



Alexithymia and change process: Contributions of a phase model

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Abstract

The research literature shows patients with alexithymia have poorer outcomes in psychotherapy. We reflect upon psychotherapy with alexithymic patients presenting one case study, from a larger research project, throughout 12 sessions. This study used a mixed-methods design with qualitative and quantitative methods exploring both client's and therapist's perspectives. From the client's perspective, different dimensions were explored: emotional process components, symptom severity, therapeutic alliance and the processing capacity regarding the phase-specific general strategies as postulated in the Paradigmatic Complementarity Metamodel (PCM). Regarding the therapist's perspective, we investigated the PCM phase-specific strategic goals promoted throughout the process and the perception of the therapeutic alliance. Quantitative and qualitative data are presented. The client presented a significant change in both alexithymia and symptom severity regarding the reliable change index, being considered a good outcome. The sequencing of general strategies as a phase-by-phase map of the therapeutic process is used to describe the development of client's and therapist's variables. We discuss that considering alexithymia in case conceptualisation may help overcome its impact on the therapeutic process, especially regarding emotional processing and the therapeutic alliance. The implications for psychotherapy intervention are highlighted.

KEYWORDS

alexithymia, case study, change process, emotional processing, integrative approach

1 | INTRODUCTION

Emotional processing difficulties, in particular, emotional regulation, are highly related to psychopathology (e.g., Gross & John, 2003). This highlights the importance of emotions in psychotherapy, and the need to consider the differences between patients in their ability to process emotions when they come to treatment. A condition often associated with emotional regulation deficits is *alexithymia*.

The term was first used by Sifneos (1973) to designate a group of cognitive and affective characteristics typical of many patients with somatic disorders. It was soon identified in several other conditions, such as anxiety disorders, depression (e.g., Zeitlan & McNally, 1993) and personality disorders (e.g., De Panfilis, Ossola, Tonna, Catania, & Marchesi, 2015). It should be noted that alexithymia does not appear to be a substantive feature of any of these disorders, but instead a related, comorbid condition (Taylor, 1984), which means

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that alexithymia should be better understood as a psychological aspect that interferes with cognitive and emotional processing. This perspective would be more useful for clinical decision-making (Ogrodniczuk, Piper, & Joyce, 2005; Silva, Vasco, & Watson, 2013a).

Alexithymia encompasses three fundamental elements, including difficulty identifying feelings, difficulty describing feelings and externally oriented thinking (Taylor, Bagby, & Parker, 1997; for a recent review see Taylor, Bagby, & Parker, 2016). In trying to understand how these processes relate in alexithymic participants, the authors (Silva, Vasco, & Watson, 2017) tested a model in which it was found that emotional awareness and emotional differentiation mediated the relationship between alexithymia and emotional regulation, defined as the ability to engage in healthy strategies to regulate emotions, when necessary, and to engage in adaptive behaviour: first, emotional awareness, which represents the tendency to attend to and acknowledge emotions, and then, emotional differentiation, which constitutes the next step with the individual being able to recognise and assign meaning to his or her emotional experience. Both abilities would enable emotional regulation. The model showed a good fit for both clinical and non-clinical samples. The association between variables was stronger in the clinical sample, which may suggest that even though emotional processing may be better thought of as being on a continuum, when in emotional distress those processes tend to be more correlated (Silva, et al., 2017).

1.1 | Alexithymia and psychotherapy

Alexithymia has been associated with poorer outcomes in psychotherapy (e.g., Leweke, Bausch, Leichsenring, Walter, & Stingl, 2009; McCallum, Piper, Ogrodniczuk, & Joyce, 2003), which seems to be independent of the type of therapy (McCallum et al., 2003). This aspect may be mediated by the therapeutic alliance since the reaction of the therapist to the patient partially mediates the difficulties in communicating feelings and externally oriented thinking style in the outcome measures (symptoms and general goals). That is, patients with alexithymia may have poorer outcomes in part because their therapists perceive them as having less value and less compatibility with them, or they may be seen as less significant members when in group therapy. Therapists may unintentionally express these feelings, which may affect the patient's experience of therapy, contributing to poorer outcomes (Ogrodniczuk et al., 2005). The results of a previous mixed-methods study (Silva, Vasco, & Watson, 2018a) suggested that a significant focus on the therapeutic alliance with alexithymic patients may increase the quality of treatment and also that it may be more useful for case conceptualisation to consider each feature of the alexithymia construct individually.

There is also evidence that the presence of alexithymic characteristics is a predictor of residual symptoms after therapy. Ogrodniczuk, Piper, and Joyce (2004) found that the difficulty identifying feelings was a significant predictor of the severity of residual depressive symptoms after successful psychotherapy treatment, regardless of the initial severity of depression and anxiety, the type of

treatment or the antidepressant drug prescribed. This seems to be met by Taylor et al. (1997), who stress the risk of the focus of therapy to be in the consequences of emotional difficulties, rather than on the emotional difficulties itself.

Nevertheless, there are findings that suggest alexithymia is partly modifiable with therapeutic interventions: studies that directly targeted alexithymic characteristics tend to report significant reductions in alexithymia scores following treatment, whereas studies that measured changes in alexithymia but did not employ any psychological interventions specifically intended to treat alexithymia have more inconsistent results (for a review, see Cameron, Ogrodniczuk, & Hadjipavlou, 2014).

Taking these into account, we emphasise the need for an adequate therapeutic approach, which explores emotional states, improves emotional processing and focuses on the therapeutic alliance. It also illustrates the need for more studies on the subject, especially regarding the therapeutic process. Ogrodniczuk (2007) stresses the importance of identifying forms of therapeutic communication that effectively reduce alexithymic functioning so that psychotherapy can be more responsive to the needs of patients. In line with this idea, Taylor (2000) suggested that the use of psychotherapy involving specific techniques to increase emotional awareness and integrate symbolic elements of emotional schemes may be beneficial in reducing alexithymic characteristics.

Although there is a lack of research on adequate psychotherapies for alexithymic patients, the research on emotional processing and the process research on psychotherapy may help enrich our understanding of alexithymia and alexithymic patients. Considering the variability associated with patients with alexithymia, and that the goal of this study was to better understand their therapeutic process, rather than developing or studying a specific therapeutic approach, the Paradigmatic Complementarity Model (PCM; Vasco, 2006; Vasco, Conceição, Silva, Ferreira, & Vaz-Velho, 2018) was used as a guide.

1.2 | Paradigmatic complementarity

The PCM grounds on complementary and sequential uses of common factors or general principles of change and specific techniques, derived from various theories and suited to patients' characteristics and needs (Vasco, 2006). One of the research fronts in Paradigmatic Complementarity is the temporal sequence of phases structuring strategic therapeutic goals. This sequence of phases is believed to be a general principle of change among different theoretical orientations, both of an integrative and of a single-nature (Vasco, 2006, Vasco, et al., 2018). According to this proposal, the therapeutic process unfolds as both patient and therapist progress along the following phases of general strategies: (a) trust, motivation, hope building and relationship structuring; (b) increasing awareness of self and experience; (c) new meaning-making regarding self and experience; (d) regulation of responsibility; (e) implementation of repairing actions; (f) consolidation of change; and (g) relapse prevention and

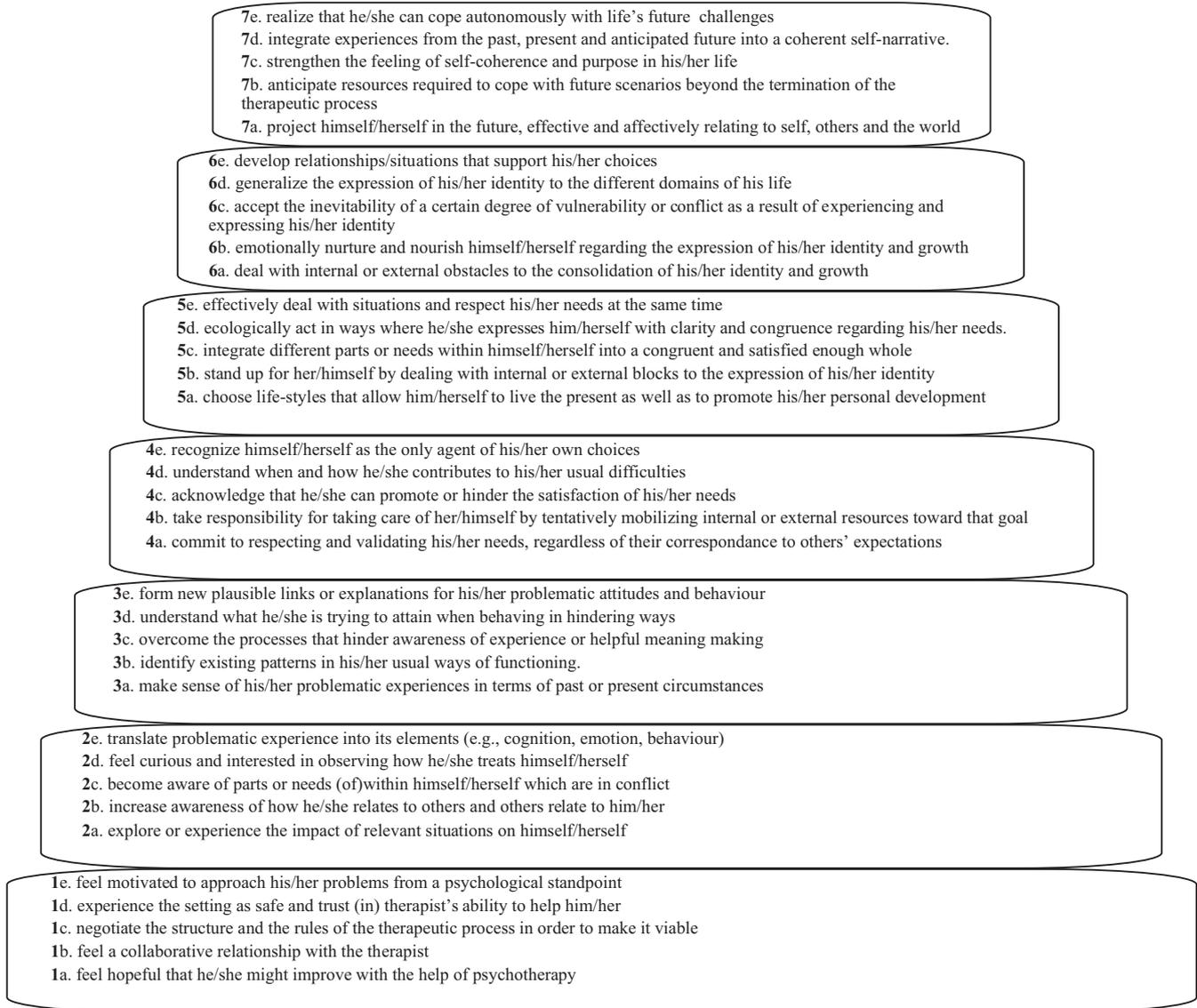


FIGURE 1 Paradigmatic complementarity phases sequential component. Note: From 'If you want to get ahead, get a sequence of general strategies: integrative decision making in real-world psychotherapy', N. Conceição, 2010, Ph.D. thesis, manuscript not published

projection of self in the future (Figure 1). These phases may overlap in part, meaning that when the therapist is mainly promoting the objectives of one phase, he is also, complementarily, promoting objectives of adjacent phases. Tendentially, the higher the linearity of the sequence, the lower the complexity of the case. This model presents the advantage of integrating different orientations, allowing the combination of relational, cognitive and emotional components, offering enough flexibility for integration. There is already evidence regarding the temporal sequence of strategic objectives as promoted by therapists (Vasco, 2006), and evidence regarding the sequential development of capacities or intermediate outcomes by the patient (Conceição, 2005). We suggest that, regarding alexithymic patients, more time and attention should be taken in the implementation of goals in the initial phases, namely (a) trust, motivation, hope building and relationship structuring, especially concerning security and trust and increasing motivation; and (b) increasing awareness of self and experience, especially concerning emotional processing. These

two phases seem to meet the needs reported when working with patients with alexithymia (Silva, Vasco, & Watson, 2013b), such as the difficulties in creating a good therapeutic alliance and deepening the exploration of emotional experience and self: listening to patient's concerns and problems; validating patient's distress and pain; promoting trust, hope, security, and motivation and bonding with the patient (phase 1) and helping patients differentiate problems; differentiating between feelings, thoughts and actions; increasing awareness of interpersonal relationships and conflicts; and increasing awareness of self-characteristics, rules and conflicts.

1.3 | Present study

The association between alexithymia and poor outcomes in psychotherapy seems recognised, but there are still several questions that remain unanswered, especially regarding how therapy unfolds and

what contributes to better outcomes: How does alexithymia impact on outcome? How do client and therapist experience the relationship? Do they perceive the difficulties in the relationship due to alexithymia? What special care should therapists have with alexithymic patients in psychotherapy? What may be the usefulness of the construct in case conceptualisation?

Guided by these questions, we selected a participant starting therapy with a high level of alexithymia from a larger research project (Silva, 2014) to present as a case study. Our goal is to deepen our understanding of what is happening in therapy when working with a client who has a high level of alexithymia. As mentioned earlier, we do not attempt to study or develop a specific therapeutic approach but rather think in terms of processes.

Considering the literature, and our own clinical experience, we would expect that a perceived better therapeutic alliance, a focus on the therapeutic alliance (phase 1), a focus on increasing awareness of the experience and the self (phase 2), and also a focused work, meaning being focused in implementing goals of a specific phase and its adjacent phases, would result in better therapeutic outcomes.

2 | DESIGN

We selected one case from a larger research project (Silva, 2014; for a characterisation of the full sample, see Silva, et al., 2018a). We present a case study using a mixed-methods design with qualitative and quantitative methods exploring both client's and therapist's perspectives. Details are presented in the Procedure section, below.

3 | METHODS

3.1 | Participants

The therapist was a clinical psychologist with a cognitive-behavioural approach. The client was a female in her early sixties and retired, who sought therapy for 'dealing with her depression' (see full description below).

3.2 | Measurement

3.2.1 | Alexithymia

The Portuguese version of the Toronto Alexithymia Scale (TAS-20) was used to measure alexithymia (Bagby, Parker, & Taylor, 1994). The TAS-20 is a 20-item self-report measure composed of three subscales: Difficulty Identifying Feelings (DIF), Difficulty Describing Feelings (DDF) and Externally Oriented Thinking (EOT). Items are rated on a 5-point scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Scores less than or equal to 51 reflect *non-alexithymia*, scores of 52–60 reflect *possible alexithymia*, and scores of 61 or

higher reflect *alexithymia*. Analysis of the Portuguese version supported the construct validity of the three subscales. Internal consistency is 0.79 for the total score (Prazeres, Parker, & Taylor, 2000).

3.2.2 | Emotional awareness and emotional regulation

The Subscales *Lack of Emotional Awareness* and *Limited Access to Emotion Regulation Strategies* of the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) were used to measure these constructs. The DERS is a 36-item self-report measure designed to assess the complexities and clinically relevant difficulties of emotional regulation, including awareness, modulation of arousal and modulation of expression. Items are rated on a 5-point scale, ranging from 1 (*almost never*, 0%–10%) to 5 (*almost always*, 91%–100%). The *Subscale Lack of Emotional Awareness* consists of items reflecting the tendency to attend to and acknowledge emotions. When these items are appropriately reverse-scored, this factor reflects inattention to, and lack of awareness of, emotional responses. The Portuguese version showed an internal consistency of 0.74. The *Subscale Limited Access to Emotion Regulation Strategies* considers the strategies one implements when regulating emotions. It consists of items reflecting the belief that there is little that can be done to regulate emotions effectively, once an individual is upset. Internal consistency is 0.87 for the Portuguese version of this subscale (Vaz, Vasco, Greenberg, & Vaz, 2010).

3.2.3 | Emotional differentiation

The Subscale *Emotional Differentiation* of the Portuguese version of the Range and Differentiation of Emotional Experience Scale (RDEES; Kang & Shaver, 2004) was used to assess emotional differentiation. The RDEES is a 14-item self-report measure composed of two subscales: Range and Differentiation. Items are rated on a 5-point scale, ranging from 1 (*does not describe me very well*) to 5 (*describes me very well*). The *subscale Differentiation*, used in this study, is constituted by eight items and assesses the ability to make subtle distinctions between similar emotions and showed an internal consistency for the Portuguese version of 0.82 (Vaz, 2009).

3.2.4 | Severity of symptoms

The severity of symptoms was measured using the Portuguese version of the Brief Symptom Inventory (BSI; Canavarro, 1999; Derogatis, 1993), a reduced version of the SCL-90 with 53 items, in which participants rate the extent to which they have been disturbed in the past week by several symptoms (0 = *not at all* to 4 = *extremely*). The BSI has nine subscales designed to assess individual symptom groups (e.g., somatisation, depression, anxiety).

In this study, we used the Global Severity Index (GSI) as a general measure of the severity of symptoms. The Portuguese adaptation was made by Canavarro (1999), showing good psychometric properties. A value ≥ 1.7 may point to an emotional disturbance (Canavarro, 1999).

3.2.5 | Therapeutic alliance

Concerning the therapeutic alliance, we used the Working Alliance Inventory—Short Form (WAI-S; Horvath, 1981; Horvath & Greenberg, 1989; Revision, Tracey & Kokotovic, 1989). The WAI-S is composed of three dimensions regarding the conceptualisation of Bordin (1979): bond, and agreement between therapist and patient on goals, and on tasks. Participants report the frequency of feeling and thoughts concerning the other element of the therapeutic dyad, on a Likert scale from 1 (*never*) to 7 (*always*). The short version has 12 items, four for each dimension (Tracey & Kokotovic, 1989). In this study, only the global score was used. Internal consistency for the Portuguese adaptation is 0.89 for the patient version and 0.85 for the therapist version (Machado & Horvath, 1999).

3.2.6 | Paradigmatic complementarity

Therapist

To assess the therapeutic interventions regarding the PCM, we used the General Strategies Inventory—Therapist's Operations Form (GSI-Top/t; Vasco & Conceição, 2008). It is the 4th version of the GSI-Top/t, developed in 2000 (Conceição, 2005). This version has 35 items and assesses the strategic goals promoted by the therapist in a specific session on a Likert scale from 1 (*not at all descriptive*) to 7 (*totally descriptive*). The therapist answers the extent to which the items describe the processing he/she tried to promote in the patient. It results in seven scores regarding the different phases of the model. The focus on a single, recent session allows for the general strategies to change during therapy and avoids assuming that respondents can accurately remember and summarise details of the strategic goals across weeks or months. Standardised item alphas for the GSI dimensions 1, 2, 3, 4, 5, 6 and 7 were 0.80, 0.57, 0.70, 0.67, 0.75, 0.70 and 0.70, respectively.

Patient

To assess the patient's developing ability regarding the PCM, we used the Patient's Change Processes Form (GSI-Pcp/t; Vasco & Conceição, 2008). The GSI-Pcp/t is a 35-item self-report. The patient answers on a scale from 1 '*not at all descriptive*' to 7 '*totally descriptive*', reflecting the extent to which the items describe his/her capacity at the present moment in psychotherapy. We can obtain a total score of ability or seven different scores concerning the different phases as explicated in the model. The psychometric data showed high levels of internal consistency of the subscales: 0.81, 0.83, 0.87, 0.86, 0.89, 0.89 and 0.88, respectively.

3.2.7 | Interview

To assess therapist's and client's perspectives regarding the change process, we developed two individual semi-structured script interviews. It followed the principle of starting with open questions and then closing them for issues that were considered essential, such as the participant's perspective on the therapeutic alliance, emotional processing and change process (for a brief version of the script, see Silva, et al., 2018a).

3.3 | Procedure

The project received research ethics committee approval from the Faculty of Psychology of the Lisbon University as well as the institutions where data were collected. The therapists who agreed to participate invited clients starting outpatient psychotherapy to the study. This invitation was made before the first session, and if the client accepted, both client and therapist signed written consent were assured of confidentiality and that they could leave the study at any point without interference with their treatment. An assessment with standardised self-reports for the outcome measures (symptoms, alexithymia, emotional awareness, differentiation and regulation) was made at the first and eighth sessions and then at the end of therapy (in this case, the 12th session) or the end of the study (the 16th session). Every two sessions (2nd, 4th, 6th...), an assessment was made with self-reports regarding the PCM and the therapeutic alliance from both client and therapist. At the end of the study, a semi-structured interview was conducted with both participants individually. This case was chosen from four alexithymic cases considered good outcomes. Since this was a naturalistic study, and the other cases were still ongoing after it ended (16 sessions of assessment), this case was selected. Being a CBT therapist was a casual condition.

3.4 | Data analyses

The first step of analysis concerned the integration and triangulation of the therapist and client experience, which is described in detail. A description of the interviews was made focused on the perception of both participants on change and how it occurred, the evolution of the therapeutic alliance and the client's emotional experience. When analysing the interviews, we wanted to stay as close to the informant's concrete and contextually anchored experience as possible, while exploring their views of what felt significant in the therapeutic process (Elliot & Shapiro, 1992). We also wanted to connect their experiences with what was observed in the self-reports. Concerning the outcome, both the reliable change index (RCI) and the client's perspective were considered. The RCI (Christensen & Mendoza, 1986; Jacobson, Follette, & Revenstorf, 1984; Jacobson & Truax, 1991) can be used to compare pre-post results of psychotherapy, considering the standard error of measurement. In the present study, we used the adaptation by Evans,

Margison, and Barkham (1998), which provides the RCI below which 5% of the difference may be due to error. This formula considers the reliability and standard deviation of the instrument. The data used to calculate the RCI came from the original Portuguese studies for all measures.

4 | CASE STUDY

Victoria was a female in her early sixties, retired and working with her husband in a family business. She mentioned depression as her main difficulty. The therapist elaborated that her depression was associated with several unresolved grief processes. She was seeing a psychiatrist and took anxiolytic and antidepressant medication for several months before entering therapy, mainly for sleeping, which she mentioned not needing by the end of therapy. It was her first psychotherapeutic process. It was considered a good outcome case from both client's and therapist's perspectives. The client started therapy with a high level of alexithymia (TAS = 76) and completed a total of 12 sessions. She presented a significant positive change in both alexithymia and symptom severity regarding the RCI (Table 1).

Victoria presented herself as a pleasant person in the interview. She talked freely about several events in her life. Victoria did not use many emotional words, although she spoke about feeling guilty and anguished. She referred to anguish as the most prevalent emotion at the beginning of the treatment. When asked about emotions and emotional changes, she usually responded with yes/no answers and did not elaborate, using physical terms, for example: *'At first it was a squeeze, but I think that it is also passing. (...) to release this tension that I had, that anguish at... at... chest anguish, I think that had passed now, at least if not completely at least 95%'*. Patient interview—9'39"

4.1 | Emotional change

The therapist referred that her changes were mainly symptomatic, which was her beginning goal: *'to relieve the depressive symptoms'*. Concerning emotional processing, she significantly decreased her lack of emotional awareness. Although there was also an increase in emotional differentiation and a decrease in limited access to emotional regulation strategies, they were not significant considering the RCI (Table 1). This seems to be in line with her symptomatic and alexithymia changes. Although she referred to feeling freer (sensation), the client seems to attribute this change to cognitive changes: *'not thinking of certain aspects the way I thought, I think it helped not being so depressed, right?'* Patient interview—16'23"

The therapist mentioned that: *'At the beginning, she was slightly gloomy, with little facial expression, a very descriptive speech, without great elaboration and with some quite repetitive contents. (...) she became more expansive, more open. (...) with a more pleasant contact, but not more open to new experiences, that was something that did not change. From a cognitive point of view, we were able to work but then stopped'*. Therapist interview—6'40".

TABLE 1 Evolution of the case considering the RCI

| Variable | Alexithymia (TAS-20) RCI = 12.7 | | Symptom severity (BSI) RCI = 0.89 | | Awareness (lack) RCI = 5.94 | | Differentiation RCI = 9 | | Regulation (limited) RCI = 7.22 | | DIF RCI = 7.19 | | DDF RCI = 6.92 | | EOT RCI = 7.87 | | | | | | | | | | | | | |
|----------|------------------------------------|-----|--------------------------------------|------|--------------------------------|-------|----------------------------|-----|------------------------------------|-----|-------------------|-----|-------------------|-----|-------------------|-----|----|----|-----|----|----|-----|------|-----|----|----|----|----|
| | 1st | 8th | 1st | 8th | 1st | 8th | 1st | 8th | 1st | 8th | 1st | 8th | 1st | 8th | 1st | 8th | | | | | | | | | | | | |
| Session | 76 | 67 | 58* | 2.26 | 1.92 | 0.92* | 27 | 22 | 22 | 18* | 26 | 31 | 34 | 28 | 27 | 24 | 31 | 25 | 23* | 21 | 19 | 14* | 12th | 8th | 23 | 24 | 23 | 21 |

*Significant change considering the RCI.

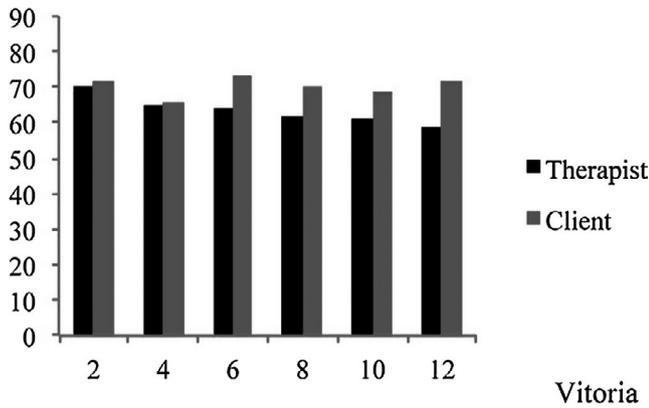


FIGURE 2 Therapeutic alliance through therapy

4.2 | Therapeutic alliance

The client perceived the therapeutic alliance as good (Figure 2). Victoria described it vaguely and seemed to be more focused on the bond, comparing it with a friendship: *'There was, there was, yes [empathy], but then I believe we build up a friendship and we talked of other things (...)'*. Patient interview—11'12"

When observing Figure 2, Victoria reported high levels of alliance quality throughout therapy. Although the data from the therapist also pointed to good levels of alliance quality, a slight decrease was observed. Integrating the interview data, it is understood that: *'...sometimes it was difficult to deal with the variables related to empathy (...) she was a person a bit monotonous, alexithymic. Furthermore, sometimes, for you to understand... that is, one has to have emotional markers to understand what is happening in therapy, and that turned out hard because on this client it was hard to identify emotional markers and even harder to verbalize them'*. Therapist interview—5'44". From this excerpt, it is observable that the therapist sensed the client as alexithymic and mentioned difficulties in the alliance related to it. One interesting aspect was that this slight decrease in the alliance quality from the therapist's perspective did not seem to affect the client's experience. Perhaps being aware of this aspect made it possible for the therapist not to act on it, as will further be illustrated.

4.3 | Therapeutic process—paradigmatic complementarity model

Regarding the therapeutic work—Figure 3 integrates in each heptagon both client and therapist experience from the corresponding session—the therapist seemed to be more focused: in session 2, the therapist was focused on building the alliance (phase 1) and on increasing awareness of self and experience (phase 2) and new meaning-making regarding self and experience (phase 3). Then, he continued to focus on the alliance and phases 3 and 4 (regulation of responsibilities). Then, he oscillated between phases 2, 3, 4 and 5 (implementation of repairing actions). Globally, he seemed more focused at the beginning and then started implementing different goals from several phases. Considering the previous studies on the

PCM, implementing different goals of several phases, and not being so focused in one phase and its adjacent phases, means that the case may be complex and represents a feeling of being lost from the therapist perspective, which can be associated with the previous aspects mentioned by the therapist at the interview: *'...one has to have emotional markers to understand what is happening in therapy, and that turned out hard because on this client it was hard to identify emotional markers and even harder to verbalize them'*.

Interestingly, in almost all assessed sessions, the therapist implemented goals of phase 2, which we consider especially relevant when working with alexithymic patients in psychotherapy. The therapist believed that he was more focused on the cognitive work and the patient responded well:

'I quite honestly think it was the work of cognitive reframing to explore alternatives because there was a substantial component of guilt in grief and it was possible to work from a more cognitive standpoint. She engaged in some behavioural experiments, and I think it was positive because it clearly opened the range of perspectives, and I think it is a case where the cognitive work results in an obvious way'. Therapist interview—2'48"

He also mentioned that he overcame the empathy difficulties: *'when we started to put together some things related to her narrative, I could see that there were things that were part of her functioning and how she related to others, that perhaps was with a lower agreeableness, with less ability to disclose because of her personal history. Moreover, maybe that helped... (...) I stopped seeing her as a distant person, almost like 'because I do not want to relate to you' (...), but maybe one person whose story made sense (...) When I could conceptualise something, I think that I did well in terms of feeling empathy towards the patient'*. Therapist interview—9'20"

Although the therapist was promoting the goals of several different phases (Figure 3), he was highly aware of these difficulties and was able to integrate them within the case conceptualisation. The patient perceived her capacities as growing, although with a small decrease in the middle of the process (session 6). Noticeably, her abilities were growing when comparing the assessment from session 2 with the end of therapy (Figure 3). From the interview, it is understood that the client perceived therapy as focused on advice and was sometimes vague in her report of changes: *'I would talk to the THERAPIST, he would say, and I would think, and then I said "maybe he is right," first I thought he wasn't right, but we... I believe we have a good relationship, and in session I would agree with him, but then I would come outside and question if it was like that, but things evolved, and I believe he is right in his words and I have been feeling freer'*. Patient interview—7'10"

5 | DISCUSSION

5.1 | Emotional processing and therapeutic alliance

The importance of emotions in psychotherapy is unquestionable; however, there are apparent differences between patients in their ability to process emotions. Considering these differences, it seems necessary to reflect upon better ways to intervene in psychotherapy in order to achieve satisfactory therapeutic outcomes.

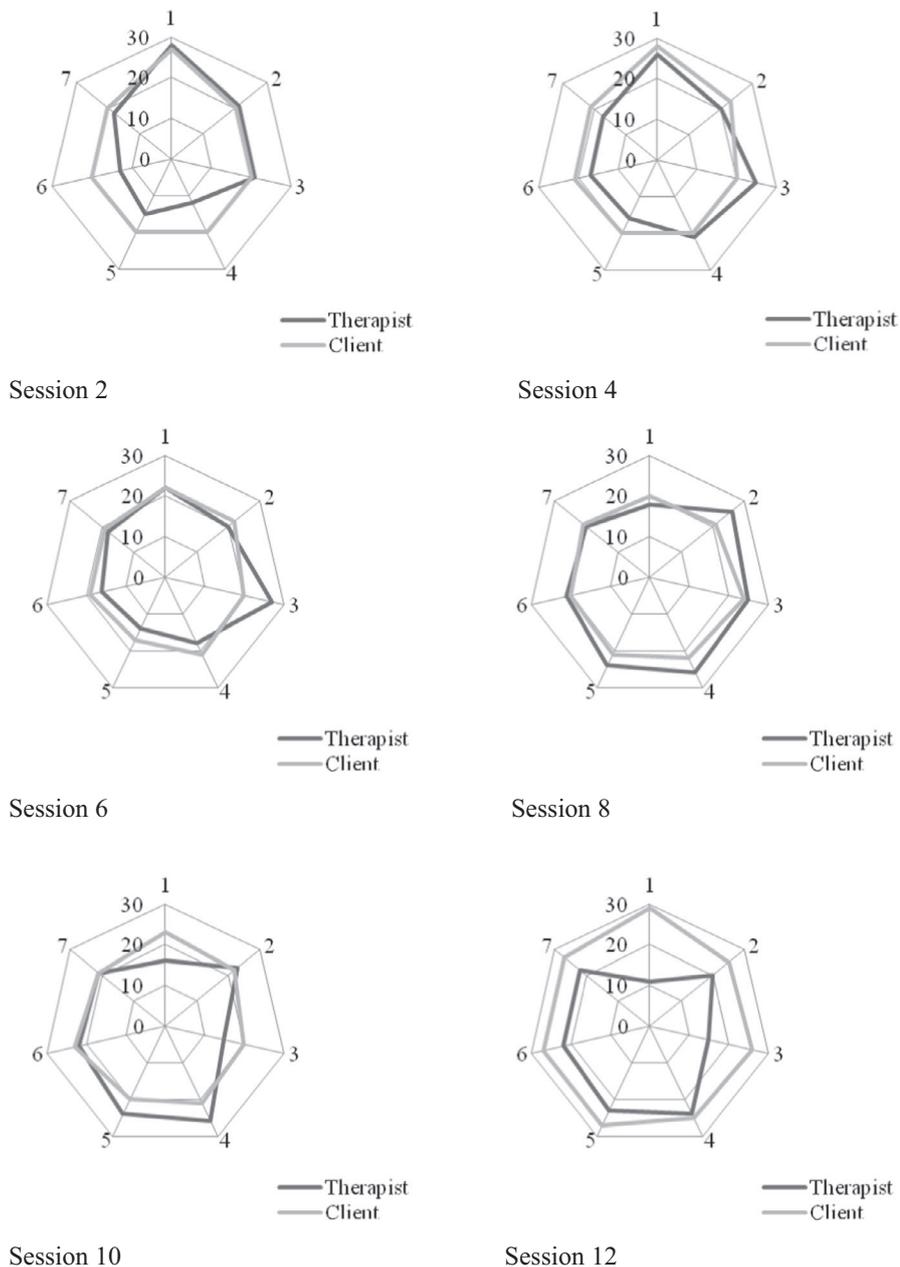


FIGURE 3 MCP client and therapist perspective

Most psychotherapeutic approaches assume that individuals have at least some awareness of, and have access to, their emotions. The characteristics associated with alexithymia appear to be extremely important in the therapeutic process because they may hinder the effectiveness of psychotherapy if not considered.

In this case study, our goal was to deepen the understanding of what is happening in therapy when working with a client that has a high level of alexithymia, and particularly to have both client and therapist perspectives. A client who had an initial high level of alexithymia that significantly decreased was presented.

The therapist perceived the client as alexithymic—identified blunted affect, low facial expression, and a descriptive and repetitive speech—and attributed the difficulties in the therapeutic alliance to this impairment. Although the quality of the therapeutic alliance slightly decreases, even though with good enough values, he was

aware of the difficulties regarding empathy, which made it possible to, with the help of case conceptualisation, overcome them and integrate the information in order to make use of it in therapy. The therapist felt that because of her functioning, they were focused on cognitive work, which allowed symptomatic changes. Although a more cognitive and behavioural work, it incited changes in emotional processing, and the client seemed more aware of her emotional processing. This aspect is something that may be expected when in the presence of an alexithymic patient—regarding the emotional processing difficulties, being more focused on cognitive or behavioural interventions. From the interview, it was felt that she did not use many emotional words, and although she spoke freely about several important events in her life, this was not accompanied by an emotional narrative. She was able to deal with her depressive symptoms, but the therapist mentioned that she was not more open to new experiences. One crucial aspect

regards the awareness of the therapist of these difficulties and being able to integrate them in the case conceptualisation.

Considering the small number of sessions—12 sessions—it could be argued whether alexithymia itself was being treated, or whether, when one treats depression in the context of high TAS-20 scores, TAS-20 scores improve simply because depression improves: if someone is in a negative mood and tends to be pessimistic, when asked to make ratings on self-reports, such as the TAS-20 or other self-report measures, on their ability to do things like identify their emotions, they may rate their abilities more negatively simply because of the negative mood; conversely, when their mood improves, they may rate their abilities more positively. Also, the client was taking antidepressants. Nevertheless, she was taking antidepressant for several months before entering therapy, and it can also be argued, considering the interviews, that her depression was associated with unresolved mourning processes, which may give strength to the relationship hypothesis. Being understood, and having a place to explore her difficulties, may have contributed to accessing her own feelings and deepening her self-awareness, contributing to the decrease in depressive symptoms. Revisiting the therapist interview: *'... I stopped seeing her as a distant person, almost like 'because I do not want to relate to you' (...), but maybe one person whose story made sense'. We did not explore core themes in the client development, but one could argue that there may have been some aspects related to the relationship with her caregivers who may have contributed to her alexithymic characteristics, especially because the mourning processes were related to her parents. Given the importance of attachment in theories of affect regulation, several studies have examined the relationship between attachment style and alexithymia (e.g., Scheidt et al., 1999; Troisi, D'Argenio, Peracchio, & Petti, 2001), presenting a positive correlation between alexithymia and insecure attachment styles. Curiously, she improved in her lack of emotional awareness, on difficulties identifying and describing feelings, but not externally oriented thinking or emotional regulation strategies (Table 1), which would be expected if it was only a matter of improving depression and seeing herself more positively.*

Another explanation could relate to the actual profile of emotional experiences in the depressed state compared with the improved state. With significant clinical depression, there is a flattening of mood and loss of emotional reactivity. In this context, it would be difficult to tell the difference between different emotions. Actually, she did not improve significantly in differentiation from 1 point, making this explanation possible. This may contribute to the discussion of whether TAS-20 scores actually reflect alexithymia as a trait-like (personality) deficit. Although alexithymia has been predominantly seen as a personality construct, we reiterate that alexithymia should not be thought of as a disorder (Silva, et al., 2013a) and would be better understood as a psychological aspect that interferes with characteristics of thoughts, feelings and underlying cognitive and emotional processing. So it should not be thought regardless of other characteristics of the client at that moment in his/her life and should be considered both as a trait and a state phenomenon. Also, it may be more useful for case conceptualisation to consider each feature of the alexithymia construct individually in order to make it

more useful for clinical decision-making. Nevertheless, it should be noted that its impact may depend upon other characteristics, and other variables should be taken into account, including personality, severity of the diagnosis and emotional difficulties. This case mirrors what we believe are the difficulties and the potential work with a client with alexithymia in psychotherapy. One should have in mind that, from the therapist's perspective, this client did not present a personality disorder. Cases with alexithymic characteristics and a personality disorder certainly may present further challenges (Silva, Vasco & Watson, 2018b).

The expression of empathy, especially from the therapist, may be helpful since it seems that the process may be blocked in alexithymic patients. Empathy has many functions. As an interpersonal function, it allows the understanding of others, their goals, intentions and feelings. Empathy also facilitates exploration, and promotes openness to experience and a curious attitude towards emotional experience, while enabling the deconstruction of assumptions and values. Through empathy, the therapist can help clients access their emotional experience, identify emotion schemes and facilitate clients' emotional processing in session. Empathy assists clients with self-reflection (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002), which may be extremely important with alexithymic patients. Alexithymia is an emotional difficulty associated with many different disorders. Reflections upon specific psychological processes that may facilitate psychotherapy, independently of the therapeutic approach or disorder, are needed.

In our research, alexithymia was not defined as a personality characteristic, and we were more focused on emotional processing. Nevertheless, considering the impact this emotional difficulty presents in the therapeutic relationship, as well as in the relationships in patients' lives, it seems clear why it has been referred to as a personality characteristic: the impact on relations may be what makes alexithymia 'visible' in everyday life. Although a more standard evaluation may be made to assess alexithymia, being focused on the relationship and the difficulties that may arise from it may also indicate a possible alexithymic functioning.

5.2 | Psychotherapeutic interventions and paradigmatic complementarity

Research has shown that complex cases tend to be less sequential than more straightforward cases (Conceição, 2005). Even though we did not present a case to compare, this seems visible on the case presented: in some sessions, the therapist seemed more dispersed (Figure 3), which seems in line with the difficulties expressed at the interview. As previously mentioned, we suggest that with alexithymic patients, more time should be taken, providing therapeutic work associated with the beginning phases. Watson, Goldman, and Greenberg (2007) suggested that cases with better therapeutic outcomes appear to be associated with good therapeutic relationships starting early in psychotherapy and the ability to be attentive and process emotional information—which we assumed would constitute

a problem for patients with alexithymia. In their case studies, for none of the patients with poorer outcomes was it easy to express their feelings and feelings of shame made it difficult to share their experiences with the therapist.

The use of PCM may be a proper orientation and a helpful guide in psychotherapy. These charts (Figure 3) may help to guide interventions. It shows therapists how lost/focused they are and whether the interventions promoted are attuned with the patient's perception of abilities/gains.

The goal of this study was not to develop or test a specific intervention with an alexithymic patient. We believe that considering the initial level of alexithymia will help to contribute to better outcomes, in three interrelated ways: better understanding of the emotional difficulties of the client; better understanding of the negative feelings the client may provoke; and, in doing so, making it possible to deal with the difficulties that hindered the implementation of emotional and relational work that the clients may need. In light of this, alexithymia should be considered in case conceptualisation.

5.3 | Limitations, suggestions and future perspectives

It is recognised that no single case study can do more than slightly increase the accuracy and credibility of a theory (Stiles, 2005), idea or perspective. Likewise, insofar as the authors are fallible and come with biases, it is likely that at least some aspects of this case could be interpreted differently by different observers. We tried to address this by presenting enough material to allow readers to form some impressions of their own.

Carrying out more case studies considering the initial alexithymia level seems essential to the development of this research field. The accumulation of cases would make it possible to determine which therapeutic principles represent universal characteristics of effective work with an alexithymic functioning, and which principles are less central. We consider that research into the alexithymia construct would become richer if it included several measures of the construct, such as an alexithymia interview. Even though the TAS-20 version for the Portuguese population presented good psychometric properties, it demands the use of introspection in subjects who are supposed to have deficits in affective (self)awareness, so using several measures of the construct would have enriched the discussion and the comprehension of the case. Also, case studies wishing to study processes in psychotherapy become richer when it is possible to cross quantitative data with observations of sessions, or excerpts of sessions, which allows access to what is done and not only the participant's report of the process. Moreover, follow-ups would have permitted access to further development of the client, which would be helpful.

Our goal was to deepen our understanding of what is happening in therapy when working with a client who has a high level of alexithymia, and our reflections clearly need further replication with sounder multimethod assessment. Nevertheless, we hope this study stimulates further investigation into the case study on alexithymia.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

ETHICAL APPROVAL

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The project received research ethics committee approval from the Faculty of Psychology of the Lisbon University as well as the institutions where data were collected.

INFORMED CONSENT

Informed consent was obtained from all individual participants included in the study.

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