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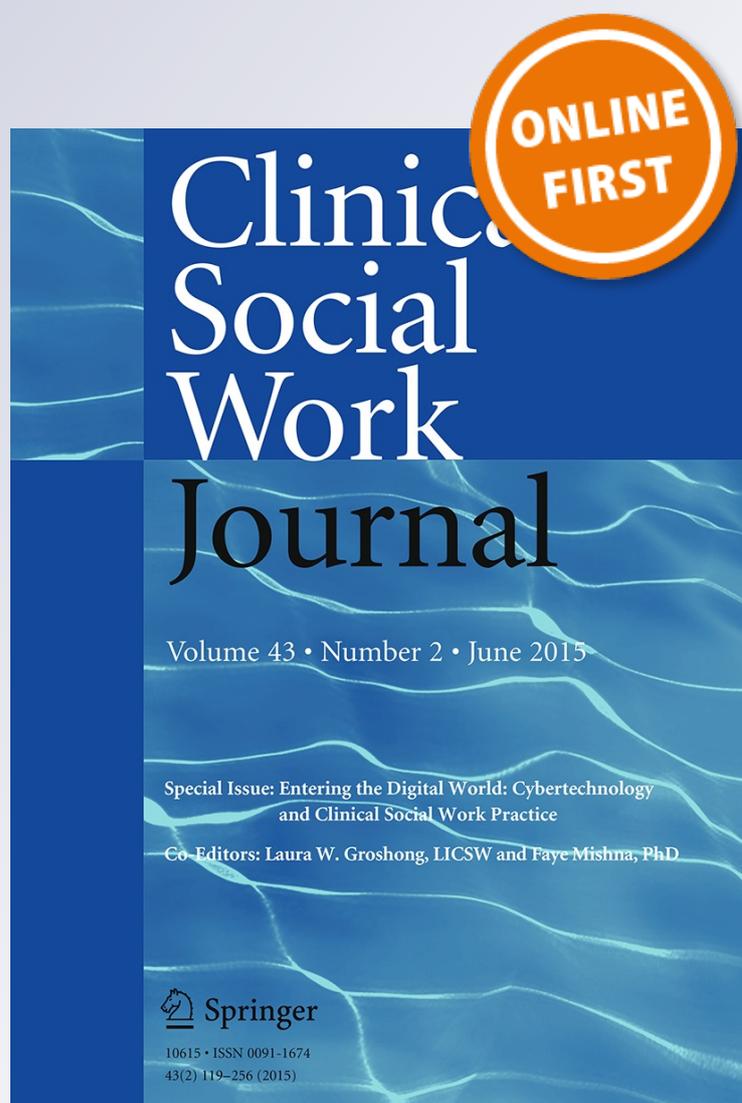
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Listening to Words, Hearing Feelings: Links Between Eating Disorders and Alexithymia

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Abstract Research suggests that eating disorders often involve difficulty with affect regulation and processing of emotions. Studies also show that many individuals with these difficulties suffer from alexithymia, or an impaired ability to use language to tolerate or process emotions. Many clients with eating disorders are highly verbal, able to talk about feelings and even have good insight into the causes of their behaviors. Yet their verbal and cognitive strengths may disguise their inability to use thoughts to manage their emotions. Such clients often have a lifelong experience of appearing more capable and competent than they feel. Self-criticism and negative self-image concretized in a negative body image are part of their eating disorder. Therapeutic exploration can increase anxiety and self-criticism, aggravating feelings of inadequacy and the concomitant need for self-soothing. Techniques that focus on affect regulation have been shown to be effective, yet a psychodynamic approach can be an important tool in such an integrative practice. In this article, clinical material and theory will illustrate some of the ways that incorporating an understanding of alexithymia into the work can enhance the use of both psychodynamic exploration of meaning and also tools to manage affect and change behavior.

Keywords Eating disorders · Body image · Eating disorders and alexithymia · Eating disorders and failure to process affects · Eating disorders, language and affects · Eating disorders and lack of signal emotions

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Even with all my languages, there still aren't the right words.

Julia Cho, *The Language Archive*

Catherine came to see me shortly before her 30th birthday. She was articulate and intelligent and spoke such unaccented, clear English that I was surprised when she said that it was not her first language and that she had only moved to the United States 10 years earlier. She had learned English as a child and seemed both proud and not completely sure of her fluency. This piece of information would be important in the course of our work. She also said that she had struggled with her weight all of her life and had lost seventy-five pounds in the past year. But she was not coming to see me about her weight. She made it clear that she had things under control in that arena and indicated that she did not need—or want—my input about it.

She had come to therapy for help with a “situation.” She had become involved with a man named Samuel, and although the relationship was not sexual, it was more intimate than most of her connections to other people. Catherine's was a solitary life, with very few relationships managing to get through her protective boundaries. Even the very limited link with Samuel had been disruptive to her feelings of well-being, but until recently it had been more or less manageable. Now it had become problematic. However, even though she understood that there were multiple factors involved, when I asked Catherine to talk about the situation, she had difficulty explaining anything other than the concrete facts. She wanted to give me some background that she thought might help me understand something about the problem. She had grown up believing that her family had little money. She had often felt deprived, not of basic things, but of toys or electronics and other “extras” that her peers enjoyed. When she asked for

something that she saw at a friend's house, she was told to wait for Christmas or her birthday, only to be regularly disappointed by the gift that she actually received on those holidays. As an aside she said that a previous therapist had linked this feeling of deprivation with her eating problems, that her inability to control her eating had to do with that childhood feeling of being repeatedly disappointed and unable to get her needs met. She also mentioned that buying clothes had been traumatic, because she was bigger than many of her peers, and her mother had always had difficulty finding clothes that fit her. Catherine believed that the larger sizes that she needed were more expensive as well, adding to the pressure that she felt from very early to "be smaller."

Her parents had both died more than ten years before our first meeting, her mother of a long, drawn out illness that ended before Catherine was eighteen, her father a few years later. To her surprise, they had actually accrued enough money to leave her a substantial inheritance. Catherine used some of the money to pay for college, but otherwise continued to live as she had when her parents were alive. After graduation she found a job and supported herself on the income from it. No one but her family and her therapists knew about the inheritance until she told Samuel about it. Shortly after this revelation, he began asking her for small loans. She had gradually realized that he had no intention of paying her back. "It's only a small amount," she said, "but I don't want to keep giving it to him." Catherine was puzzled that this bothered her so much since, she reiterated, the amounts were always small. It should not have been "a big deal." I said that small things could still be big issues and Catherine sighed. When I asked if she could say what she was feeling, she seemed surprised. She had not been aware of sighing and had no idea what she was feeling at the moment. She said, "I don't know what I feel. I just want to know what to do."

Such a statement can be troubling to a psychodynamically-oriented therapist, yet in my experience, it is not uncommon for clients with eating disorders to have some variation of this response—albeit not always put quite so bluntly—when asked about feelings. Research has linked a number of eating disorders to alexithymia, that is, an inability to use thoughts and words to help process feelings (e.g. see McClintock Greenberg 2009; Pinaquy et al. 2003; Sands 2003; Zerbe 2008). Yet I have found that many clients with eating disorders, who seem to be able to talk about and understand their feelings actually suffer from a subtle version of alexithymia. Especially in the case of verbal, intelligent clients like Catherine, this inability may not be recognized, resulting in confusion and frustration for both therapist and client. Understanding this subtle but powerful impact of alexithymia can enhance the use of both psychodynamic exploration and non-psychodynamic

tools for managing affect and changing behavior. In this article I will address some of the ways that alexithymia can silently contribute to the negative self-image, low self-esteem and poor body image associated with disordered eating behaviors. I will discuss how this often hidden factor also impacts the ways in which even bright, articulate and thoughtful clients are—or are not—able to regulate affects. Clinical material from my work with Catherine will illustrate these issues. Although Catherine was diagnosed with Binge Eating Disorder, I suggest that the question of alexithymia should be considered when working with anyone with eating and body image issues.

Alexithymia

The term alexithymia is derived from Greek, meaning "without words for emotions." Initially applied to psychosomatic disorders (Sifneos 1973), it is now viewed as a construct that crosses diagnoses. Alexithymia today is generally used for clients who have difficulties using language and words to process their emotions. Those who suffer from it also often have troubles tolerating and managing feelings and therefore often have problems with both impulse control and affect regulation (Barth 2014b, 2015; Bruce et al. 2011; Castanier and Le Scanff 2009; Krystal 1988; McClintock Greenberg 2009; Stewart et al. 2002; Woodman et al. 2009). Both poor impulse control and difficulty with affect regulation and self regulation are also often found in clients with eating disorders, leading some clinicians and theoreticians to hypothesize a link between these disorders and alexithymia (Fernández-Aranda et al. 2006; Krueger 2001; Pinaquy et al. 2003; Sands 2003; Zerbe 2008). Krystal (1988) also notes that alexithymic individuals have limited "signal emotions," or warning signs that potentially difficult feelings are building, also often found in clients with eating issues (2014b).

Perhaps not surprisingly, given that alexithymia involves difficulties with impulse control and affect regulation, some observers consider it to be a normal component of adolescent development (e.g. see Barth 2015; Schore 1994; Siegel 2013). The development of difficulties in this arena dovetails perfectly with adolescent vulnerability to problems with body image and eating disorders (Gowers and Shore 2001; Zerbe 2008). The term "alexithymia" has often been viewed as implying a difficulty naming feelings (McDougall 1989). In my experience, however, many clients suffer a more subtle form of alexithymia. Those with a wide range of eating issues are often verbal, able to talk about feelings and even have good insight into the causes of their behaviors. These verbal and cognitive strengths can disguise an inability to use their thoughts to manage their emotions, leading to unrealistic

expectations not only from a therapist, but also from themselves. Their experience in therapy can echo a childhood precociousness that masked age-appropriate developmental needs and turned into a lifetime of hiding vulnerability behind areas of competence. As a result of this dichotomy, in many cases neither the vulnerabilities nor the strengths have been integrated into a more complete and cohesive sense of self. Self-criticism and negative self-image resulting from this misunderstood duality is often concretized in a negative body image. A sense of falseness, of a hidden badness, can be part of this split between their obvious abilities and pockets of originally age-appropriate developmental “lags.”

While these clients often struggle with unformulated and/or dissociated emotions and thoughts (e.g. Bromberg 2001; Petrucelli 2015; Sands 1991), the unrecognized presence of alexithymia can interfere with attempts to integrate the psychological meanings of these experiences. Emotional and historical causes of body dysmorphia and problem eating, as well as of anxiety about dependency needs, fears of rejection and loss of support and more may all be clearly verbalized and understood within a historical context, without leading to behavioral or dynamic change. Indeed, because of the gap between the words and the actual feeling experience, these explanations can reinforce existing feelings of inadequacy, increase the need for affect regulation and self-soothing provided by eating behaviors, and lead to feelings of frustration and helplessness for both client and clinician. Alexithymia is one reason that CBT and therapeutic interventions directed at affect regulation and mindfulness can be more effective than psychodynamic exploration; but in my experience, the presence of alexithymia is also a reason that it is even more productive to integrate such interventions with a psychodynamically-based therapeutic relationship and, eventually, with psychodynamic understanding (Barth 2014a, b).

Alexithymia and Resistance

Alexithymia can make it appear that bright, verbal clients are stubbornly clinging to symptoms and resisting change. Yet a focus on the concrete is not simply an attempt to avoid the pain of intolerable feelings, but is also a way of holding a fragile, poorly integrated self together. Kohut (1971) has described this phenomenon in hypochondria, which sometimes accompanies eating disorders. Obsessional focus on the body as well as cutting and other self-harming behaviors that also are frequently found in individuals with some eating disorders can also be explained as attempts to maintain self-cohesion. Wood and Williams (2008) have suggested that these behaviors may be a

concrete way of actually feeling something in their bodies. They may also be a way of physiologically experiencing the difference between what is inside and what is outside of themselves and, as Stolorow (1975) puts it, “re-establishing a sense of existing as a bounded entity, a cohesive self.” (Stolorow 1975, p. 443).

For these clients, feelings often have a physical instead of an emotional presence. Because they seem to reside in the body, it is the body that has to be soothed. Physical actions like use of drugs, alcohol, sex, bingeing, purging, over-exercise and starvation can be attempts to not only maintain self-cohesion but also soothe the body self where the feelings are. Yet while these activities may provide momentary solace, they often increase feelings of shame, discomfort, and low self-esteem, thus undoing the positive effects and requiring further and often greater solace-seeking behaviors. Negative body image both represents these intolerable emotions and also leads to further attempts to manage them physically. With clients who are verbal and appear to be insightful, it would seem that understanding the meanings of the behaviors would help them make the changes necessary. Further, it often seems to clinicians that these clients should be able to understand the harmful consequences of their bodies, and should be able to change as a result of education about the dangers of the behaviors. Over the years as I have listened to my own clients, as well as to colleagues and supervisees describe their frustration and confusion when their clients continue to engage in these behaviors even after seeming to understand these dangers, I have found that alexithymia helps to explain what is happening when these interventions do not lead to change.

What may appear to be intentional resistance can be understood through the lens of alexithymia as an inability to use language to manage both the “as-if” frame of dynamic exploration and also the feelings that are stirred up by these explorations. Literal thinking can lead to both self-blame and parent-blaming when understanding historical antecedents is expected to both explain and undo all complex, painful and confusing feelings. A wordless fear of dependency, a sense of possibly exploding or imploding, and a dread of being both overwhelmed by feelings that cannot be managed and sucked into a black hole of emptiness can interfere with a client’s ability to join fully with a clinician, no matter what approach or technique is offered. The behaviors that are in question become even more necessary for soothing. The danger of losing them also increases the need. It is for these reasons that I encourage the use of multiple modalities with such clients. In this stage of fear and anxiety about loss of powerful and important self-soothing tools, cognitive behavioral, mindfulness and suggestions for physical ways of managing feelings can be key.

Clinical Vignette: The alexithymic gap between words, thoughts and feelings is, I would suggest, one of the reasons that Catherine's understanding of the psychological link between childhood feelings of deprivation and her eating behaviors had never had much of an impact on her eating behaviors. The thoughts made sense to her, but they did not help her manage her feelings. Nor did they help her keep off the weight she had lost, which she gradually regained in the first year of our work together. Catherine sometimes sounded as though she was unwilling to explore her feelings, but she was not being unreasonable or defiant. She was simply communicating that talking about her emotions had little meaning to her. Certainly, she knew *that* she felt. But the idea of trying to explore or open up her emotions was like asking her to begin to speak in an unknown language. This was a meaningful analogy for understanding Catherine, although not useful as an interpretation or explanation of symbolic meaning. She was fluent in three languages and learned a fourth while we were working together. Language was, not surprisingly, important in her family, and Catherine often proudly noted that she spoke English better than other family members. Yet she was susceptible to any potential criticism of her facility with the language. For example, she had an amazing grasp of colloquial English, but she was always hyper alert to the possibility that she had misused a phrase or was not familiar with a particular structure used by a colleague. Her self-esteem and even her sense of who she was could change based on how well she felt she had spoken English on a particular day or in a given situation, as well as by how others responded to her word choices and sentence structure.

I gradually came to understand that neither her keen intelligence nor her love of language made it possible for her to use words to process her feelings. For instance, she understood when I said that she ate to soothe herself, but this did not make her feel any more empathic to herself. In fact, she was extremely critical of this behavior and felt that she should stop now that she knew what she was doing. She also could put into words that her attitude towards her body was partly related to beliefs expressed both in her family and also in the culture in which she grew up, where thinness represented social status and success. But this verbal knowledge did not diminish either Catherine's extremely critical attitude towards her body or her ongoing use of food for self-soothing. Just as with her use of English, Catherine was hyper alert to and very critical of her body from the point of view of an outside observer. Her feelings about her physical self were almost always based on some sort of external measures—the actual number in pounds of her weight, the size clothing she could wear, and whether or not she could fit comfortably into a seat on

public transportation or in a theater. If one of these numbers went down, she could feel good. If they went up, she was fat, bad and a failure in every way possible.

Catherine looked at her feelings from the outside as well. She was able to name feelings, and she clearly experienced them, but she could not describe how they manifested themselves either in her body or in any of the other affectively meaningful ways that are key to the process of metabolizing and managing affect (see Fonagy et al. 2003; Schore 1994; Siegel 1999, 2013). I learned in those early sessions that the language that had the most affective resonance for Catherine involved words that described boundaries and limit setting. When she had troubles setting limits with herself or with someone else, she often needed help spelling out the limit and thinking about where she stopped and the other person began. Sometimes this was literal—what were her physical limitations in a particular situation? Where did her body stop? Where did she overflow into someone else's space? Where was the other person's body encroaching on hers? Sometimes, much later in the work, the ideas could be more abstract. We could talk about personal space and emotional need (although she still preferred that I not use the word "feeling.") But in those early sessions, we worked on establishing the concrete specifics of boundaries, and her right to have them, in particular with Samuel.

In response to her question about what to do, I asked Catherine if she knew what she *wanted* to do. She said that she wanted to stop giving Samuel the money, but she did not think she could. I asked if she felt that she had a right to declare that the money was hers? She shook her head "no." I said that that would make it hard to limit what she gave him, and she started to cry. "I can't," she said, but it was not until many months later that we were able to find a way to talk about what was going on at that moment. Catherine had plenty of words, but none that would help her to adequately describe what she was experiencing, even to herself. Nor were there words that helped her integrate what she wanted, needed and felt with what she could actually do. Her thoughts did not seem to communicate with her feelings.

Thoughts and Feelings

This failure of communication between feelings and thoughts is not unusual in clients with alexithymia. Thus, like Catherine, many individuals with eating disorders may easily talk about feelings but not be able to describe what the feeling they are talking about *feels* like. Hagman (2014) suggests that we cannot have thoughts without feelings or feelings without thoughts, so that in most of us left and

right brain are always in communication with one another, even when one side is stronger or better developed than the other. When alexithymia is present, it appears as though the communication between the different parts of the brain gets scrambled or diverted. Words and thoughts do not help a person with alexithymia decipher what they are feeling, and feelings do not enrich thoughts. Processing both aspects of experience can become more and more difficult, especially as symptomatic behaviors become entrenched as a path between the two.

Alexithymia can make it hard for a client to communicate with her or himself. It also makes it difficult for a clinician and a client to hear and speak to one another, no matter how carefully they listen or how much work they put into choosing the right words. When it is present, a therapist and a client may speak the same words but not give them the same meaning. Like a precocious toddler who functions above his or her developmental level, a client with alexithymia often has significant strengths accompanied by lacunae of underdeveloped aspects of self. Alexithymia represents an often-unrecognized gap between the capacity to talk intelligently about themselves and the ability to use these words to process feelings or change behaviors. This mismatch between ability to “understand” and capacity to integrate the understanding into genuine self-awareness leading to behavioral change can contribute to a frustrating therapeutic experience that echoes a lifetime of relationships. A concomitant sense of disappointing others and of not living up to their own expectations can then be reflected in defensiveness, isolation, feelings of helplessness and hopelessness and self-denigration. Awareness of the presence of alexithymia can help a clinician avoid repeating this relational dynamic, or when it does occur, address it in such a way as to ameliorate the negative impact.

Clinical Vignette: Like many of the analysands described by Kohut (1971, 1977) Catherine needed words to exactly reflect her experience in order for them to have meaning for her. For instance, at one point, having learned that Catherine was having troubles spending the money her parents had left on herself, I said that some people see such a legacy as a connection to their parents, and do not like to spend it because they do not want to lose that connection. Catherine looked blank, then shook her head and said, “I don’t agree.” She did not mean that she thought it impossible for anyone else to feel the way I had described. She was simply expressing the fact that it was not how she felt. This way of communicating her feelings—to make them a matter of opinion, or of fact—was telling. Renik (2006) points out that it can be useful for therapists to share our thought processes with some clients. In the earliest sessions I learned that Catherine found it helpful when I

“thought out loud”—that is, when I shared with her how I got to a particular idea or concept. This was made obvious when we began talking about boundaries. When Catherine began to cry about not being able to tell Samuel “no,” I said that I thought she was having troubles with boundaries. She was not sure what I meant, so I shared some of my thoughts about limit-setting. I told her that I thought that boundaries were very important to our ability to feel safe and comfortable. I also shared that boundaries could be hard to set, especially when others did not seem to agree about where the limits should be.

Links between eating disorders and difficulty with limit-setting have been identified by numerous authors (e.g. Arkell and Robinson 2008; Levander and Werbart 2012; Telch 1997). I would learn that Catherine had, throughout her life, fluctuated between almost boundless binge eating and the kind of rigid diet regimen that she was on at the moment. But in that early session, I simply said that I thought Samuel was breaching her boundaries and that I thought that was problematic and not just for her, but for anyone. I reiterated that many of us have difficulties setting limits, for many different reasons.

Taking a cue from the fact that she was nodding enthusiastically, I asked if she could talk about what she was thinking about. (I learned very quickly that whether I asked about feelings or thoughts, Catherine answered with thoughts. I therefore tried to use the word “thoughts” while I worked to find some ways to help her actually make contact with some of her feeling experiences.) She said that her parents had set strict limits with her and her brother, but they had not believed in boundaries that went the other way. “We kids didn’t get to set boundaries,” she said. “We just did what we were told.” I said that I thought that was what was making it hard with Samuel. She was doing what she was told—but I wondered if she could try to do what she thought was right instead. She said she was not sure what that was. I teased out with her that she did not want to give him free access to her money and then I repeated what we had just said. Once I had said it back, she said, “Oh, okay, so I should just tell him that?” I asked what she thought would happen. “What if he doesn’t listen?” she said.

In that session and the one following, we did some role-play, with Catherine trying out different ways to respond to Samuel’s demands and counter-demands. I had no idea what to expect from this interplay, and was surprised when, in the next session, she told me that she had explained to Samuel that he could not have anymore of her money, and he had accepted the limit without question, without anger, and without any other apparent negative repercussions. When I asked how she felt about it, she grinned widely. “I think it’s great!” she said.

Proprioceptive Awareness

Understanding some of the family dynamics around food and eating, physical appearance and weight, boundary setting, and other concrete symbols of status and worth helped us find ways of talking about why Catherine was so critical of and ashamed of her body. But external gauges—her weight, her size, her precisely correct use of another language—were ways for Catherine to regulate affect and in particular affect surrounding self-esteem. Catherine had little information about what it actually felt like to be in her own body, and less about what her body actually looked like. Body dysmorphia and self-criticism for bodily imperfections are common symptoms in eating disorders. What is also common is a lack of proprioceptive awareness—that is, an inability to recognize bodily sensations in anything but their strongest forms (Eshkevari et al. 2012). The lack of proprioceptive information has also been found in clients with alexithymia. For example, Castanier and Le Scanff (2009) describe studies in which respondents spoke of only being able to feel something in their bodies when they were engaged in dangerous or risky behavior.

I would suggest that this lack of proprioceptive awareness causes the common failure to “see it coming” (when the “it” is either a feeling or a behavior) in individuals with eating disorders. The frequently reported sensation that a need to binge, exercise, cut or burn oneself, or even a sudden awareness of having gained a great deal of weight “comes from out of nowhere” seems to me to be related to a failure of “signal emotions,” which Krystal (1988) calls the small indications that powerful or unpleasant feelings are beginning to build. Because individuals suffering from alexithymia have no warning until emotions “hit” them full force, and therefore no way of modulating their feelings in earlier, more manageable stages, they often need body-based methods for self-soothing, such as drugs, alcohol, sex, extreme physical activity, and bingeing, purging or severely restricting food intake, and self-harm.

I have found that it can be useful to acknowledge and sometimes even explain the lack of proprioceptive information accessible to clients with eating disorders. Mindfulness practices and a number of cognitive behavioral techniques can provide useful tools for making connections between thoughts, emotions, and physical sensations. This work often goes slowly and is most useful when done within the context of a safe relationship in which feelings of inadequacy and self-criticalness about not being able to make contact with bodily-based information can be defused. A number of integrative authors, including Barth (2014a, b), Connors (2006), Frank (1999), Wachtel (1997) and Zerbe (2008), offer suggestions for therapeutic interventions that help clients develop both proprioceptive

awareness in combination with insight. Some of these suggestions are for mindfulness and breath work, cognitive behavioral techniques, and long term talk therapy. It can also be useful to help clients to focus on and learn to recognize hints from their bodies that will help them build both signal emotions and tools for managing those feelings.

In my experience, these interventions are most successful within the context of a supportive, interested and nonjudgmental therapeutic relationship. A clinician can encourage a client to pay attention to small details of bodily sensations and help them find words for those sensations. For instance, many clients cannot say where in their bodies they actually feel hunger or how they know what they feel. A clinician who recognizes the presence of alexithymia will look for ways to enhance the communication between the part of the brain that “knows” and the part that “feels” (Hagman 2014). Our bodies have many ways of communicating hunger—not simply in our stomachs (which is where we often think the feelings reside), but in our throats, mouths and even thoughts. Although popular weight loss techniques encourage dieters to ignore “mouth hunger,” I find it more useful to consider it a valuable piece of information.

Clients are also often surprised when I suggest that thoughts can be an early signal that they are getting hungry. Images of food and thoughts about eating can be indications that their body needs food. Such signals are meaningful and should be acknowledged. The part of the brain that uses words has to accept what the part that registers feelings is communicating. Only then can meanings be deciphered and emotional needs be differentiated from physical hunger. Only then can appropriate action be taken. Once clients begin to listen to thoughts as having physical meaning, they can begin to pay attention to other ways that they communicate feelings to themselves and to others. Borrowing from Sullivan’s (1953) detailed inquiry, I ask clients to try to tell me tiny details about thoughts and bodily experiences related to feelings. If someone tells me they are anxious, I ask them to try to say how they “know” this is what they are feeling. What are the clues that it is anxiety and not sadness? How can they tell they are anxious and not happy? This is not an easy task, even for someone without alexithymia. Since so many of our emotions are felt in our bodies, it can be helpful to ask about bodily sensations. “Do your hands feel a little sweaty?” “Is your heart beating more rapidly?”

Helping clients learn that their bodies are often full of information about their emotions can also help them feel less critical of themselves for the sometimes overwhelming need to soothe their bodies. I explain that they use food to soothe themselves from the inside out. I also suggest that the ability to hear and respond to the physical manifestations of their feelings is adaptive. It will also be an

important aid in the process of learning other ways to soothe themselves. In the same vein, I also encourage clients to pay attention to their thoughts. Rather than view thoughts as defensive or as “intellectualization,” I work with clients to see their thoughts as reflections of feelings. Valuing thoughts not simply for themselves, but as links to feelings helps to reinforce a strength that many of these clients bring into therapy—their minds. That strength can then be utilized in the work of building a greater capacity to tolerate and regulate their affects, which will gradually lead to a more cohesive and integrated sense of self.

Countertransference

The progression to self-awareness and insight, which is not speedy in many therapeutic experiences, can be both slow and also concrete when someone has alexithymia. It is not uncommon for a clinician to become irritated with articulate and intelligent clients like Catherine who seem to be almost intentionally negativistic or resistant. Such countertransference frustration can mirror lifelong experiences of frustration from others who saw their strengths and could not understand why they were not living up to their abilities. Like the precocious toddler with pockets of age appropriate, undeveloped abilities, they are blamed for something that is not in their control. Often actually having been such advanced or gifted children, alexithymic individuals may both internalize the criticism and simultaneously project their criticism outwards. Defenses of projection and projective identification may lead to a therapist's feeling criticized and/or denigrated by a client; but before the experience can be unraveled, work must be done to make the feelings both tolerable and identifiable. I have found it helpful to recognize the adaptive component of some of this apparent resistance (Barth 2014a, b), but the presence of alexithymia adds yet another layer to this understanding. In some instances, referral to a nutritionist, mind–body worker, psychopharmacologist or other adjunct clinician can be perceived as “giving up” on the part of both therapist and client. But not only can their input aid in the work, but a client's reactions to the referral can sometimes add to an understanding of some of dynamics that have remained out of awareness. This is how it happened with Catherine.

Clinical Vignette: After a series of painful events in her life, I became concerned about Catherine's growing and unremitting depression and referred her to a psychiatrist for an evaluation and medication consult. I took it for granted that she understood that I was sending her to the psychiatrist because of my concern, but I am not sure that I used the word “depression,” since I had found that

Catherine often felt both labeled and reduced by the use of diagnostic terms. I did say that she seemed to be struggling with feeling unhappy and, when she immediately became self-critical, I commented that she seemed to think it was her fault. She nodded and brought up her anger at herself for regaining the weight she had lost prior to starting therapy.

Although we had talked about the possibility that her increased eating was her way of trying to manage some of the painful feelings that were emerging as we talked about both her history and her current struggles with difficult life events, she used this to underscore her flaws and reinforce how bad she was. Still, she agreed to my referral, saying she thought it was a good idea. After she met with the psychiatrist, she told me almost gleefully that he had told her that she was seriously depressed, and that he would be depressed as well if he had to deal with all of the things she had told him about. When I asked why she seemed so pleased, she said that his naming it made it real, adding, “Otherwise, maybe I'm just making these things up.”

I wondered why, when the psychiatrist labeled her feelings, she felt heard and understood, but when I labeled them, she often felt criticized and misunderstood. Not only were there obvious transference issues (I believed she identified me with both her critical mother and her own harsh superego), but because credentials were extremely important for Catherine, his age, gender and the fact that he was a doctor would have given him a power I did not have. When I tried to explore this with Catherine, she seemed to genuinely have no idea what I was referring to. Although splitting and projective defenses were present, what seemed to be helpful to her was my acknowledgement that I had not put either my understanding or my sympathy for her into words as clearly as the psychiatrist had. I noted that the slow pace at which we progressed, which I believe was not so much resistance but related to alexithymia, was difficult for her and wondered if she blamed me for any of it. She responded with further criticism of herself for the length of time therapy was taking.

It was helpful when I began to understand that, although her criticalness actually often did appear directed at me, it was not about me, even in a projected form. Because Catherine's feelings only emerged in broad outline, irritability directed at another person was indistinguishable from irritability directed at herself. Recognizing the presence of alexithymia can help ameliorate such frustration in both participants. Helping an individual with alexithymia learn to use language to process emotions is by definition often a slow and painstaking process, and progress is often made in baby-sized steps.

Alexithymia, Trauma and Culture

Some theorists have suggested that alexithymia is the result of childhood trauma (e.g. Krystal 1988; Schore 1994), and there is no question that Catherine suffered both in early childhood and also in adolescence, with the serious illnesses and subsequent loss of both of her parents. Yet I have worked with numerous clients who were unable to use language to process emotions who had no history of emotional or situational trauma. I have come to believe that alexithymia is to some extent a disorder of the current era, so much so that, without being named, it has become integrated into popular culture. Spike Jonze's 2013 movie "Her," for example, depicts a world in which people, having lost the ability to put their feelings into words, have to hire someone else to figure out what they are feeling. Many clients who come for therapy these days are like Theodore, the main character in Jonze's movie, with highly developed verbal abilities and an apparent capacity for insight, but without the expected concomitant of self-knowledge helping them manage their affects (see Barth 2015, 2014a, b).

The work of therapy with individuals with alexithymia is multi-faceted. Research has shown that a combination of techniques directed at self-regulation, management of affects and behaviors, and harm reduction can be useful (Bruce et al. 2011; Castanier and Le Scanff 2009; Stewart et al. 2002; Woodman et al. 2009). A growing body of evidence has also shown that a longterm psychodynamic therapeutic relationship is an important factor in a client's ability to make changes that last (de Maat et al. 2009; Shedler 2010). In my own experience with clients and reports from supervisees, students and colleagues, I have found that combining a psychodynamic approach with concrete tools for affect management and self-regulation is extremely useful. A clinician's ability to understand and respond to some of the dynamics, including the importance of even maladaptive defense systems, without necessarily spelling them out directly to clients, can make the slow progress more tolerable for both client and clinician. This is especially true in the early stages of the work, but can continue throughout even a long therapeutic relationship.

Not all clients with alexithymia are alike. The symptoms of alexithymia cross diagnostic categories, personality styles and character types. Thus there are no easy answers to how to work with these issues. Some are very interested in understanding and exploring meaning, while others, like Catherine, do not particularly find that avenue either interesting or useful. But in either case, one of the tasks of a clinician working with clients struggling to find a link between words and feelings, both emotional and physical, is to lend ourselves as tools in the process. Winnicott

(1965) suggests that analysts must take painful feelings and digest them for themselves, giving them back only when a client is ready to absorb them and in quantities that a client can tolerate. Alexithymia requires a similar treatment. We try to understand what a client might be feeling; and then we try to assess what they can use of our understanding. In many cases, this means translating our understanding of feelings into another language—that of the body, of the brain, or of action.

Final Clinical Vignette: Over time, and with adjunctive assistance from a psychopharmacologist, a nutritionist, and a variety of body workers, Catherine got better. As she began to both know and feel her own boundaries, she also gradually found words that genuinely helped her decipher, recognize and think about her feelings. It was clear that not only was I important to her, but that our work together, despite a number of ups and downs in both the therapeutic process and also in her life, was important. During the time we worked together Catherine earned a doctorate degree, wrote and published professionally, taught in her professional field, and developed meaningful friendships as well as closer and more satisfying relationships with members of her family. She also lost the weight she had gained in the early stages of our work, and with support from an innovative nutritionist, was able to maintain that weight loss, despite several more blows from life that might have made her—or anyone—give up.

Summary

Alexithymia, or an inability to use language to process emotions, can be a subtle, undiagnosed component of eating disorders even in articulate, intelligent clients. Historically the term has been used to describe an inability to talk about or find words for feelings (Krystal 1988; Bromberg 2001; McDougall 1989), yet there is evidence that it exists in a wide range of individuals with eating disorders (Barth 2014a; Pinaquy et al. 2003; Sands 1991) In this article we consider the possibility that alexithymia exists but is often missed in clients with eating disorders who are verbal and insightful. In these cases, when it is not recognized and incorporated into the clinical work, therapy can simply reinforce a client's lifetime habit of hiding areas of vulnerability behind genuine areas of competence. Self-criticism and negative self-image resulting from this dichotomy are often concretized in a negative body image. Unaddressed, alexithymia can contribute to sense of falseness and hidden badness. Addressing the concrete components of a client's actual experience can lead to a more cohesive and realistic sense of self, with strengths and vulnerabilities, flaws and assets. These feelings may still be

concretely represented in the body, but as they become more inclusive and integrated, negative feelings and eating symptoms often diminish. An extensive clinical example illustrates how this process can unfold.

References

- Arkell, J., & Robinson, P. (2008). A pilot case series using qualitative and quantitative methods: Biological, psychological and social outcome in severe and enduring eating disorder (anorexia nervosa). *International Journal of Eating Disorders*, *41*, 650–656. doi:10.1002/eat.20546.
- Barth, F. D. (2014a). *Integrative clinical social work practice: A contemporary perspective*. New York, NY: Springer.
- Barth, F. D. (2014b). Putting it all together: An integrative approach to psychotherapy with eating disorders. *Psychoanalytic Social Work*, *21*, 19–39.
- Barth, F. D. (2015). Alexithymia, affect regulation, and binge drinking in college students. *Journal of College Student Psychotherapy*, *29*, 132–146.
- Bromberg, P. (2001). *Standing in the spaces: Essays on clinical process, trauma and dissociation*. London: Routledge Press.
- Bruce, G., Curren, C., & Williams, L. (2011). Alexithymia and alcohol consumption: The mediating effects of drinking motives. *Addictive Behaviors*. doi:10.1016/j.addbeh.2011.11.024.
- Castanier, C., & Le Scanff, C. (2009). The influence of personality and emotional style on engagement in risky sports: A review of the literature. *Science & Motricite*, *2*, 39–78.
- Connors, M. (2006). *Symptom-focused dynamic psychotherapy*. Hillsdale, NJ: Analytic Press.
- de Maat, S., de Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: A systematic review of empirical studies. *Harvard Review of Psychiatry*, *17*, 1–23.
- Eshkevari, E., Rieger, E., Longo, Matthew R., Haggard, P. & Treasure, J. (2012). Increased plasticity of the bodily self in eating disorders. *Psychological Medicine*, *42*, 819–828. ISSN 0033-2917.
- Fernández-Aranda, F., Jiménez-Murcia, S., Álvarez-Moya, E. M., Granero, R., Vallejo, J., & Bulik, C. M. (2006). Impulse control disorders in eating disorders: Clinical and therapeutic implications. *Comprehensive Psychiatry*, *47*, 482–488.
- Fonagy, P., Gyorgy, G., Jurist, E., & Target, M. (2003). *Affect regulation, mentalization and the development of the self*. London: Karnac Books.
- Frank, K. A. (1999). *Psychoanalytic participation: Action, interaction, and integration*. London, England & New York, NY: Routledge.
- Gowers, S. G., & Shore, A. (2001). Development of weight and shape concerns in the aetiology of eating disorders. *British Journal of Psychiatry*, *179*, 239–242.
- Hagman, G. (2014). *Creative analysis: Art creativity and clinical process*. London & New York: Routledge.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Krueger, D. W. (2001). Body self: Development, psychopathologies, and psychoanalytic significance. *Psychoanalytic Study of the Child*, *56*, 238–259.
- Krystal, H. (1988). *Integration and self-healing: AFFECT, trauma, and alexithymia*. Hillsdale, NJ: Analytic Press.
- Levander, S., & Werbart, A. (2012). Personality-related responses to the psychoanalytic process: A systematic multicase study. *Psychoanalytic Psychology*, *29*, 1–16.
- McClintock Greenberg, T. (2009). *Psychodynamic perspectives on aging and illness*. London/New York: Springer.
- McDougall, J. (1989). *Theaters of the body: A psychoanalytic approach to psychosomatic illness*. New York: W.W. Norton & Company.
- Petrucelli, J. (Ed.). (2015). *Body states: Interpersonal and relational perspectives on the treatment of eating disorders*. New York: Routledge.
- Pinaquy, S., Chabrol, H., Simon, C., Louvet, J.-P., & Barbe, P. (2003). Emotional eating, alexithymia, and binge-eating disorder in obese women. *Obesity Research*, *11*, 195–201. doi:10.1038/oby.2003.31.
- Renik, O. (2006). *Practical psychoanalysis for therapists and patients*. New York: Other Press.
- Sands, S. (1991). Bulimia, dissociation and empathy: A self psychological view. In C. L. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia* (pp. 34–50). New York: Guilford.
- Sands, S. (2003). The subjugation of the body in eating disorders: A particularly female solution. *Psychoanalytic Psychology*, *20*, 103–116.
- Schore, A. N. (1994). *Affect regulation and the origin of the self*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *65*, 98–109.
- Siegel, D. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York and London: Guilford Books.
- Siegel, D. (2013). *Brainstorm: The power and purpose of the teenage brain*. New York, NY: Penguin Publishing Co.
- Sifneos, P. E. (1973). The prevalence of alexithimic characteristics in psychosomatic patients. *Psychotherapy and Psychosomatics*, *22*, 255–262.
- Stewart, S. H., Svolensky, M. J., & Eifert, G. H. (2002). The relations of anxiety sensitivity, experiential avoidance, and alexithymic coping to young adults' motivations for drinking. *Behavior Modification*, *26*, 274–296.
- Stolorow, R. (1975). The narcissistic function of masochism (and sadism). *International Journal of Psycho-Analysis*, *56*, 441–448.
- Telch, C. F. (1997). Skills training treatment for adaptive affect regulation in a woman with binge-eating disorder. *International Journal of Eating Disorders*, *22*, 77–81. doi:10.1002/(SICI)1098-108X(199707)22:1<77:AID-EAT10>3.0.CO;2F.
- Wachtel, P. (1997). *Psychoanalysis, behavior therapy and the relational world*. Washington, D.C.: American Psychological Association.
- Winnicott, D. (1965). *The maturational processes and the facilitating environment*. New York: International Universities Press.
- Wood, R., & Williams, C. (2008). Inability to empathize following traumatic brain injury. *Journal of the International Neuropsychological Society*, *14*, 289–296.
- Woodman, T., Huggins, M., Le Scanff, C., & Cazenave, N. (2009). Alexithymia determines the anxiety experienced in skydiving. *Journal of Affective Disorders*, *116*, 134–138.
- Zerbe, K. (2008). *Integrated treatment of eating disorders: Beyond the body betrayed*. New York and London: W.W. Norton & Company.

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