I'm not robot!

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The construct of alexithymia encompasses the characteristics of difficulty identifying feelings, externally oriented thinking, and a limited imaginal capacity. These characteristics are thought to reflect deficits in the cognitive processing and regulation of emotions and to contribute to the onset or maintenance of several
medical and psychiatric disorders. In this article, we review recent methods for assessing alexithymia and examine how assessing alexithymia and examine how assessing alexithymia is associated with heightened physiological arousal, the tendency to notice and report physical symptoms, and unhealthy compulsive behaviors. Alexithymic patients
may respond poorly to psychological treatments, although perhaps not to cognitive-behavioral techniques, and it is unclear whether alexithymia include its overlap with other traits, whether it is secondary to illness or trauma, the possibility of subtypes, and low
correlations among multiple measures. Nonetheless, we encourage the assessment of alexithymia in applied settings. Self-Care Assessment worksheet Grounding Exercise interactive Boundaries Info Sheet worksheet Coping Skills:
Anxiety worksheet What is the Cycle of Anxiety? video Alexithymia is a broad term to describe problems with feeling emotions. In fact, this Greek term used in Freudian psychodynamic theories loosely translates to "no words for emotion." While the condition is not well-known, it's estimated that 1 in 10 people has it. While Freudian theories are
largely considered dated, this condition seems to be increasing in awareness. It's often seen as a secondary diagnosis in other preexisting mental health conditions has problems expressing with and identifying emotions. In fact, studies
show that it only affects a small percentage. People who do have alexithymia may describe themselves as having difficulties with expressing emotions. Others may furthermore have trouble identifying their emotions. Such individuals don't necessarily have apathy. They
instead may not have as strong of emotions as their peers, and may have difficulties feeling empathy. Read on to learn more about the possible causes of alexithymia isn't well understood. There's a possibility it may be genetic. The condition may also be a result of brain damage to the
insula. This part of the brain is known for its role in social skills, empathy, and emotions, with some studies linking insula lesions to apathy and anxiety. Links to autismThe symptoms of autism spectrum disorder are wide-ranging, but there are still some stereotypes associated with this condition. One major stereotype is a lack of empathy, something
that has largely been debunked. At the same time, some research indicates that up to half of people with autism itself. Emotions and depressionIt's also possible to experience alexithymia with depression. It has been noted in major depressive
and postpartum disorders, as well as schizophrenia. Research indicates that between 32 and 51 percent of people with depressive disorders also have experienced trauma, especially during early childhood. Trauma and neglect at this stage may cause changes
in the brain that can make it difficult to feel and identify emotions later in life. Other associated condition may be present in certain neurological diseases and injuries. These include: As a condition may be present in certain neurological diseases and injuries. These include: As a condition may be present in certain neurological diseases and injuries.
associated with an inability to express feelings, an affected person might come across as being out of touch or apathetic. However, a person with alexithymia might personally experience the following in social contexts: angerconfusion difficulty "reading faces" discomfortemptiness increased heart ratelack of affection panic This condition may also make
it difficult for a person to interpret body changes as emotional responses. For example, you might have trouble linking a racing heart to excitement or fear, but are still able to acknowledge that you're experiencing a physiological response in the moment. Alexithymia is diagnosed by a mental health professional. It's not officially recognized by the fifth
edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Instead, your mental health provide a self-reported questionnaire. Another possible test is an MRI performed by a neurologist. This will provide images of the
insula in the brain. There's no one single test for alexithymia, much like neurological disorders and mental illnesses in general. It can take time to receive the right diagnosis. To date, there isn't a single individual treatment for alexithymia. The exact treatment approach depends on your overall health needs. For example, if you have depression or
anxiety, taking certain medications for these conditions for the conditi
responses. Some research has suggested the importance of beginning with your heart rate monitor or fitness watch can also help. With practice, you may become better able to distinguish anger from excitement and fear, for
example. A journal can also help you document your physical responses and emotional patterns. It's also important to keep in mind that negative emotions are just as important to keep in mind that negative emotions are just as important to keep in mind that negative emotions are just as important to keep in mind that negative emotions are just as important to keep in mind that negative emotions are just as important to keep in mind that negative emotions are just as important to keep in mind that negative emotions are just as important to keep in mind that negative emotions are just as important to keep in mind that negative emotions are just as important as positive ones. Learning how to identify these emotions are just as important as positive ones.
people who experience it, as well as friends and loved ones. If you think you're having trouble with recognizing or describing feelings, consider talking to a doctor about it. They can help guide you to the right therapy options to help improve on these important life skills. If you don't already have a mental health professional, our Healthline FindCare
tool can help you connect to doctors in your area. Alexithymia isn't widely known, but this condition has been studied for more than four decades. It's presented in individuals who have difficulty recognizing and expressing feelings, and it often coincides with another underlying neurological condition or mental health disorder. While not inherently
dangerous, this condition may inadvertently lead to interpersonal and relationship issues. The good news is that there are therapies available that can help you improve on mental health skills. Not only will this help with relationships with others, but more importantly, you may feel better, too.Read this article in Spanish. 1. Guillen V, Santos B, Munoz
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journal is cited, in accordance with accepted academic practice. No use, distribution or reproduction is permitted which does not comply with these terms. Main features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies included in the review. Author, yearSample features of the clinical studies in the review. Author yearSample features of the clinical studies in the review. Author yearSample features of the clinical studies in the review. Author yearSample features of the clinical studies in the review. Author yearSample features of the clinical studies in the review. Author yearSample features of the clinical studies in the review. Author yearSample features of the clinical studies in the review. Author yearSample features of the clinical studies in the review. Author yearSample features of the clinical studies in the review. Author yearSample features of the review of 
assessment (initial sample N = 144; directly interviewed N = 109)Gender 100% femalesAge, mean 21.5 ( ± 5)Diagnosis AN (N = 63) or BN (N = 39) (DSM-IV)BMI n.s.Illness duration, mean 4.3 ( ± 4.8)Comorbidities, anxiety and depressive disorders, substance-related disorders diagnosed with Mini International Neuropsychiatric Interview
(MINI).Multicenter research project involving academic psychiatric hospitals. Treatments could include (1) pharmacotherapy, any kind, for at least 3 months; (2) Psychotherapy. Assessment at baseline and 3-year follow-up with: clinical
interviewBDI-13CGIMINIMMPI-2 (Negative Treatment Indicators scale) TAS (cutoff ≥56) Explore the relationship between alexithymic features and treatment choices in a naturalistic prospective study. Global improvement of alexithymia and depression. TAS scores not influenced by antidepressants, psychotherapy, or both. Patients received differen
treatments (number, type) according to their alexithymic profile. Patients with high levels of alexithymia: more treatments and more antidepressants. Patients who became alexithymic during follow-up: more often re-hospitalized; fewer psychotherapies. 4Tchanturia et al. (15)N = 33 who attended all 10 sessions and completed both pre- and post-
intervention assessments (63% of the sample who completed baseline measures) Gender n.s. Age, mean 24.5 ( ± 8.2) Diagnosis AN (n.s.) Inpatient, South London and Maudsley National Adult EDs Service. CREST: manualized 10-session intervention addressing emotion
processing, in individual format. Includes psycho-education, experiential exercises, homework tasks. RSASTASMotivational ruler exploring importance to change and "ability to change"; BMIDecrease of anhedonia (RSAS) and alexithymia (TAS)
after CREST.Increase of perceived "ability to change" and of BMI.3Giombini et al. (32)N = 32 who completed the group cycleGender 87.5% femalesAge, mean 14.03 ( ± 1.75)Diagnosis AN (DSM-5 criteria)Weight for height %, mean 75.68 ( ± 6.44)Illness duration n.s.28.1% comorbidities.Inpatient child and adolescent EDs unit offering multi-
disciplinary treatment (individual, family, and group therapy). CREST-YP: manualized 5-session intervention, weekly, in group format. Includes psychoeducation, experiential exercise, homework. Semi-structured qualitative interview created ad hoc. SQERQ-CARSASTASMotivational ruler assessing self-reported importance to change and ability to
change.Data collected at the beginning and at the end of the cycle.Suitability of CREST-YP.Experience of YP receiving CREST-YP.Experience of YP receiving emotions; Emotions and ED; Homework, Suggestions for improvement.Quantitative results only partially supporting qualitative ones: no
significant change in ERQ-CA, RSAS, TAS, and motivational ruler scores. CREST-YP is a suitable intervention for YP with AN.4Beadle et al. (44)N = 20 AN patients tested both during starvation and after weight restoration (out of N = 26 tested at baseline); compared to 16 age-matched healthy women at comparable timepoints. Gender 100%
femaleAge in the AN sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample, mean 24.4( ± 5.5). Diagnosis AN (ANP or ANR)BMI: mean 15.7. Weight restoration defined as a BMI of at least 18.5 (in the 20 patients sample at least 18.5 (in the 
cognitive behavioral therapy, group and individual therapy, supervised eating, occupational and recreational therapy, physician supervision. EATEDI-3YBC-EDSHDRSHARSWAIS-IV CPT II Stroop Color and Word TestWCSTTAS-20IRI MMPI-2 (37 items). Differences (demographic, cognitive, clinical, and personality characteristics) between participants
with AN and healthy controls. Differences between the starvation and weight restoration phases within the AN group. Examination of relationships between alexithymia, emotional empathy, and self-regulation, controlling for depression and/or BMI when relevant. In the group of AN patients, decrease of DIF and EOT from the starvation to the weight
restoration phase. No change in DDF. Overall improvement in alexithymia.60hmann et al. (45)N = 29Gender 100% femaleAge, mean 1.2 (range 13–17)Illness duration, mean 7.2 months (range 2–18). Comorbidity in N = 23 cases N = 5 patients (17%) treated with
antidepressants. N = 3 had previous psychotherapy. Eating Disorder Outpatient Clinic, Department of Child and Adolescent Psychiatry, Medical University of Vienna (recruitment between May and September 2003-2006). A maximum of 40 weekly sessions (90 minutes each) of Multimodal G-CBT program, including 9 modules; therapeutic motivation.
psycho-education, individual problem analysis, (teaching of) problem solving strategies, soft and communication skills, hedonistic training, elements of awareness, body and schema psychotherapy. Family sessions once monthly. YSR (baseline and 3-6-9 and 12-months follow-up: EDEBDIFBAASWMUMEV-HEV-AMUM-
SOCSPSSIASBIKSTASTo assess changes of the psychopathological measures during the course of G-CBT and 1-year follow-up. To investigate whether emotional risk factors might complicate the course of the disorder. Hypothesis: patients with less disturbed handling of emotions
would have a better treatment outcome. Severe and multiple emotional deficits, difficulties of emotional control, problems in intrafamilial communication and expression of emotions. Alexithymia and SOC were disturbed and resistant to change in all
patients. Problems in handling, detecting, and expressing emotions are involved in promoting and maintaining anorexic behavior, and are resistant to change, especially in the patients with poor outcome. 4I ancu et al. (46)N = 30 soldiers with EDG ender 90% female. Age, mean 19.5 (range 18–21). Diagnosis N = 10 AN (33%); N = 15 BN (50%); N = 5
EDNOS (17%) (DSM-IV).BMI n.s.Illness duration n.s.Comorbidity90% had a personality disorder (mostly borderline ornarcissistic) according to the SCID-II questionnaire at the Zeriffin Mental Health Clinic, IsraelDefense Forces (2001–2003). Weekly group meetings (90 minutes) 6 months (lead by a social
worker with a social worker and a dietitian as cotherapists) Meetings included: psychoeducation; cognitive behavioral therapy combined with a dynamic approach. Assessment before and after the intervention with: EDI-2EAT-26TAS-26DESTo examine the efficacy of treatment program. To evaluate the rate of alexithymia and dissociation proneness in
the sample (before and after treatment). Treatment was associated with a significant improvement associated with a significant decrease on the DES and TAS-26 scores. Lundbad et al. (47)N = 30Gender 100% femaleAge range 25-40. Diagnosis AN and/or BN (type of eating disorder
described by patients and EDI-2 questionnaire) BMI n.s. Illness duration, > 5 years Comorbidities, n.s. Referred from the Department of General Psychiatry, Sahlgrenska University Hospital (Anorexia and Bulimia Clinic for Adults), Sweden. Psycho-pedagogic method facilitating the ability of patients to cope with negative feelings: 8 weekly written and
oral sessions teaching and coaching about emotional/affective status, in a group format. TASTAS scores changes after intervention (pre- to post- intervention) of alexithymia (TAS). Alexithymia negatively correlated with education; no correlation with illness duration, weight loss, depression, general psychoneurotic
pathology.1Becker-Stoll and Gerlinghoff, (48)N = 47 (N = 18 AN; N = 25 BN; N = 4 EDNOS)Gender 100% femaleAge, mean 21.7 (± 3.4; range 16–30). Diagnosis AN and BN (DSM-IV criteria). BMI, mean in AN 16.2 (± 1.5); mean in BN 22.8 (± 6.1)Illness duration n.s. Comorbidities n.s. Day Hospital at the TCE, Max Planck Institute of Psychiatry,
Munich (2001).TCE: three-phase treatment program consisting of a 4-week outpatient motivation phase, and a 4-month day hospital phase, and a 4-month outpatient follow-up treatment program consisting of a 4-week outpatient motivation phase, and a 4-month outpatient follow-up treatment program consisting of a 4-week outpatient motivation phase, and a 4-month outpatient motivation phase and a 4-month outpatient motivation phase and a 4-month outpatient motivation phase and a 4-month outpatient mo
confrontation, relaxation techniques, and dance therapy. Pre- and post-treatment assessment with: EDI (total score) TAS-20To determine whether a 4-month treatment outcome in the ED population. High levels of alexithymia in AN and BN patients,
without any difference in TAS scores between AN and BN.TAS scores decreased from pre- to post-treatment as well as EDI ones. Baseline scores for alexithymia did not predict post-treatment outcome. 4Elzakkers et al. (49)N = 70 (N = 56 assessed at 1-year follow-up) Gender 100% femaleAge, mean 27.3 (± 9.7) Diagnosis,
% ANR/ANP 49/51 (Severity of eating disorder symptoms was rated with the EDEQBMI, mean 15.5 ( ± 1.9)Illness duration, mean 8.6 ( ± 8.1)Comorbidities n.s. National specialist center for the treatment of eating disorders. Treatment including individual and group therapies, psychomotor therapy, rehabilitation on and outpatient, day-hospital or
inpatient basis. Baseline, 1- and 2-year follow-up. BMIBDI-IIEDEQIGTMacCAT-TSTAITASFull remission defined as satisfying 2 out of the 3 criteria described above. Mental capacity. Relation of the disorder course with psychological variables and
decision making. Full mental capacity group: mild AN at follow-up; improvement of BMI. Diminished mental capacity group: moderately ill category (DSM-5) at follow-up; no improvement of alexithymia; improvement of BMI; higher likelihood of inpatient
treatment.6Adamson et al. (50)Individual CREST, N = 66Gender 100% femaleAge, mean 25.8 (range 18-53)Diagnosis AN, (DSM-5)BMI, mean 14.8 (± 1.3)Illness duration, mean 8 (± 8.5)Score above the AQ10 cutoff 32%Group CREST, N = 62Gender 100% femaleAge, mean 25.5 (range 18-63)Diagnosis AN, DSM-5BMI, mean 14.8 ± 1.4)Illness
duration, mean 7.6 ( ± 8.3) Score above the AQ10 cutoff 34% Comorbidities, n.s. Inpatient. CREST in individual (N = 66) and group formats (N = 62). Individual format: manualized 8 weekly sessions, 40–45 minutes. Psychoeducation and experiential exercises. Group format: manualized 8 weekly sessions, 60 minutes. Optional, participants can drop out at any
time. Assessment before and after individual and group interventions with: RSASTASMotivational ruler (ability to change, importance to change) AQ-10BMIEffectiveness of CREST interventions. TAS and RSAS scores. ASD symptoms. Individual CREST: improvement in patients' alexithymia; increase in motivation; no impact on social anhedonia;
significant effect of ASD symptoms on RSAS and TAS scores. Group CREST: increase in motivation; no impact on social anhedonia and alexithymia; significant effect of ASD symptoms on TAS scores. 2
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