OVERVIEW, IMPLICATIONS, SUGGESTIONS AND LIMITATIONS
CHAPTER VI
OVERVIEW, IMPLICATIONS, SUGGESTIONS AND LIMITATIONS

Somatoform disorders are marked by personal morbidity and cost to health services. On the one hand physicians suspecting some fatal illness related to symptoms render the patients to repeated tests, reinforcing the sick role. On the other hand the patients are chronically dissatisfied with medical care resulting in doctor-shopping. The burden on family and medical care facilities is immense, and personal dysfunction in occupational and social behaviour makes the patient an invalid. Once diagnosed, the psychiatrists preoccupation with the so-called 'serious mental illness' gives somatoform disorders low priority. The health planners, have erroneously equated severity with diagnosis rather than level of need and disability, resulting in the neglect of research and planning for better care of these disorders. In this framework, these patients are provided with minimal support as they may be viewed as feigning the symptoms. Or due to their preoccupation with physical symptoms, and limited psychological mindedness, and the attribution of improvement to change in physical symptoms rather than the resolution of conflicts and sharing of emotions, they generate frustration and negative counter-transference in the therapist who might make efforts to help them. A strong need was thus felt to understand the core basis of this illness in generation of severe dysfunction and a response of neglect or antagonism in the health care provided.

The review of literature revealed that aforesaid could well be explained by the presence of alexithymia in these patients. The inability or deficits in experiencing and expressing emotions, and having an externally oriented thinking style could be resulting in an inability to express conflicts or communicate psychological distress in words, and hence being exhibited as somatic symptoms. Non-organic physical symptoms could also be due to alexithymia precipitated misperception of affective and other benign physical sensations, as the deficit could be at identification as well as description of the felt-emotions. The patient
experiencing psychological distress seeks help; yet due to the alexithymic traits he is unable to explain his feelings, and gives only a concrete story about physical symptoms. Realizing that the treating person has not fully understood the gravity of distress, he keeps on repeating these complaints on every visit. Further, alexithymia having generated negative effect on the treatment provider, results in subquality and inadequate care. Chronicity is thus maintained by alexithymic characteristics.

Results of the present study validate the above stated connection. The somatoform patients were more alexithymic than the matched controls. The patients had significantly more difficulties in the experience and expression of emotions, and had an externally oriented cognitive style. Females with alexithymia were more prone to exhibit somatoform disorder than did the males, but in the general population, alexithymia did not have gender specificity. There was no impact of age on alexithymia. However, education was negatively correlated with it, alexithymia being most prevalent among illiterates and those with education below matric. Joint families rather than nuclear families precipitate somatoform disorders in alexithymic individuals. But, alexithymia is present irrespective of the type of family. The doubts expressed by a number of researchers about the relevance of alexithymia to non-western cultures could be put to rest for Indian population in view of the current study results wherein it has been conclusively found both in the patients as well as the normals. Thus, an Indian female high on alexithymia, living in a joint family with education below matric, is at highest risk for developing somatoform disorder. Converseley, the most effective treatment for somatoform disordered patient would comprise of therapy aimed at reducing alexithymia, generating a nuclear family bonding and encouraging the individual for educational pursuits.

Man is a social animal and to view him out of social context would provide a misleading and incomplete description of his life situation. In view of this, the present study
examined some social determinants or influencing agents of alexithymia and consequently of somatoform disorders.

The current exploration revealed that somatoform patients when compared with normals had poorer perceived social support; more stressful life events and lesser desirable life events. They more often made use of magical thinking, helpseeking, externalization and negative cognitive evaluation, and less often used problem solving techniques to deal with stress. Their verbal fluency was markedly low but communication and cohesion in the family was very high, resulting in the family functioning to be perceived better than that in the normal families.

Alexithymia was negatively related to perceived social support, desirable life events, verbal fluency, and coping with stress using distraction or religiosity. A positive relationship was evident between alexithymia and undesirable life events especially which were ambiguous or impersonal, and the coping mechanisms used were magical thinking, help seeking, externalizing and negative cognitive evaluation.

The subclinical alexithymic traits, i.e. those found in the normal controls were also related to the use of distraction and avoidance coping mechanisms. While clinical alexithymia was correlated with good family functioning particularly related to cohesiveness and communication pattern in the family, but subclinical alexithymia was related to leadership pattern and role division in the family.

Regression analysis revealed that the independent variables studied in the current study were responsible for 45% of variance, of which 38% was due to six of the 33 variables studied namely lack of social support, absence of religion as a coping mechanism, poor verbal fluency, use of external attribution and help seeking to deal with stress, and impersonal life events.
It is thus evident that alexithymic individuals are relatively alienated. The reduction in perceived and network social support may be due to alexithymia related deficiencies in social skills. The communication style puts off people who could have been sources of social support, thus, rendering the alexithymic individual to deal with life’s upheavals in isolation. The deficits in verbal fluency coupled with limitations in expression of emotions would not make the alexithymic very socially adept. Social support, which is the most important buffer for the onslaught of negative life events is inadequate amongst alexithymics, making them highly vulnerable. High incidence of undesirable life events, thus reported, may well be due to the lack of external support. Adding to the distress is the fact that internal support in the form of efficient coping mechanisms is also absent in these individuals. The methods used for coping which are directed towards saving the injured ego from hurt rather than using problem solving to take concrete steps to handle stress. Neither are they able to defocus from the problem by using distraction, nor are they able to utilize rationalization by relying on religion, as is commonly observed in the Indian population.

The strength of Indian families is evident from the obtained results. On the one hand, unlike the Western reports of increased alexithymia with age, it was not found in the current study. These contrary findings may be due to the fact that the status of members in terms of respect and decision making persists over time and may even improve with age in our culture. However, it was observed that family has tended to become one of the factors involved in alexithymia. Cohesion reaching the level of enmeshment, and communication marked by over involvement or detouring, was such that the individuality may have been lost for the sake of family belongingness. By being "caring" and providing "support" to the "sick" person, the family tends to withdraw from social networks, resulting in marked increase in the cohesion and communication. However, while this results in while the much needed social support, it also brings in pseudo-normalcy at the face value, and adds to alexithymia at the emotional level.
The above findings have significant implications for the management of alexithymic patients for the medical professionals, families and the policy makers. The treatment providers need to be aware of alexithymic deficits in their patients so that the treatment is modified accordingly. When alexithymic traits in the patients precipitate the counter-transference of boredom and resulting therapeutic impasse, the doctor sensitized to the meaning and functions of patients alexithymic communicative style can modify the treatment to make it more relevant and efficacious.

To this effect the therapy would need to be in the following four stages.

Stage 1: Make the patient an observer of his inner states and their nonverbal cues.
Stage 2: Develop affect tolerance, and hence decrease the perceived frightening nature of affect.
Stage 3: Recognize the emotions as signals that are self-limited in duration and controllability.
Stage 4: Begin to verbalize the emotional states with the therapist as teacher and guide, providing feedback and enhancing self esteem and consequently self reliance and independence in thought and action.

Once the verbalisation develops, patients reliance on physical symptoms as a mode of communication is likely to reduce or even disappear. The therapist handling an alexithymic, while working on the four stages of therapy, has also to focus on the psychosocial aspects. While providing the emotional support as well as becoming a part of patients meagre social support network, efforts have also to be directed at exploring and incorporating the other available sources which an alexithymic is not optimally utilizing. Social skills training aimed at maintaining these contacts and at developing skills for making new social networks, needs to be provided. Getting rid of the inhibitions and actively participating in the social activities, is to be encouraged.
Family counselling should be one of the most important aspects of the intervention. Stable family functioning is to be achieved wherein the members have opportunities for independent thinking and action, and family members working as cotherapists help to draw out the alexithymic to augment his emotional expressiveness. Family is to become the main source of social support.

Therapist must also aim to enhance ego strength and improve self esteem of the alexithymic patients so that he becomes so confident and self reliant that he does not get enmeshed in the family. This will also help in his coping repertoire reaching the level of maturity. The perceived level of negativity of undesirable life events will improve as the coping ability changes. The use of problem solving rather than negative cognitive evaluation or hoping for miracles or dependence on others, would go a long way in handling the unavoidable stresses in life. The focus of therapist must, thus, include coping skills training wherein help seeking and external attribution or magical thinking are substituted by problem solving skills. Cognitive restructuring for modifying the mental set wherein perceptions are negatively evaluative, needs to be substituted by positive evaluative cognitive style so that realistic rather than dysfunctional perceptual mode is utilized. Alexithymics have been found to have higher negative life events. By making their outlook positive, these can be managed more effectively. The same event can be differently viewed by different people. The optimistic and pessimistic perception will determine the level and type of impact that a life event has on the individual. Also, improved problem solving skills, and increased opportunities for taking responsibilities within the family framework in turn will enhance coping and decision making skills; which in turn will make the alexithymic more self reliant in the family context. The consequent improved self confidence and self esteem will in turn result in increased effectiveness in handling stressful life event.

Verbal fluency can be improved by incorporating cognitive retraining in the therapy. Cognitive retraining would not only go a long way in improving verbal fluency, but may also
have a ripple effect on the emotional expressiveness, because both are frontal lobe functions. Tasks included in the cognitive retraining can be specific to frontal lobe i.e. related to information processing skills, attention-concentration enhancement skills and related emotional expressiveness like role playing and modeling.

Hence, rather than rendering the somatoform patients to repeated tests, or being negativistic towards them, there is a need to make a comprehensive therapeutic package for them which includes social skills and coping skills training, emotion enhancement training, social support generation, family counselling and cognitive retraining.

The policy makers have repeatedly been called upon to take effective steps for eradication of illiteracy. The present study furthers this case. The illiterate individuals are a major vulnerable group to exhibit alexithymia and related to it have poor verbal fluency, poor coping skills and a dysfunctional family environment. Lack of education may be a serious handicap in their articulate expression of problems in the clinics. Education would not only improve their expressiveness but would also improve their self confidence. Education has not just its direct effect but it initiates a chain reaction resulting in improved personality functioning. Alexithymia is not specific to somatoform disorders. It has immense clinical significance in both medical and psychiatric settings where it may be colouring the picture of presentation of symptoms as well as be responsible for the inadequacy and ineffectivity of the treatment rendered. Thus, a consultation liaison must be developed between the physician and psychologist so that adequate management can be implemented.

SUGGESTIONS FOR FURTHER WORK

The current study can be a baseline which initiates more intensive work in each of the variables identified, i.e. the study of relationship between alexithymia and social support, life events, coping, family environment and verbal fluency are each independent areas of...
research. The current study is an exploration done in the area while controlling the extraneous factors (sociodemographic factors). But more intensive work is needed to understand the further intricacies and subtleties which mark human behaviour. Specifically, impact of perceived and actual deficits in social support available and a study of possible reasons for the poor social network is needed. Families current functioning has been examined, but the longitudinal work is needed to understand the evolution of this personality trait and its impact on family functioning over the developmental periods. The relationship between verbal fluency and alexithymia requires comprehensive evaluation. There is a need for developing specific measuring instruments for conclusive evidence regarding this relationship. Also, similar works are needed for different psychiatric disorders and certain medical conditions. It would clarify whether alexithymia as a personality trait is universal or not, and if it is, whether or not its manifestation changes in different disorders. Further, the effect of sociodemographic characteristics could be studied by evaluating alexithymia over its various categories.

LIMITATIONS OF THE STUDY

The results of the current study have a fair degree of generalizability. The sample size was good and the gender representation was almost equal. The two groups had been made comparable on their representation of various categories in age, education, occupation and the type of families but there was unequal distribution of sample in their subcategories. Along with the global effects as studied in the current study, there is a need to make comparisons on the basis of category variations. The relationship of alexithymia and verbal fluency cannot be generalized because one of the tests failed to exhibit discriminant validity. A more robust test is needed for the same. Further assessment of families is also called for before its findings are generalized. Specific evaluation of the type of dysfunctional interactions in the family need to be assessed before the clear relationship can be defined.