

When a Patient Has No Story To Tell: Alexithymia

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Once the distortions are cleared away, most patients who come to the emergency room tell stories that seem to grow out of the problems they claim to have and the pain they claim to feel. These stories reverberate with emotions congruent to their themes. But occasionally, patients who clearly have problems and are in great emotional pain tell noncongruent stories. They will insist that they have no problems, that life is fine and that they have no idea what is wrong. Their story is that they have no story. These patients seem unable to find the words necessary to describe their feelings.

In 1972, Peter Sifneos introduced to psychiatry the term *alexithymia*, which (derived from the Greek) literally means having no words for emotions (a=lack, lexis=word, thymos=emotions). Alexithymia is not a diagnosis, but a construct useful for characterizing patients who seem not to understand the feelings they obviously experience, patients who seem to lack the words to describe these feelings to others. Identifying this deficit in expressivity is important because doing so gives the clinician a leg up in making a diagnosis and charting a therapeutic course.

Many individuals with alexithymia have [somatic complaints](#). Considerable empirical evidence links prolonged states of emotional arousal, and the concomitant physiological arousal, with susceptibility to certain [somatic disorders](#). Clearly, someone who cannot verbally express negative emotions will have trouble discharging and neutralizing these emotions, physiologically as well as psychically. All feelings, whether normal or pathological, are ultimately bodily feelings. Those with alexithymia lack a lived understanding of what they experience emotionally.

From the perspective of development, alexithymia implies a glitch in the process that permits the expression of feelings in words that capture the body's involvement in these feelings. Perhaps the child's mother failed to sufficiently encourage a language of feelings (surely excluding her from the pantheon of Winnicott's "good enough" mothers). Alternatively, emotional trauma later in life may compromise the connection between what is felt and what can be grasped about this feeling and can be put into words, particularly if that link were tenuous to begin with.

If a patient has no story to tell a clinician, even at a time when emotions are stirred high enough to prompt an ER visit, it seems a good bet that person has no story to tell themselves either. Having no story almost certainly implies an impaired identity: Who we know ourselves to be depends heavily on the story we tell ourselves about who we are. The [inability to express emotions](#) verbally implies a

deficient interior life. Inevitably, those who cannot match words to feelings will live out that deficit in their contacts with others as well. To have no words for one's inner experience is to live marginally, for oneself and for others.

"Kisha," 16, was brought to the ER by her mother after she held a curling iron to the outside of her upper left arm, causing a large, painful burn. Kisha had just started her junior year in high school and also worked as a cashier in a convenience store. She was an average student, but her mother assured me she was one of the most popular girls in her class. Kisha lived with her parents, two sisters and brother. She had never used illicit drugs or abused alcohol. "I'm a virgin," she said easily and proudly when I asked if she had a current boyfriend, which she did not. Kisha denied physical and sexual abuse, and her mother later corroborated her denial. Asthma, occasional bronchitis and seasonal allergies were her only concessions to good health.

Kisha acknowledged feeling depressed recently, although she did not admit to having any of the [symptoms of a major depressive episode](#). Her appetite had not changed, and she was sleeping up to 10 hours a day, the norm for her. My best diagnostic call was [depressive disorder, not otherwise specified](#).

Asked how she felt during the interview, Kisha answered with an easy smile, "I feel fine." It seemed to me the happy face owed more to practice than to spontaneity. I doubted her affect reflected her mood, then or earlier that day. When I asked Kisha why she burned herself so seriously, she looked at me blankly and said she did not know. She denied anything had changed in her life recently. She acknowledged no disappointment or setback, no problems at home or at school. According to Kisha, everything was fine.

The burn that brought Kisha to the ER on the evening I interviewed her was not her first act of self-mutilation. Seven months earlier, she had jumped out of a second-story window. Inexplicably, she did not go to a hospital, either for medical treatment or for psychiatric evaluation. I was the first mental health clinician Kisha had spoken to.

During the previous year, Kisha also had made modest cuts with a razor on the underside of one forearm and on her cheek. "I was just bored," was her explanation. Asked why she jumped out of the window, her only response was, "I have no idea." She denied this potentially lethal act had anything to do with what was going on in her life at the time. Despite my persistent efforts to elicit more information about the reason for Kisha's self-destructive behavior, she did not offer a scintilla of explanation. That she was acknowledging no reasons for what she had done did not strike her as the least bit odd.

Kisha's mother told me with understatement that her daughter "keeps it all inside." Clearly, Kisha was not the only minimizer in this family. The mother also volunteered that Kisha had trouble getting over disappointments. The day before she burned herself with the curling iron, a woman who had promised to take Kisha to a museum in another city abruptly canceled the trip. At the time she jumped from the window, Kisha was having problems with a boyfriend, and the relationship soon ended. Kisha vigorously denied she had difficulty getting over disappointments in general or that a particular disappointment had anything to do with any of her self-destructive acts. Her mother thought differently.

Kisha had no words for the feelings that led her to do these things. But her silence spoke volumes. Clearly, she had emotions she did not acknowledge or understand. This young woman put a smile on her despair. She gave no hint of what was going on under the mask.

Most patients who come to the ER after harming themselves seem eager to discuss the meaning of their behavior. Rather complex issues are clarified, often with startling insight. These patients are willing to have their initial, often self-deceiving explanations challenged and to allow the subtext of their

destructive act to be interpreted to them. But after Kisha burned her arm, no words came to name the emotions that drove her to do this. She clarified nothing, for herself or for me. Kisha was alexithymic.

Particularly memorable among the many self-mutilating patients I have evaluated in the ER was a 19-year-old college student who had cut marks of various lengths and depths all over her arms, legs and torso. The incision that brought her to the ER was made with a razor blade on the underside of her right wrist. After making the initial incision, several repetitive cuts went deeper than she intended, and she severed a tendon. The hand surgeon who was called in the middle of the night to do the repair had trouble locating the proximal end of the tendon, which had retracted into the forearm after snapping. While he called his supervisor for assistance, I completed my interview.

This young woman, lying on a gurney under bright fluorescent lights, facing a long period of rehabilitation with an uncertain outcome, unabashedly told me about the problems she had, her feelings of anxiety and depression, and how for many years she had tried to counter this emotional pain by cutting her body and watching the blood come.

Many patients who mutilate themselves as Kisha did have borderline personality disorder. During the interview, and later in a separate conversation with Kisha's mother, I looked hard for borderline dynamics and borderline symptoms. Besides Kisha's obvious, although unacknowledged, proclivity for turning disappointment into physical self-injury, I could not identify any.

Kisha denied any further intention or plan to harm herself. I took her at her word, for the moment anyway. But I knew she was not finished with these self-destructive acts. Kisha did not need to be hospitalized. She did need immediate, intense outpatient therapy with someone who knew how to draw her out and help her put words to the feelings-whatever they were, wherever they came from-that were eating at her from the inside and causing her to mutilate herself on the outside. Fortunately, her parents had insurance. I referred her to a nationally known psychiatric hospital in the city for outpatient care.

"Maureen," 37, was brought to the ER by her parents. "I've been very depressed," she said when I asked why she had come. The day before Maureen had gone to another ER, specifically, she told me, "to get a different antidepressant." She was taking fluoxetine (Prozac), prescribed by a general practitioner two years earlier, with little or no benefit. Denied this medication, she became, by her own account, "hysterical" and "ran out" of the ER without receiving discharge instructions.

"I feel like I have hit rock bottom," Maureen told me. "I cry all the time. I feel like I have no control over myself." She had been seen by two psychiatrists briefly 15 years earlier, but had received no treatment since, in spite of periodic recurrences of her depression. "I feel as depressed now as ever," she said. "I have no hope of getting better." The depression had become worse during the preceding three months. During that time, her sleep had increased from seven to 10 hours a night. Also, her appetite had increased somewhat, and she had gained five pounds (she appeared slightly overweight).

Maureen had two years of college and worked as a photographer for a company that supplied photos of sports events for high school and college yearbooks. Her job was competitive and stressful. At certain times of the year she worked up to 80 hours a week, often facing deadlines. "I put more pressure on myself than the job does," she said with no apparent regret. In spite of her increasing depression during the past three months, Maureen's boss was satisfied with her work, but Maureen did not feel she was performing well. Everything required more effort now. It was harder to concentrate. Maureen found what she did less interesting, and she cut back her social activities considerably. She got little joy from work and contact with friends. Losing her edge made her feel guilty.

Clearly, Maureen was having an episode of major depression. From her story and from the fact that she had been on fluoxetine for two years, an underlying dysthymic disorder was also quite likely, giving her what is known as "double depression." She also experienced a good deal of anxiety and took clonazepam (Klonopin) as needed. Maureen denied ever using illicit drugs or abusing alcohol. The toxicology screen was positive only for barbiturates. (She took [butalbital and acetaminophen] for headaches; the hospital's benzodiazepine test did not detect clonazepam at therapeutic levels.)

Maureen insisted she had no intention or plan to harm herself, but added, "I can't imagine living my life this way indefinitely." Fifteen years earlier, she had "tried to get up the nerve to take a bottle of pills," but could not. Five years earlier, she had sat in her car with the motor running and the garage door shut for five minutes, but terminated this potentially lethal act because, she told me, she "couldn't go through with it."

When I asked Maureen why she thought she was feeling depressed, she did not acknowledge a single negative factor in her life (unlike Kisha, she did at least admit to having symptoms of depression). Questioning her about her marriage, job, finances and family produced no revelations. She had supportive parents, a relatively secure if stressful job she liked and excelled at, and no financial problems. She had been married for about 15 years, had no children and thought her relationship with her husband was good.

When asked about her sex life, Maureen told me with no apparent regret that her partner was impotent and that they had had sex only a few times during their marriage, though they still shared some lesser intimacies. How did Maureen feel about this lack of sex in her life? "I got used to it," she said nonchalantly. She insisted she was "very happy" in her marriage and that she had no complaints about her husband.

Maureen readily volunteered that her first sexual experience occurred at 15 years of age, and that she had had six or seven sexual partners before marrying. She reported these facts almost clinically, as if speaking about someone else. As she told me this, sitting upright on a gurney in tan, cuffed shorts, bare legs unself-consciously displayed, making good eye contact and talking in a pleasant, round tone, I was not convinced Maureen had made as good an accommodation to living a sexless life as she would have herself and me believe.

I regret not asking Maureen if she had been involved with another man (or a woman) at any time during her 15-year marriage, if she had wanted to be or if she was frustrated by her own efforts, past or present, to be involved. Her answers could have given some hint of what was underneath a story that had no words for feelings so painful she was at "rock bottom," saw no hope of feeling better and had gone to two different ERs in two days.

Maureen had severe headaches (not migraines, her doctor told her) and abdominal pain. Several years earlier, she had a total hysterectomy for endometriosis and was taking Premarin (estrogen). Hoping to get a better sense of how much pain Maureen's body caused her, I asked her to rate that pain on a scale of one to six (the somatic concern item on the Brief Psychiatric Rating Scale [BPRS]). Quickly, she answered four. If Maureen had no words for her emotional pain, at least she could be quantitative about her physical pain! Perhaps she was one of those alexithymic patients who had somatic symptoms related to her inability to discharge negative emotions and neutralize the physiological concomitants of prolonged emotional arousal. Kisha, on the other hand, acknowledged only those somatic symptoms related to the physical injuries she inflicted on her body.

Maureen was in considerable emotional distress, but she did not need to be hospitalized. I referred her to a psychiatrist committed to doing intensive outpatient psychotherapy. The ER attending wrote a prescription for venlafaxine (Effexor) (the "different antidepressant" Maureen had come for) and suggested she stop fluoxetine, which seemed to have done little for her after two years. Unlike many medications that need to be tapered to prevent rebound effects, fluoxetine can be discontinued without tapering because of its long half-life and that of its active metabolite, norfluoxetine.

Although not fully empirically validated, alexithymia is a useful clinical construct. For Kisha and Maureen, this word, so descriptive in its Greek roots, specifies a real phenomenon and identifies a deficit of self. Neither woman shut down or clammed up just for their ER interviews; the disconnect between feeling and words was part and parcel of their daily experience. Both women were personable, outgoing and articulate-except about what they felt. Neither showed any sign of schizoid personality disorder, a diagnosis that needs to be considered when patients seem detached from their feelings and lack insight. Being able to say that Kisha and Maureen had no words for their feelings is a major first step in identifying what is pathological about their worlds. How could anyone who cannot discharge negative emotions over a long time not be depressed? Or have any number of other emotional, as well as somatic, problems?

Identifying a patient as alexithymic opens a door to that person's pathological world and creates a fertile field for exploration in therapy. A workable identity can develop only after the elements of a person's life coalesce into a minimally satisfactory story. Paraphrasing Winnicott, a "good enough" identity requires a "good enough" story. It is the therapist's job to help the alexithymic patient convert a nonstory into a story that is at least partially authentic, so a more authentic identity can evolve from that story.

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