Psychiatry Research 190 (2011) 43–48

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Effect of alexithymia on the process and outcome of psychotherapy: A programmatic review

John S. Ogrodniczuk [a,*], William E. Piper [a], Anthony S. Joyce [b]

[a] Department of Psychiatry, University of British Columbia, Suite 420 - 5950 University Boulevard, Vancouver, BC, Canada V6T 1Z3
[b] Department of Psychiatry, University of Alberta, Edmonton, Alberta, Canada

ARTICLE INFO

Article history:
Received 3 July 2009
Received in revised form 18 March 2010
Accepted 18 April 2010

Keywords:
Alexithymia
Psychotherapy
Treatment outcome
Therapy process

ABSTRACT

Most psychotherapeutic approaches assume that individuals have some access to their emotions. Thus, patients who are unable to identify, differentiate, and articulate their emotions present therapists with a difficult challenge. Such patients may suffer from alexithymia. Despite much attention in the clinical literature, research on alexithymia in the treatment setting has been sparse. Thus, many of the assumptions about psychotherapeutic treatment of alexithymic patients remain untested. This article summarizes findings from a series of studies that examined the effect of alexithymia on various aspects of the psychotherapeutic enterprise. Findings indicated that alexithymia has little effect on patients' treatment preferences, yet there was some tendency for alexithymic patients to prefer group therapy. However, alexithymia was associated with poor outcome in both traditional psychodynamic psychotherapy and supportive therapy. This negative effect was found in individual and group psychotherapies. In the context of group therapy, higher levels of alexithymic features elicited negative reactions from one's therapist, which partially contributed to the poor outcome experienced by such patients. Finally, the negative reaction that therapists had toward patients with high alexithymia appeared to be in response to the lack of positive emotion expressed by these patients. Clinical implications and ideas for future research are considered.

1. Introduction

"The assumption that other people's emotional responses are like our own is the basis of empathy and as such is basic to all human intercourse. The uncritical acceptance of this assumption, however, has led us to the false expectation that all patients have to them the affective functions necessary for the utilization of psychotherapy" (Krystal, 1982–1983, p. 353). Indeed, most psychotherapeutic approaches assume that individuals have at least some awareness of and access to their emotions. However, some patients have great difficulty identifying and expressing feelings or emotional aspects of social interaction. Such patients may suffer from alexithymia, a term coined by Sifneos (1973). Alexithymia is characterized by an impoverished fantasy life and limited imagination, an impaired capacity for empathy, a propensity for impulsive behaviour, a tendency to somatize emotions, and a penchant for offering undifferentiated descriptions of emotional experience (Warnes, 1986; Taylor, 2000). According to Taylor (2000), the core features of alexithymia include difficulty identifying feelings and distinguishing them from bodily sensations of emotional arousal, difficulty describing feelings to other people, and an externally oriented cognitive style.

Current conceptualizations describe alexithymia as a trait deficit in the cognitive processing of emotional experience, such that individuals have a limited capacity to symbolize emotions and elaborate upon emotional experience (Taylor and Bagby, 2004). Thus, the construct of alexithymia is relevant to mental state understanding (Jurist, 2005; Choi-Kan and Gunderson, 2008; Dimaggio et al., 2009). As the editors of this special of Psychiatry Research ("Meta-cognitive and social cognitive dysfunction in psychiatric disorders: Focus on psychosocial issues and treatment") have pointed out, mental state understanding involves a variety of processes (e.g., emotional awareness) that influence a person's capacity to think about aspects of the self and how these interact with the world, a capacity variously referred to as mentalizing, theory of mind, meta-cognition, and self-reflection (Dimaggio et al., 2011). The ability to perceive, reflect on, and communicate affectively laden mental states is crucial for regulating one's emotions (Mohaupt et al., 2006; Lane, 2008). Furthermore, the capacity to differentiate one's emotional experiences from those of another is necessary for managing interpersonal relations (Guttman and Laporte, 2002). Difficulties identifying, interpreting, and describing one's emotions and those of others, characteristics of alexithymia, would therefore impede a person's ability to manage affectively oriented mental contents and

* Corresponding author. Tel.: +1 604 822 8034; fax: +1 604 827 4106.
E-mail address: ogrodnic@interchange.ubc.ca (J.S. Ogrodniczuk).

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doi:10.1016/j.psychres.2010.04.026

interactions with others (Lane, 2008). In the presence of such impairment, emotions remain global and undifferentiated, leading to a relative inability to use one's own emotions to guide adaptive behaviour. As such, alexithymia has been conceptualized as one form of impairment that is part of a larger network of dysfunctions that contribute to difficulties understanding mental states (Dimaggio et al., 2009). Indeed, in a unique study, Moriguchi et al. (2006) found that alexithymia was related to impaired mentalizing, which in turn was associated with hypoactivity in the medial prefrontal cortices. The deficit in mentalizing was associated with impairment in the higher cognitive ability to take a perspective different from the self, a skill that may be essential for the comprehension of the mental states of both self and others. As Swiller (1988) points out, it is important to keep in mind that alexithymia is not a psychiatric disorder, but rather a characterization of thinking, feeling, and relating processes among patients with a wide range of psychiatric diagnoses. Further, alexithymia is not a dichotomous construct (i.e., you have it or you don't), but rather a dimensional one (i.e., people exhibit different levels or degrees of alexithymia).

Patients who are unable to identify, differentiate, and articulate their emotions present psychotherapists with a difficult challenge (Taylor, 1984; Kleinberg, 1996). Alexithymia constricts a person's ability to elaborate on inner feelings, to engage in abstract thought, and to appreciate the possibility that somatic symptoms may be the manifestation of psychic distress (Sifneos, 1973). Patients with high levels of alexithymia know that they do not feel good, but do not know how to say or describe what they are feeling. They have difficulty presenting material spontaneously and fixate on their physical symptoms and minute details of external events. Alexithymia is believed to complicate the establishment and maintenance of a therapeutic alliance, as it may predispose an individual toward narcissistic rage, hyper-irritability, and impulsive behaviour (Tacon, 2001). It has been shown to be associated with the use of primitive and immature defences such as projection and denial (Parker et al., 1998), as well as acting-out, dissociation, and passive–aggressive behaviour (Taylor et al., 1997). The lack of integration between affect and cognition, the use of immature defences, and a proclivity toward impulsive behaviour have significant implications for treatment (Krystal, 1979; Taylor et al., 1997).

Despite the considerable attention it has received in the clinical literature, there has been very little research that has examined the effect of alexithymia on the process and outcome of psychotherapy. Most research on alexithymia has focused primarily on etiological factors and associated pathologies (e.g., Bailey and Henry, 2007). Thus, many of the assumptions and musings about the psychotherapeutic treatment of an alexithymic patient remain untested. The work of our research group may represent one of the more comprehensive and systematic investigations of alexithymia in the context of psychotherapy. This article reviews a series of studies that we have conducted which attempted to provide some clarity regarding the role that alexithymia plays in the treatment setting.

2. Does alexithymia affect patients' willingness to engage in psychotherapy?

Given that alexithymic patients appear to lack the very skills that psychotherapy requires, e.g., self-reflection, interest in internal events, and access to feelings, it would seem reasonable to assume that they would tend to avoid psychotherapeutic treatment and prefer other forms of treatment, e.g., pharmacotherapy. However, it is unknown whether alexithymic patients actually prefer pharmacotherapy over psychotherapy, as no previous study has actually tested this assumption. We recently examined this issue (Ogrodniczuk et al., 2009) by collecting data from new patients ($N=145$) at two different psychiatric outpatient clinics. In this study (as with all of our studies), we assessed alexithymia using the Toronto Alexithymia Scale-20 (TAS-20) (Bagby et al., 1994). It measures the three core features of alexithymia: difficulty identifying feelings, difficulty communicating feelings, and externally oriented thinking. We developed our own treatment preference scale, which gave respondents the choice of selecting Medication Treatment, Psychotherapy (the type of psychotherapy was not defined), or No Treatment (wait and see). The scale also asked respondents to indicate whether they would prefer individual or group therapy if they selected "Psychotherapy" as their treatment preference.

We found that alexithymia did not significantly differ among the groups of patients who chose medication treatment, psychotherapy, or no treatment at all. Our finding suggests that high alexithymia is just as likely to be present among those who prefer psychotherapy as those who prefer medication treatment or those who would prefer to take the wait-and-see approach to dealing with their problems. This suggests that it is not appropriate to assume that alexithymic patients have reservations about entering into a psychotherapeutic treatment. Thus, psychotherapy should be considered potentially viable for these patients. Additionally, we found that patients who preferred group therapy had higher levels of alexithymia compared to those who preferred individual therapy. It is possible that alexithymic patients perceive group therapy as a setting that affords some opportunity to be a passive observer. They may feel that individual therapy would require their constant participation in an activity (i.e., talking about feelings) that they may not be completely comfortable with. Alternatively, alexithymic patients may believe that sharing therapy with others provides an opportunity to learn how to work with feelings. Overall, the results from our study suggest that, while psychotherapy with alexithymic patients may be challenging, this type of treatment appears to be readily accepted by such patients.

3. Does alexithymia affect the outcome of psychotherapy?

A widely held assumption is that alexithymic individuals are ill-suited for dynamic psychotherapy and that supportive psychotherapy is more appropriate (Sifneos, 1996). We used data from two clinical trials of individual ($N=144$) and group ($N=107$) psychotherapies to test this assumption (McCallum et al., 2003). Each trial involved randomly assigning patients to either interpretive or supportive psychotherapy (Piper et al., 1998, 2001). Briefly, the primary objective of interpretive therapy was to enhance the patient's insight about repetitive intrapsychic and interpersonal conflicts that served to underlie and sustain the patient's problems. The interpretive therapist focused on exploring uncomfortable emotions, interpreting unconscious conflicts, using the transference as a therapeutic mechanism, and emphasizing the patient's role in the development and resolution of problems. The primary objective of supportive therapy was to improve the patient's immediate adaptation to his or her life situation. The supportive therapist focused on guiding the patient toward more adaptive modes of behaviour by using guidance, advice, and problem solving, directed blame for the patient's problems on external circumstances, and did not emphasize affect exploration.

The individual therapies were once-weekly, 50-minute sessions for 20 weeks. The group therapies were once-weekly, 90-minute sessions for 12 weeks. The individual therapy sample consisted of patients with mixed diagnoses, primarily depression, dysthymia, and personality disorders. The group therapy sample consisted of patients suffering from complicated grief. In each study, we assessed alexithymia using the Toronto Alexithymia Scale-20. Outcome in the individual therapy study was represented by three outcome factors: general symptoms, social–sexual maladjustment, and personalized target objectives. Outcome in the group therapy study was also represented by three factors: general symptoms, grief symptoms, and personalized target objectives.

In the individual therapy study, we found that alexithymia features were associated with two of the three outcome factors. Specifically,