20–28 represent moderate depression while 29–63 scores are taken to represent severe depression. It is a reliable and valid tool for monitoring depressive symptoms (Beck, Steer and Brown, 1996)

Sample

Six cases are reported with whom the intervention was done, three male patients and three female patients, all suffering from clinically significant depression diagnosed by a trained psychiatrist on the basis of ICD 10. The case details of the patients provided the intervention are in table 1(male patients) and table 2(female patients)

Table- 1: Case Details of Male Patients Suffering From Depression

Males	Case 1: 22 years Referred by psychiatrist	Case 2: 25 years Referred by relative	Case 3: 44 years Self referred
Education	BA	Btech	MBA/ex-army
Marital status	Single	Single	Married
Occupation	Student : MA	Student : MBA	Business
Father/Mother	Doctor/Doctor	Colonel/teacher	Spouse: business
Siblings	MBBS(student)	Fashion designer	Son & daughter
Personality Traits	Schizoid-anancastic	Dependent-anxious avoidant	Anancastic- dependent
Precipitating Trigger	Death of grandmother	NDA training	Australia immigration
Drug therapy	Concurrent	Initially present Off for 2&1/2 yrs	Initially approx. for 3 months
Duration of illness on contact	Ten months	Three years	One year
CBT	10 + 2	18 + 7	13 + 4
Depression	Mod-severe + suicidal	Mod-severe	Mild-moderate
BDI Scores(Pre)	58	46	23
BDI Scores(Post)	28	12	12
TAS Scores(Pre)	94	69	80
TAS Scores(Post)	50	40	50

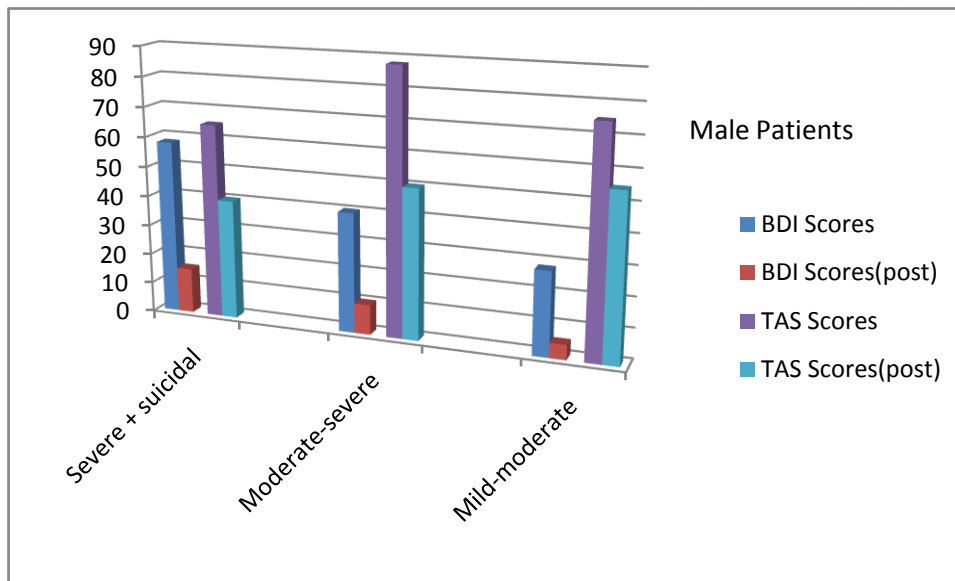
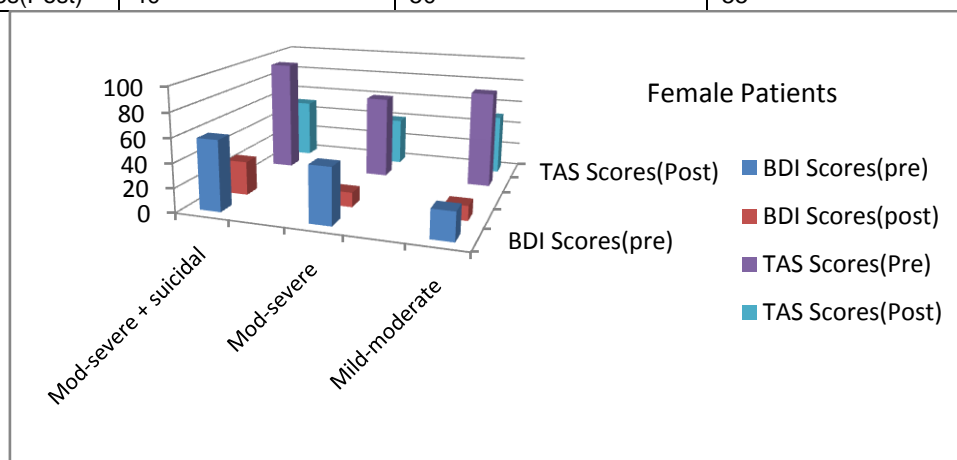


Table- 2: Case details of Female Patients Suffering From Depression

Females	Case 4: 22 years Self referred	Case 5: 43 years Referred by friend	Case 6: 57 years Referred by psychiatrist
Education	MA	Paramedic	MA
Marital status	Single	Married	Married
Occupation	Gazetted officer	Private practice	Homemaker
Father/Mother	Officer /Homemaker	Spouse: business	Spouse: business
Sibling	Btech (student)	No child	2daughters +1son + grandkids
Personality traits	Anancastic- anxious avoidant	Dependent-anxious avoidant	Anancastic- dependent
Precipitating trigger	Hostel in new town	Conflict with In-laws	New neighbourhood
Drug therapy	Concurrent	5 years Off for over 3 yrs	Initially for 6 months Off since 8 months
Duration of illness	4 years	9 years	2 years
CBT	21 + 5	15 + internet	8 + 4
Depression	Severe + suicidal	Moderate-severe	Mild-moderate
BDI Scores(Pre)	58	40	28
BDI Scores(Post)	15	10	5
TAS Scores(Pre)	65	88	75
TAS Scores(Post)	40	50	55



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Discussion

Lumley, Neely and Burger (2007) had stated that "Alexithymia is associated with heightened physiological arousal, the tendency to notice and report physical symptoms, and unhealthy compulsive behaviors. Alexithymic patients may respond poorly to psychological treatments, although perhaps not to cognitive-behavioral techniques, and it is unclear whether alexithymia can be improved through treatment." They had shared two cases wherein the role of alexithymia played a crucial role in the outcome. The current study has made efforts towards moving further towards creating a specific structure within the CBT framework so that the intervening effect of alexithymia can be minimized resulting in a more adaptively skilled individual. Post therapy the individuals not only overcame the specific debilitating symptomatology but also the inhibitions to optimum functioning due to the personality deficits related to alexithymia. McGillivray, Becerra, & Harms, (2018) reported that reduction in alexithymia during treatment was a significant predictor of a reduction in psychological distress over the course of group cognitive behavior therapy that they conducted for psychological distress, however, they found that alexithymia by itself did not significantly reduce. In the cases being reported here, alexithymia had marked reduction. Hence, it is indicative that the improvement in alexithymic features was not entirely due to the CBT for depression but due to the specific adjunct inputs stated. Similarly, the complex interaction between alexithymia and depression resulting in effects on the psychotherapeutic mechanism of change in psychodynamic psychotherapy has been reported in multi-somatoform disorders (Probst, Sattel, Gündel, Henningsen, Kruse, Schneider, & Lahmann, 2017). The authors reported that alexithymia moderated the relationship between the therapeutic alliance and the outcome, but again did not address alexithymia in therapy. Specifically for depressive disorders a similar research was conducted by Quilty, Taylor, McBride, & Bagby (2017), and found similar results for CBT. They too, however, focused on the pre therapy alexithymia scores and its impact on therapists' ease and affectivity in forming therapeutic alliance rather than analyzing the patients' perspective. The present work is a preliminary work towards filling this gap in therapeutic research.

All the patients had a precipitant which required interpersonal adjustment. All the patients had traces of cluster C personality disorders. There was external pressure from significant others towards performance and the parents/ spouse were social well established. The internalization of the emotional reactions being exhibited as depression may have been averted if these patients had been able to recognize and express optimally in their interpersonal interactions. There was a need to realize, accept, and express before their life events overwhelmed them, specifically, in Case 1 the expression of the grief, in case 2 the hardships of his training at NDA, in case 3 his fears about the unknown in a new nation for the welfare of his children, in case 4 the cultural shock

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from moving from rural home to a metropolitan hostel, in case 5 the inability to conceive a child, in case 6 adjustment related to new maids and neighbors. Having cluster C traits but not knowing how to manage them aggravated the situation. They all had high scores on alexithymia as well as depression which decreased clinically significantly after intervention. The gains were maintained on follow-up. The improvement was evident across the gender and across the age. Cases 2, 4, 5, and 6 were extremely verbose and their alexithymia became evident only on analyzing the content of the speech output which was concrete and factual. Thus, like cases 1 and 3, some alexithymic individuals may be obviously so but others may need specific observation to be able to catch it.

Social learning processes have been reported as having important contribution to the development of alexithymia (Borens, Grosse-Schultze, Jaensch, & Kortemme, 1977 c.f. Levant, Hall, Williams, & Hasan, 2009) with Socialization as a crucial critical link to alexithymia (Levant, Richmond, Majors, Inclan, Rossello, Heesacker, ... & Sellers, 2003) as "Normative Male Alexithymia" hypothesis. They claimed that a socialized pattern of restrictive emotionality influenced by traditional masculinity ideology restrains boys from expressing and talking about their emotions so that they fail to develop a vocabulary for, nor an awareness of, many of emotions. Although his rationale does not find its relevance to only the male population, but in all the six cases the patients had harsh and restrictive parenting. Cases 1, 2, 3, 4 and 5 had both working parents with long working hours and stressful working conditions and disciplinarian approach to interactions with the patient. Case 6 was an adopted child. Levant, Hall, Williams, & Hasan (2009) talked about the greatest deficits in identifying and expressing emotions inducing a sense of vulnerability (like sadness or fear). Its impact on attachment has also been brought out. The cases under study revealed that these deficits are evident irrespective of the gender. This is in line with Heesacker et al. (1999) who concluded that "... despite a number of men's psychotherapy articles focusing on alexithymia ... as an emotional deficit of men ... recent empirical research on alexithymia suggests there are no gender differences ..."

During the course of the therapy, as there alexithymia became more controlled and they learnt to be observant of their inner world and more expressive towards the outer world, their concrete mode of thinking and observation changed spontaneously. This helped in their problem solving and also resulted in better attributional style with enhanced empathy. The interpersonal relations improved many fold by default. Thus the ripple effects of this improvement went beyond the set goals of therapy and became the personal reinforcers for continued efforts. The role of the therapist for this latter part was only to help them link these changes to their improved emotional handling of the situations. Better understanding of their own emotions provided an impetus to the CBT related to their depressive cognitions because the insight into the emotional triggers could be utilized for

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cognitive restructuring. Being able to express their hurt and feelings related to their stressors, there was lesser need to internalize them into depressive cognitions; and it became easier to seek social support for handling the same. Similarly was brought out in the review of emotional expressiveness by Wester, Vogel, Pressly, & Heesacker (2002) that relatedness and counselling outcome improves markedly with enhanced emotional expressiveness, and this has been confirmed in self report empirical reports irrespective of the gender.

All the cases reported continued for therapy sessions and maintained contact even for booster sessions, even though only two had sought help by themselves. Ogrodniczuk, Piper, & Joyce (2011) in their review of factors that can prevent pre-mature termination of psychotherapeutic process have stated that "facilitation of affect expression" and "facilitation of therapeutic alliance" are two significant factors. Both of these have been addressed in the current cases, and it is emphasized that any therapy must incorporate alexithymia based goals as well.

An advantage in the current cases was that the patients were all educated and exhibited psychological mindedness. This could have had major impact on the positive outcome of the intervention inputs. It has been recorded to play a significant role in group therapy (Kealy, Sierra-Hernandez, Piper, Joyce, Weideman, & Ogrodniczuk, 2017), but it was found in the present cases of individual therapy too.

Conclusion

The current case reports make a good case for incorporating specific inputs for handling alexithymia in the patient population suffering from depression and reiterates that gender differentiation may not be an issue during this process. The same needs to be empirically tested on other diagnostic categories which have been reported to have significant alexithymia. These cases also encourage us to accept that Indian adult population is as receptive to therapeutic inputs as any other.

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