



Research Article

Exploring Alexithymia in Somatization using Rorschach Psychodiagnostics

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Abstract

It has been classically postulated that alexithymia is related to a pervasive inability of emotional recognition and expression. This leaves some individuals little choice but to somatise unprocessed emotions commonly caused by internal conflicts. The present study thus aimed to explore the nature of conflicts, controls and stress tolerance, affect, self-perception, and interpersonal perception and behavior in somatization patients with alexithymia. 30 individuals of both sexes and of the age range 20-50 years, diagnosed with somatization disorder and alexithymia, were purposively undertaken for the study. Toronto Alexithymia Scale 20, Sack's Sentence Completion Test and the Rorschach Test – Exner's Comprehensive System were used to screen for alexithymia, to measure conflicts and the other aforementioned domains respectively. Results revealed that conflicts related to self-concept, sex, and family were primarily present in this sample. Characteristic patterns of underlying vulnerabilities seemed to account for poor stress tolerance, affective complications, negative self-perception, and maladaptive interpersonal functioning. It is suggested that alexithymia and a tendency to develop conflicts in somatization are based on the foundation of certain fundamental personality predispositions. Identifying said personality patterns could aid in appropriate and effective goal-setting in psychotherapy, specific to this otherwise treatment-resistant patient population.

Keywords: somatization; alexithymia; conflicts; Rorschach domains.

Table of Contents

Method

Results

Discussion

Limitations, Implications and Future Directions



Conclusion

References

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The historical journey of somatization can be traced from the identification of ‘hysteria’ as an illness with an organic basis to it being recognized as a functional syndrome that is reflected in the diagnostic labels of modern day psychiatry. Originally known as Briquet’s syndrome (Feighner et al, 1972), the term ‘somatization’ under the heavy influence of psychoanalytic theory was eventually coined by Wilhelm Stekel in the early 20th Century, referring to the German word ‘*organsprache*’ which can be roughly translated to “*conversion of emotional states to physical symptoms*”(Marin & Carron, 2002). In fact, somatization as a condition still appears to lack an all-inclusive, universally adequate definition and is instead conceptualized as medically unexplained symptoms that are the physical expression of psychological distress, commonly prevalent in a wide variety of clinical set ups (Heinrich, 2004). This multidimensional nature of somatization is reflected in existing literature, as etiological studies of all presentations of the condition have broadly considered the interdependent role of personality, cognitive, psychodynamic and social and cultural factors in shaping the symptom experience (Kirmayer & Looper, 2006). Furthermore, the epidemiology of somatization differs as per age (Hilderink et al., 2013), sex (D’Souza & Hooten, 2019), educational background, marital and socioeconomic status (Baitha et al., 2020) and even manifestation (Escobar et al. 2010). The conceptualizations of the construct itself tend to vary in eastern and western cultures (Parker et al., 2001a) such that in India, somatization is generally viewed as a culturally sanctioned idiom of distress (Desai & Chaturvedi, 2017). Socio-cultural differences also become prominent in the wide spectrum of symptoms of varying localizations, expressions and chronicity of bodily distress displayed by patients with somatization within and across cultures (Obimakinde et al., 2014). Additionally, a large number of studies reporting sub-threshold but clinically significant somatic experiences, that may appear as primary symptoms, co-morbid or associated



complaints of some other psychiatric illness (Heinrich, 2004) have led researchers to argue that somatization is not a specific disease but rather a process with a variety of manifestations. As a result, doubts remain whether its classification only imposes pseudo-uniformity to an otherwise fluid and heterogeneous phenomenon (Oyama et al., 2007; Scheriber et al., 2000).

Initially considered to be an offshoot of Freudian neurotic pathology, alexithymia, literally meaning 'no mood for words', was first defined by Sifneos in 1973 as a distinctive deficit in one's emotional awareness or in one's capacity to verbalize affect (Taylor, 1987). The concept of alexithymia has come a long way from being a pre-paradigmatic construct (Taylor et al., 1991) to being an empirically sound model consisting of characteristic sub-domains (Watters et al., 2016b) that being, difficulty in identifying and describing feelings and externally oriented thinking (Bagby et al., 1994a). This particular model of alexithymia after rigorous time-tested experimentation has proven to be of significant clinical validity (Goerlich, 2018) and has been associated with a large number of illnesses, both psychiatric and psychosomatic in nature (Lewke et al., 2012). More relevant to the context of somatization, a language of physical complaints motivated by such a dearth of verbal and non-verbal symbolic vocabulary had been historically termed as 'somatothymia' by Stoudemire (1991). This implies that rather than entirely lacking an emotional life, individuals with alexithymia are more likely to communicate their feelings using somatic channels and manifestations (Mattila et al., 2008).

However, although a large number of studies have found that individuals with somatization obtain elevated scores on alexithymia measures (Waller et al., 2004) others have found no association between alexithymia and the prevalence of medically unexplained symptoms (Kooiman et al., 2004). A certain category of literature has also questioned the exclusivity of alexithymia in lieu of spuriously high positive relationships with other clinically relevant psychological concepts with apparently overlapping components, such as negative affectivity (Suslow & Donges, 2017) and emotional dysregulation (Epifanio et al., 2018). Herein lays the need for further exploration of alexithymia as a syndrome. Furthermore, although relevant to several mental disorders, literature is yet to conclude on distinctive mechanisms of the alexithymic contribution in illness-specific psychopathology (Kojima, 2012). In addition, an almost exclusive reliance on self-report measures in alexithymia research restricts applicability of obtained results (Vanheule, 2008) as subliminal yet characteristic aspects of the construct tend to remain undetected.



Since alexithymia is often viewed as a barrier to psychotherapeutic efficiency, more so in somatization due to a dispositional lack of emotional insight (Lumley et al., 2007), it is imperative to explore the underlying patterns that lie common in both these conditions. Given that somatization has been frequently conceptualized as serving defensive purposes to an alexithymic deficit (Levine, 2013), conflicts become significant in this context. Although existing literature of relevant pathological correlates (Landa et al., 2012a; Morris et al., 2007; Mousavi & Alavinezhad, 2016; Neff, 2003) implies the possibility of development of conflicts related to self and others in both these conditions, their exact nature remains unestablished. As the clinical phenomenology of both these processes appears to be mostly unconscious in essence, research highlights the importance of the Rorschach technique in the exploration and understanding of related, appropriate dimensions of personality as well (Sultan & Porcelli, 2006).

Method

In relation with the above background, the present study was undertaken to find out the nature of conflicts, controls and stress tolerance, affect, self-perception and interpersonal perception and behavior in somatization patients with alexithymia syndrome; with special focus on conflicts related to family, sex, interpersonal relations and self-concept and domain-specific response categories of aforementioned variables as per the Rorschach Test – Exner's Comprehensive System.

In terms of research design, the present study was a cross-sectional, exploratory, descriptive study. Purposive sampling technique was employed. The sample consisted of a total of 30 patients ($N = 30$) with alexithymia syndrome and diagnosed with somatization disorder as per ICD 10, in the age range of 20-50 years. Data was collected from two outpatient psychiatric clinics in Kolkata, India.

The inclusion criteria of the present study involved outpatients of both sexes diagnosed with somatization disorder as per ICD 10, with single or multiple somatic complaints, in the age range of 20-50 years, under psychotherapeutic and/or pharmacotherapeutic treatment.

The exclusion criteria involved patients presently diagnosed with a general medical condition, patients with a previous history of a physical illness that maybe related to lasting somatic symptoms, patients with other co-morbid psychiatric conditions as the primary diagnosis, illiterate patients and uncooperative patients.



The tools used in this study were an Informed Consent Form, a Socio-Demographic Form, a Semi-Structured Clinical Interview Form, Toronto Alexithymia Scale 20 (TAS-20), Sack's Sentence Completion Test (SSCT) and Rorschach Test – Exner's Comprehensive System.

Informed Consent Form: was used to explain the purpose and process of the study, with emphasis on clauses of confidentiality and voluntary participation.

Socio-demographic Form: was used to record the name, age, sex, educational background, occupational status and monthly income, residential status and family type of the patient.

Semi-Structured Clinical Interview Form: was used to record the age of onset and duration of illness, presence of other psychiatric features, previous history and current status of general medical conditions/ physical illnesses, family history of psychiatric illness, history of brain pathology if any, type and duration of treatment and the number and nature of somatic complaints.

Toronto Alexithymia Scale 20 (TAS 20) (Bagby et al.,1994a): is a self-report scale measuring alexithymia that is comprised of 20 items. It has 3 subscales: difficulty identifying feelings (7 items), difficulty describing feelings (5 items) and externally oriented thinking (8 items). Higher scores in each sub-scale indicate higher tendencies in the constructs they measure. Items are rated using a 5-point Likert scale where 1 indicates 'strongly disagree' and 5 indicates 'strongly agree'. There are 5 items that are negatively keyed (items 4, 5, 10, 18 and 19). The total score of alexithymia is obtained by adding the responses to all 20 items. The TAS-20 uses cut-off scoring, such that a score equal to or greater than 61 indicates alexithymia.

Sack's Sentence Completion Test (SSCT) (Sacks & Levy, 1950): is a semi-projective test that contains 60 items meant for adults. It covers the four areas of adjustment with 15 sub areas in total: 1. Family: attitude towards mother, father and family, 2. Sex: Attitude towards women and heterosexual relationships, 3. Interpersonal Relations: Attitude towards friends and acquaintances, colleagues at work or in school, boss at work or at school, subordinates, 4. Self-concept: attitude towards fear, guilt, life purpose (goal), attitudes toward the ability of self, past and future. Each item is scored 0, 1 or 2 depending upon the extent of conflict assessed. The average scores of each area reveal the severity of conflict in each area. An average score of 0 indicates no conflict; that of 0-1 indicates not significant to mild level of conflicts, that of 1



indicates mild level of conflicts, that of 1-2 indicates mild to severe level of conflicts and that of 2 indicates a severe level of conflicts.

Rorschach Test – Exner’s Comprehensive System (Exner, 1974): is a projective test used to assess the structure of personality. 10 standardized ink-blot cards are shown and scores in terms of location, determinants, content, developmental quality (DQ), form quality (FQ), popular responses (P), organizational activity (Z scores) and special scores are obtained. The scores are operated upon and analyzed as per the structural summary and a Rorschach profile is interpreted accordingly. The sub-domains of controls and stress tolerance, affect, self perception and interpersonal perception and behavior, along with their related variables were considered in the present study.

Thus the following sections of results and discussion aimed to describe in details the nature of alexithymia, profile of intrapsychic conflicts and relevant Rorschach domains of personality patterns and predispositions that were characteristic of the present sample.

Results

The mean age of the sample was 38 years (See Table 1). Majority of the sample was females, with an educational status up to matriculate, who were unemployed home makers having monthly income of less than Rs 10,000, settled in sub-urban areas of residence in nuclear families.

The mean age of onset of illness was 34 years and the mean duration of illness was 4 years (See Table 2). The majority of the sample had undergone treatment, with a larger proportion of the sample having received psychiatric treatment for a shorter duration of time. The mean number of somatic complaints reported was 5. Majority of the sample reported the presence of other psychiatric features with a larger proportion reporting the presence of anxiety features specifically. Majority of the sample reported the absence of a history of general medical condition and family history of psychiatric conditions.

Table 1.
Socio-demographic Details of the Sample (N=30).

Variables	M (SD)	Categories	n / (%)
Age (in years)	38 (8.94)	-	-
Sex		Male	1 / (3.3)
		Female	29 / (96.7)
Educational Status	-	Primary Level	13 / (43.40)
		Up to Matriculate	14 / (46.6)
		Above	3 / (10.0)
Occupational Status	-	Employed	11 / (36.7)
		Home Maker	19 / (63.3)
Monthly Income	-	< Rs 10,000	17 / (56.7)
		< Rs 20,000	12 / (40.0)
		> Rs 20,000	1 / (3.3)
Residence	-	Rural	Nil
		Suburban	24 / 80.0
		Urban	6 / (20.0)
Family Type	-	Nuclear	19 / (63.3)
		Joint	11 / (36.7)

Table 2.
Clinical Features of the Sample (N-30).

Variable	Categories	n / (%)	M (SD)
Age of Onset of Illness (in years)	-	-	34 (8.66)
Duration of Illness (in years)	-	-	4 (4.05)
	Untreated	8 / (26.7)	N/A
Type and Duration of Treatment (in years)	Treated	22 / (73.4)	4 (4.05)
	Psychiatric Medicine	14 / (46.7)	3 (2.37)
	General Medicine & Psychiatric Medicine	8 / (26.7)	5 (3.23)
Number of Somatic Complaints (Based on Body Parts Affected)	-	-	5 (1.94)
	Present	21 / (70.0)	-
Other Psychiatric Features	Anxiety Features	11 / (36.7)	-
	Depressive Features	7 / (23.3)	-
	Anxiety & Depressive Features	3 / (10.0)	-
	Absent	9 / (30.0)	-
History of General Medical Condition (Presently In Remission)	Present	14 / (46.6)	-
	Absent	16 / (53.3)	-
Family History of Psychiatric Condition	Present	6 / (20.0)	-
	Absent	24 / (80.0)	-



Majority of the sample reported the presence of cramps, pain, tingling sensations, burning sensations, numbness, heated sensations and weakness in decreasing order of percentage of occurrence. (See Table 3)

Table 3.
Nature of Somatic Complaints Reported.

Nature of Somatic Complaints	<i>n</i> / (%)
Pain	21 / (70.0)
Cramps	22 / (73.3)
Burning Sensations	13 / (43.3)
Tingling sensations	21 / (70.0)
Pins and Needles	2 / (6.7)
Heated sensations	9 / (33.3)
Numbness	13 / (43.3)
Weakness	9 / (33.3)
Tremors	4 / (13.3)
Restricted Breathing	1 / (3.3)
Strange Taste	1 / (3.3)
Nausea	1 / (3.3)
Tightness/Stiffness	5 / (16.7)
Dizziness	3 / (10.0)
Itching	1 / (3.3)
Heaviness in Body Parts	4 / (13.3)
Congestion	1 / (3.3)

The mean alexithymia total score of the sample was 75, where the maximum possible score was 100 and the minimum possible score was 1, indicating a high measure of alexithymia in the sample (See Table 4).

Table 4.
Toronto Alexithymia Scale (TAS 20) Profile of the Sample (N-30).

Domain	<i>M</i> (<i>SD</i>)	Maximum Possible Score	Minimum Possible Score
Alexithymia Total Score (> Cut-off 61)	75 (5.93)	100	1

The four domains of conflicts in decreasing order of mean scores were that of self concept, sex, family and interpersonal relations (See Table 5). The domains of self-concept, sex and family were in the mild-severe level of severity while that of interpersonal relations was in the mild level of severity. All sub-domains of conflicts were in the mild to severe category of severity, except that of attitude towards women (under 'family') and attitude towards co-worker (under 'interpersonal relations') which were in the not significant – mild category of severity.



Table 5.

Sack's Sentence Completion Test (SSCT) Profile of the Sample (N=30).

Domains with Sub-domains	M (SD)	Range of Disturbance
1) Family	1.2 (0.30)	Mild-Severe
Attitude towards Women	0.9 (0.48)	Not significant-Mild
Attitude towards Father	1.6 (0.43)	Mild-Severe
Attitude towards Family	1.1 (0.42)	Mild-Severe
2) Sex	1.4 (0.33)	Mild-Severe
Attitude towards Women	1.4 (0.39)	Mild-Severe
Attitude towards Heterosexual Relationships	1.3 (0.52)	Mild-Severe
3) Interpersonal Relations	1.0 (0.29)	Mild
Attitude towards Friends and Acquaintances	1.2 (0.43)	Mild-Severe
Attitude towards Co-worker	0.7 (0.37)	Not significant-Mild
Attitude towards Superiors	1.1 (0.48)	Mild-Severe
Attitude towards Subordinates	1.1 (0.44)	Mild-Severe
4) Self- Concept	1.5 (0.19)	Mild-Severe
Attitude towards Fear	1.4 (0.49)	Mild-Severe
Attitude towards Feelings of Guilt	1.6 (0.29)	Mild-Severe
Attitude towards Goal of Life	1.6 (0.27)	Mild-Severe
Attitude towards Ability to Self	1.6 (0.23)	Mild-Severe
Attitude towards the Past	1.3 (0.44)	Mild-Severe
Attitude towards the Future	1.4 (0.42)	Mild-Severe

Rorschach response alternatives as per Exner's Comprehensive System, specific to the domains of controls and stress tolerance, affect, self perception and interpersonal perception and behavior that were represented by maximum number of individuals in the sample when compared to other response alternatives was tabulated (See Table 6).



Table 6.
 Domain Specific Rorschach Responses with Maximum Weightage (N=30).

Domain	Response	n / (%)
Controls and Stress Tolerance	Adj D - 0	19 / (63.3)
	CDI - 4 or 5	20 / (66.7)
	EA < Average	24 / (80.0)
	Both Sides of EB>0, EA>3.5, L<1 ; OR; Both Sides of EB>0, EA>6, L>0.99, EA<4, L>1	7 / (23.3) & 6 / (20.0)
	Adj es – Average	13 / (43.3)
	eb Left > eb Right & Sum C' – 1 or 2	19 / (63.3) & 14 (46.7)
Affect	DEPI - Negative or Sub-Threshold	20 / (66.7)
	EA, EB and L – Ambitent	12 / (40.0)
	EBPer - N/A	21 / (70.0)
	eb Left > eb Right, Sum T<1, Sum C' < 2, Sum V- 0, Sum Y < 2	25 / (50.0)
	W Sum C > Sum C'	16 / (53.3)
	Afr < Average	18 / (60.0)
	Intel Index < 4	23 / (76.7)
	CP – 0	30 / (100.0)
	FC - (CF +C) + 1 or greater Or 2 x (CF+C), Pure C- 0	22 / (73.3)
	2 > S > 0	23 / (76.7)
	Blends, EB and L < Average	18 / (60.0)
	Stress Blends < 1	22 / (73.3)
	Unusual Complexity - 0	28 / (93.3)
	Colour-Shading Blends - 0	22 / (73.3)
Shading Blends < 1	25 / (83.3)	
Self Perception	OBS – Negative	30 / (100.0)
	HVI - Negative	26 / (86.7)
	Fr+rF - 0	30 / (100.0)
	Ego Index < Average	12 / (40.0)
	FD - 0, Sum V - 0, R < 17	15 / (50.0)
	An + Xy < 2	14 / (46.7)
	MOR < 2	20 / (66.7)
	Human Content >3 (Self-concept based on imagination)	17 / (56.7)
Interpersonal Perception and Behavior	CDI – 4 or 5	20 / (66.7)
	HVI - Negative	26 / (86.7)
	p > (a + 1)	16 / (53.3)
	Fd - 0	28 / (93.3)
	Sum T - 0	29 / (96.7)
	Sum Human Content and Pure H - Average	18 / (60.0)
	Human Content>3, PHR>GHR	14 / (46.7)
	COP - 1 or 2, AG - 0 or 1	17 / (56.7)
	PER < 2	26 / (86.7)
	ISOL Index < Average	18 / (60.0)

Note: **Adj D** - Adjusted D, **CDI** - Coping Deficit Index, **EA** - Experience Actual, **EB** - Erlebnistypus, **Adj es** - Adjusted Experience Stimulation, **eb** - Experience Base, **Sum C'** - Sum of Achromatic Color, **DEPI** - Depression Index, **L** - Lambda, **EBPer** - EB Pervasive, **Sum T** - Sum of Texture, **Sum V** - Sum of Vista, **Sum Y** - Sum of Shading, **Sum C'** : **W Sum C** - Constriction Ratio, **Afr** - Affective Ratio, **Intel Index** - Intellectualization Index, **CP** - Colour Projection, **FC** : **CF + C** - Form-Colour Ratio, **Pure C** - Pure Colour Responses., **S** - Space Responses, **OBS** - Obsessive Style Index, **HVI** - Hypervigilance Index, **Fr + rF** - Reflection Responses, **Ego Index** - Egocentricity Index, **FD** - Form Dimension, **An** - Anatomy, **Xy** - X-Ray, **MOR** - Morbid Responses, **a : p** - Active: Passive Ratio, **Fd** - Food, Sum Human Content & Pure **H** - Interpersonal Interest, **GHR: PHR** - Good Human Representational Response: Poor Human Representational Response Ratio, **COP** - Cooperative Movement, **AG** - Aggressive Movement, **PER** - Personalized Answers, **ISOL Index** - Isolation Index.

Discussion

The discipline of psychosomatic medicine pioneered the principle that un-acknowledged, unresolved emotions along with personality make up have an undeniable impact on bodily functions. Along this line of thought, the present study attempts to infer the content of conflicts and the contributing underlying factors which predominates the picture of alexithymia syndrome in patients with somatization.

Nature of alexithymia in the sample

In terms of the alexithymia total score, the mean has been found to be 75 for the current sample which represents a general high measure of the construct. Sub-domains of 'difficulty identifying feelings', 'difficulty describing feelings' and 'externally oriented thinking' have been considered to be descriptive features of the sample owing to their individual contributions in the elevation of the resultant alexithymia total score.

Nature of conflicts in the sample

Conflicts related to self-concept have been found to be the most prominent, followed by conflicts related to sex, family and interpersonal relations in decreasing order of significance. In terms of range, conflicts related to self-concept, sex and family fall in the mild to severe range of disturbance and may require therapeutic aid for resolution, while conflicts related to interpersonal relations fall in the mild range of disturbance which the individuals are likely to be able to resolve on their own.

In the domain of self concept, guilt has been found to be a primal (state and trait like) reaction to everyday failures (Lundh & Simonsson-Sarnecki, 2001). It is also likely to act as both the cause and effect of the person's incapacity for self direction and realization of appropriate goals setting (Ünüböl et al., 2018). As a result, there may be reduced chances of achievement to base a sense of self efficacy, which explains existing research findings of low self-esteem in this population (Mousavi & Alavinezhad, 2016). An omnipresent fear of potential disability (Katz et al., 2009) & uncertainty regarding future possibility of failures is also indicated. It appears that these individuals might be less occupied with their accumulating past transgressions than with the likelihood of facing similar challenges in future. Moreover, in the domain of sex, expectations of togetherness in heterosexual relationships may remain unmet owing to opposing



individualistic needs and behaviours (Montebarocci et al., 2004), as well as due to a lack of confidence in self. It is also possible that they may appear mistrustful instead. In addition, the present sample consisting predominantly of females is likely to view other women as threats for having more expertise in sustaining heterosexual relationships (Neumann et al., 2015).

Furthermore, conflicts related to family reveal that these individuals may inexpressively perceive father figures as restricted or unresponsive in meeting their needs, in contrast to possible maternal figures. A modelled deficit in expression and/or possible emotional deprivation may be due to family norms of restricted affectivity or a generally dysfunctional family climate, as has been suggested in past literature on alexithymia as well (Kench & Irwin, 2000; Schulte & Petermann, 2011).

In terms of interpersonal relationships, these individuals may themselves prioritize peripheral relations (friends, superiors and subordinates) less but may still end up perceiving poor social support being extended to them. However, this perception and resultant conflicts if any; are less likely to impact life satisfaction in comparison to heterosexual and familial relations (Ali et al., 2012).

Nature of controls and stress tolerance, affect, self-perception and interpersonal perception and behavior in the sample

With respect to the Rorschach domains, findings regarding controls and stress tolerance reveal a less mature personality organization ($Adj D = 0$, $CDI = 4$ or 5) and poor stress regulation in these individuals (Luminet et al., 2004) that creates vulnerabilities in coping with regular interpersonal demands. This indicates limited psychological resources ($EA < Average$) and emotional knowledge (Ciarrochi et al., 2001; Wilpart et al., 2017) that are only adequate for coping in unambiguous, well-structured environments. As a result, they may be frequently and easily overwhelmed by day-to-day requirements of life. These estimates of stress control have been found to be fairly reliable ($EA < Average$, Both Sides of $EB > 0$, $EA > 3.5$, $L < 1$; or; Both Sides of $EB > 0$, $EA > 6$, $L > 0.99$, $EA < 4$, $L > 1$, $Adj es = Average$). However, contrary to previous conceptualizations of alexithymia (Lumley, 2000), only a minority of the sample appears to experience an excessive internalization of these feelings (16.7 % scored $eb Right > eb Left + es > 4$ and 33.3% scored $Sum C' > 2$). This suggests that internalized states such as anxiety, depression, tension, apprehension etc. cannot fully account for the relationship



between somatization and alexithymia (Mattila et al., 2008), and that other more fundamental factors are probably at play.

Results in the domain of affect indicate that unlike other subtypes of alexithymia where florid signs of nervousness, guilt, anger, emotional fatigue, depression, anxiety caused by maladjustment go hand in hand (Khan, 2017) only a few individuals of the current sample (16.7%) may have a personality organization that is marked by frequent episodes of apparent affective disruption (DEPI = 5, CDI < 4). However, a masked presence of underlying emotional disturbances (DEPI = negative or sub-threshold) that are beyond awareness of the person and are thus somatised is possible.

The sample has a predominance of ambivalents (EA, EB and L measures in the range of ambivalents) with an inconsistent and confused approach towards logical versus emotional problem-solving and judgment, contrary to an avoidant approach as has been highlighted by existing research (Tominaga et al., 2013).

In addition, only a minority of the sample (16.7%) appears to be in distress at present, due to an unusual inhibition of expression of negative feelings and their resultant impact (Right side eb > Left side eb, Sum C' > 2), which is unusual since verbal inhibition of emotions in alexithymia has been frequently reported in the past (Grandi et al., 2011).

In fact, it has been implied that marginally lesser number of individuals (46.7%) inhibit emotional release regularly (Sum C' > W Sum C), as opposed to what was expected to be a more characteristic feature of the whole sample. This indicates that emotional inhibition is more of an active, defensive process unlike the affect constriction in alexithymia which is considered to be a deficiency (Lumley et al., 2007). These individuals also appear less willing and/or interested to process emotional stimuli due to an inability to grasp the same (Afr < Average) which results in discomfort in confronting emotions. This is consistent with existing evidence of mediational properties of difficulty in identifying feelings that influence psychosomatic experiences in alexithymia (Panayiotou et al., 2014). There are no indications of a mature defence like intellectualization (Intel Index < 4), which explains the need to adopt infantile, pre-verbal defences like somatization (Bogutyn et al., 1999). There are also no indications of difficulty in modulating emotional discharge (FC = (CF + C) + 1 or greater or = 2 x (CF+C), Pure C = 0), which rules out emotional modulation as a problem area as opposed to a deficit in accessing intense emotions (Matilla, 2009). This implies that emotional regulation is a construct separate



and discrete from alexithymia, although in literature they have been documented to coexist often (Pandey et al., 2011). However, there seems to be a simplistic trait-like affective psychological organization regardless of situational stress (Pandey & Choubey, 2010), which makes them vulnerable to behavioral disruptions in the face of emotional complexities (Blends, EB and L < Average, Stress Blends < 1, Unusual Complexity – 0, Shading Blends < 1). Even then, only a few struggle with attaining emotional closure (Colour-Shading Blends – 0), although probably because detachment from emotions nullifies any need as such to begin with. There is no evidence of any denial or convenient reality bending of unpleasant experiences (CP = 0) or of an oppositional attitude/ anger ($2 < S > 0$). However, negative feelings although aroused in a tolerable range, can become unusually burdensome due to inexpression.

Findings related to self perception strongly imply a generally negative estimate of personal worth (Ego Index < Average) and competence (Moormann et al., 2008) and a lack of narcissistic preoccupations (Fr+rF = 0). They may be involved in routine self inspecting behavior (FD = Sum V = 0, R < 17), however this is more likely to be merely external or sometimes interoceptive in nature. Bodily and self image related preoccupations that cause a disconcerting sense of vulnerability appear to be present (An+Xy > 2). A small minority of the sample (33.4%) is also likely to perceive apparent negative attributions or blemished features (MOR > 2) more than usual. All of this accounts for the experience of somatosensory amplification in the sample (Longarzo et al., 2015). Resulting impressions on self image/value tend to be based on imaginary experiences mostly (Human Content > 3), which is in line with the classical concept of the 'fragmented self' of the alexithymic personality (McDougall, 1980a). There is no indication of standards of precision or perfection (OBS = Negative), but because these individuals seem to knowingly have menial and commonplace standards of achievement, failures are further likely to add on to a negative self worth. They are also not intrinsically mistrustful and accusatory towards others (HVI = Negative), probably because they cannot afford to be so with such feelings of inadequacy. However, this implies some amount of insight regarding the source of difficulties being within the self as opposed to being external.

In terms of interpersonal perception and behavior, the sample appears to be less socially mature (CDI = 4 or 5), with mostly superficial relationships. They may appear to be inept or insensitive and may shy away from discourse and close emotional ties (Spitzer et al., 2005) due to an exaggerated concern regarding maintenance of personal space. As a result, although not guarded by nature (HVI = Negative), these individuals may be judged as rejecting, cold, sceptic



and distrustful by others because of said deficits (Vanhuele et al., 2007) which further jeopardize the chances of any meaningful and fulfilling socialization. This leads to inevitable interpersonal dissatisfaction, despite the lack of evidence of any actual social isolation (ISOL Index < Average). To add to this, they are mostly passive ($p > a + 1$) and avoidant of responsibilities in relationships (Tominaga et al., 2014) most likely due to aforementioned sense of self incompetence and resulting feelings of helplessness. However, they are not defensively authoritative (PER < 2) or unnaturally submissive or dependent (Fd = 0). Instead, they are likely to acknowledge & express needs for closeness unusually or conservatively (Sum T = 0) due to unease, with little concern about manifesting one's own desires and needs to others (Vanhuele et al., 2007) which further feeds into their negative social image. Findings also indicate that they lack necessary adaptive skills (Human Content > 3, PHR > GHR) especially in terms of communication (Besharat, 2010), despite harboring social interest (Sum Human Content and Pure H = Average) and a generally positive and hopeful view of interpersonal endeavors and interactions (COP = 1 or 2, AG = 0 or 1). This in turn leads to a prominent gap between their social reality and social desires. However, these findings do not indicate an inherent fearful or avoidant attachment style in this sample as has been claimed consistently for this population thus far (Landa et al., 2012b).

Limitations, Implications and Future Directions

This study had some limitations. A larger sample size and a randomized sampling method could have aided in better generalizability of the results. Additionally, TAS-20 could only be used as a screening tool and no estimate of predominance of one sub-domain of alexithymia over another could be obtained. Since this was also a descriptive study, no cause-and-effect relationships between the conflicts and personality domains could be established.

However, there are also some strengths and implications to be highlighted. The present study focuses on the process of somatization rather than somatization as a stringent diagnostic entity. It also aims to explore domains of conflicts and underlying vulnerabilities that may prove to be descriptive of this population and can help to isolate relevant variables for further research. Few studies have attempted to explore the content of conflicts in alexithymia in the context of somatization. The study also takes into account the language-constricted nature of this population and relies on the use of semi-projective and projective methods. It does not restrict



itself to identifying individual Rorschach variables as has been done before but explores relevant domains as a whole. Furthermore, all variables included are of therapeutic relevance.

The findings of the present study could be further substantiated and enriched if future research could include and explore samples from larger community populations, defence mechanisms against intrapsychic conflicts, intervention models targeting relevant personality predispositions and masked presence of depression and/or anxiety in this population and compare somatization patients with and without alexithymia syndrome and patients of different age ranges, genders and diagnoses of somatising conditions along these dimensions.

Conclusion

In summary, the primary concern with the present sample seems to be the indication that they are almost entirely unable to understand emotions as they are, and not that they deliberately inhibit or internalize what they consciously feel. It is this emotional incapacity and confusion caused by deficits of alexithymia that lead to the experience of an unprocessed mass of distress resulting from a pervasive lack of coping resources, poor stress regulation and tolerance, predisposition-based complications in affective styles, negative self-perception and interpersonal maladjustment and dissatisfaction. As such, internal turmoil tends to be language-less without conscious identification, description and internal orientation, and subsequently it is more likely to take the shape of conflicts. Thus, certain innate, primitive underlying patterns of personality makeup along with the alexithymia traits, make these individuals more susceptible to develop intrapsychic conflicts related to the self and significant others. When these burden the psyche beyond capacity of tolerance, they are likely to be expressed as somatised anguish. These findings also suggest that such individuals are not as wilfully avoidant, suspicious, resistant and/or aloof as they appear to be but are simply unequipped to yield to interpersonal advances as well as therapeutic efforts because of constitutional vulnerabilities found.

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Competing Interests

The authors have declared that no competing interests exist.



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