

PSYCHOTHERAPY OF A PATIENT WITH PROMINENT ALEXITHYMIC CHARACTERISTICS

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Introduction

Psychotherapists are often aware of the difficulty in treating patients using dynamic methods when patients have a predominant somatic presentation with poor psychological elaboration of their difficulties. Sifneos (1972) coined the term 'alexithymia' to describe patients who have difficulty in recognising and verbalising their emotions, associated with a restricted fantasy experience. Freyberger (1977) distinguished two forms of alexithymia - Primary alexithymia which is innate, and which possible predisposes to various psychosomatic disorders, and secondary alexithymia, which is acquired, and serves a defensive function. Krystal (1979) noted that alexithymia is the single most factor diminishing the success of psychotherapy and suggests modifications in therapy as follows. First, enabling the patient to introspect and observe the nature of his alexithymic disturbance. Next enabling the patient to tolerate affects. Finally to help the patient to verbalise affects.

This report outlines the therapy that was attempted on a patient with marked alexithymic characteristics.

Case Report

Mr. H.L.T., a 28 year old M.A. graduate working as a clerk in Post and Telegraph department presented with 8 years history of headache and two months history of dizziness, weakness, palpitations, blurring of vision, loss of appetite, sleep disturbance and episodes of crying. The onset of the headache was related to difficulties in financial and occupational spheres. He felt that working in the clerical cadre was not on par with his educational qualifications. However he perceived the situation as being inevitable. Preoccupation with this would precipitate or aggravate his headache. He also reported brooding about certain aspects of life like poverty, accidents, widowhood etc., which would similarly precipitate or aggravate his headache. Slowly his symptoms increased and there was constriction in his interests. He gave up his earlier pursuits of dramatics and literature. His earlier preoccupations markedly reduced, but he continued to experience continuous headache. Gradually he became convinced that he was suffering from a physical illness. He did not experience any

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psychic anxiety or depression along with the headache, though it was evident that the headache would exacerbate during periods of stress. Progressively he became markedly dependent on his wife for his day to day needs. He consulted several doctors including physicians and psychiatrists and underwent extensive investigations and prolonged treatment. Despite assurances from doctors, he continued to hold the belief that he was suffering from a physical illness, which the doctors had failed to recognize. Two months prior to coming to NIMHANS, he developed additional symptoms suggestive of anxiety and depression. These symptoms were, however confined to the somatic sphere, with very poor psychological elaboration.

After a detailed psychiatric and physical evaluation, patient was diagnosed to be suffering from depressive neurosis as per ICD-9. He was admitted for inpatient management.

What was striking about his clinical picture was the prominence of alexithymic characteristics. He would endlessly elaborate his bodily symptoms. He, constantly reported a sensation of 'feeling intoxicated'. Tingling sensation in the limbs, dizziness, weakness, blurring of vision, and palpitations were his constant complaints. His appetite was reduced and he had disturbed sleep. In other words, he had all the features of anxiety and depression but did not report any subjective anxiety. Often tears would roll down his eyes, but when asked about the same, he did not report any particular reason. He reported feelings of depression, but explained this as a result of his long standing physical illness. He did not report any worries or preoccupations. When asked to elaborate on the kinds of thoughts he was getting, he would say that he did not think of anything in

particular. The members of the treating team attempted at different times to take him up for therapy but could not establish adequate rapport with him as patient would only speak of his bodily symptoms and nothing else. He elicited reactions of boredom, irritation and helplessness from the treating team. He scored above the cut off for alexithymia on the Beth Isreal Hospital Psychosomatic Questionnaire (Sifneos, 1973), an interviewer rated scale to assess alexithymia. After further discussions among the treating team, it was finally decided to take the patient for dynamic psychotherapy with modifications for alexithymic subjects as suggested by Krystal (1979).

As a first step, the patient's wife who was being over protective and who seemed to reinforce patient's alexithymia by her excessive concern over patient's bodily symptoms, was requested to return back to her place. As an immediate consequence patient's somatic symptoms markedly increased. He expressed his hostility on the therapist by such statement like "No doctor has been able to cure me, let me see what you can do" etc. When an attempt was made to focus on his conflicts, he would display resistance by a persistent narration of his bodily symptoms, preventing further exploration.

In the first few sessions, the therapist listened patiently to his complaints. This enabled the establishment of rapport. Over this period the patient become more amenable to exploration of emotional experiences.

In the subsequent sessions, the psychological and somatic components of emotions, and how they have an adaptive function were explained to the patient. Illustrations were given to facilitate the examination of his emotional state (e.g.

'what would you experience when you were suddenly confronted by a tiger?' etc). The patient was asked to examine his own present emotional state and compare it with what would be expected in tentative situations like the one mentioned above. This enabled the psychological interpretation of the bodily sensations he was experiencing. The patient gradually became aware that his symptoms were a reflection of his mood state and not due to a mysterious physical illness. With this understanding his somatic symptoms reduced in intensity. On the subsequent sessions focus was given to the areas of conflict and how his somatic experiences were related to his conflicts.

After a span of twenty sessions covering 8 weeks it was possible to achieve some degree of conflict resolution and symptomatic improvement. The patient was discharged with a request to attend followup sessions as an out-patient. Patient came for followup on two subsequent occasions. There was a mild relapse of his symptoms during the followup visits, which appeared to be related to his wife's continued reinforcement of his somatic symptoms. Patient however did not come subsequently for followup and did not respond to two letters that were written by the therapist.

Discussion

This case report highlights the clinical presentation of the alexithymic subject as also the therapeutic approach towards alexithymic subjects. The patient appears to have developed alexithymia as a defense against his long standing conflicts. In this regard he could be considered to belong to the group of secondary alexithymia described by Freyberger (1977). Even when he developed symptoms of anxiety and

depression, the psychic components were masked by alexithymia. Jones (1984) reported a case of panic attacks with panic masked by alexithymia. In the eastern cultures especially somatic presentation of psychological problems is very common (Srinivasan et al 1986). Some of these patients might have marked alexithymic characteristics posing difficulties in psychotherapeutic intervention. The above case report illustrates the modifications in psychotherapeutic technique that need to be employed in these subjects. This patient, however dropped out of therapy after two visits following discharge. This outlines the need for a systematic evaluation of the long term efficacy of psychotherapeutic intervention in alexithymic subjects.

References

- FREYBERGER, H. (1977), Supportive psychotherapeutic techniques in primary and secondary alexithymia, *Psychotherapy and Psychosomatics*, 28: 337-342.
- JONES, B. (1984), Panic attacks with panic marked by alexithymia, *Psychosomatics Vol. 25 No.11*, 1-2.
- KRYSTAL, H. (1979), Alexithymia and Psychotherapy, *American Journal of Psychotherapy*, 33: 17-31.
- SIFNEOS, P.E. (1972), *Short-term Psychotherapy and emotional crisis*, Cambridge, Harvard University Press.
- SIFNEOS, P.E. (1973), The prevalence of "alexithymic" characteristics in psychosomatic patients, *Psychotherapy and Psychosomatics*, 22: 255-262.
- SRINIVASAN, K., SRINIVASA MURTHY, R. & JANAKIRAMAIAH, N. (1986). A Nosological study of patients presenting with somatic complaints, *Acta Psychiatrica Scandinavica*, 73: 1-5.
- WORLD HEALTH ORGANISATION (1977) *International classification of Diseases*, Geneva, 9th revision. World Health Organisation.