Citation:

Parker, J. D. A. (2005). The relevance of emotional intelligence for clinical psychology. In R. Schulze & R. D. Roberts (Eds.), *Emotional intelligence: An international handbook* (pp. 271-287). Hogrefe & Huber.

13

The Relevance of Emotional Intelligence for Clinical Psychology

James D. A. Parker
Trent University, Canada

Summary

This chapter examines the relevance of the emotional intelligence (EI) construct for clinical psychology. Although virtually no direct clinical research yet exists using the EI construct, several related constructs have generated a large clinical literature. Of particular relevance is the alexithymia construct. Although initially linked with individuals experiencing psychosomatic problems, alexithymia has come to be associated with a variety of clinical disorders, such as substance use disorders and eating disorders. Within various non-clinical populations, alexithymia has been associated with a variety of health, lifestyle, and interpersonal problems. Individuals who score high on measures of alexithymia are often unsuitable clients for many forms of insight-oriented psychotherapy. In response, several clinicians have developed therapeutic modifications for working with these individuals. As summarized in the chapter, these modifications attempt to increase client awareness of problems in the way they process and experience their emotions. Techniques particularly suited to the use of group intervention are also described.

13.1 INTRODUCTION

This chapter examines the relevance of the emotional intelligence (EI) construct for clinical psychology. To date, little clinical research exists related to EI. This is undoubtedly a result of the fact that reliable and valid measures for EI have only recently become available. Although there is little direct literature available on this topic, there are several constructs that overlap with EI that have generated a relatively large clinical literature. The first section of this chapter identifies several of these overlapping constructs (particularly the personality variable of alexithymia), along with summarizing some of the more important findings from the relevant clinical literature. The second part of this chapter describes a number of specialized psychotherapeutic techniques that may be helpful when working with individuals who have problematic levels of EI.

13.2 PRECURSORS TO THE EMOTIONAL INTELLIGENCE CONSTRUCT

Although various models have been proposed for the EI construct (Bar-On, 1997, 2002; Boyatzis, Goleman, & Rhee, 2000; Mayer, Caruso, & Salovey, 1999; Salovey & Mayer, 1990), implicit in all are important implications for clinical psychology. The ability to identify and communicate internal mental states, the ability to link particular mental events with specific situations and personal behaviors, the ability to use information about feelings and emotions to guide future behavior, as well as the ability to mentally regulate negative or extreme emotional states, constitute core abilities in most models of EI. The clinical implications of these types of abilities are vast, since they have been associated with a variety of clinical disorders, such as substance use disorders, somatoform disorders, eating disorders, and anxiety disorders; within various non-clinical populations, these abilities have been linked with a variety of health, lifestyle, and interpersonal problems (Taylor, Bagby, & Parker, 1997). These are also the type of basic abilities often linked with successful outcomes from various types of clinical interventions (Ackerman & Hilsenroth, 2003; Greenberg & Safran, 1987; Horowitz, 2002; Krystal, 1988; Taylor, 1987). For example, successful insight-oriented psychotherapy often depends on the client's "ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experiences and behavior" (Applebaum, 1973, p. 36).

To date, little empirical literature exists on the implications of EI and clinical psychology. This state of affairs is likely a result of the lack of reliable and valid measures for the EI construct. However, if one broadens the search to include research on related constructs, a rather sizeable literature can be found. One of the oldest relevant literatures is associated with research trying to predict successful outcomes in psychotherapy. As is frequently noted in the clinical literature (Krystal, 1982; Silver, 1983; Taylor, 1977, 1984), many individuals respond quite poorly to insight-oriented psychotherapy. From the very start of

treatment some individuals are more difficult to manage than others. These are often the same individuals who stop treatment after a few sessions, become quickly frustrated by the slow pace of therapy, and question the relevance of topics raised by the therapist (Beckham, 1992; Saltzman, Luetgert, Roth, Creaser, & Howard, 1976).

Taylor (1977) has noted that the patient is not the only one frustrated in these types of situations: "the therapist enters into a relationship expecting to be fed interesting fantasies and feelings only to encounter increasing frustration, dullness and boredom" (Taylor, 1977, p. 143). Not surprisingly, counter transference problems are a risk when working with these clients (Silver, 1983; Taylor, 1977). These types of difficulties (within the therapeutic process) have several important practical implications. One of the most obvious is the termination of therapy by the client. Depending on the populations being examined, an early study by Owen and Kohutek (1981) reported that drop out rates from psychotherapy can be as high as 80% to 90%, with almost half of the terminations occurring after the first few sessions (Baekeland & Lundwall, 1975; Pekarik, 1983; Reder & Tyson, 1980; Sue, McKinney, & Allen, 1976).

Given the potential for high termination rates among many clients, it is not surprising that the search for variables that might identify individuals less likely to benefit from psychotherapy has a long research history (see, e.g., Bachrach & Leaff, 1978; Barron, 1953; Tolor & Reznikoff, 1960). Knowing something about a potential client's level of emotional competency may be very useful to the therapist at the start of treatment. Although there are many reasons why individuals terminate psychotherapy (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985), various emotional and social competencies appear to play an important role (Krystal, 1988; Mallinckrodt, King, & Coble, 1998; McCallum, Piper, & Joyce, 1992; Pierloot & Vinck, 1977; Piper, Joyce, McCallum, & Azim, 1998; Taylor et al., 1997). A rather sizeable literature has developed on the personality variables that predict successful outcomes with psychotherapy (Bachrach & Leaff, 1978). Some of the related constructs that have been identified include private self-consciousness (Fenigstein, Scheier, & Buss, 1975), self-awareness (Bloch, 1979), need for cognition (Cacioppo & Petty, 1982), ego strength (Lake, 1985), and levels of emotional awareness (Lane & Schwartz, 1987). Among these various overlapping constructs, psychological mindedness and mindfulness appear to have generated some of largest bodies of empirical literature (Langer, 1989; McCallum & Piper, 1997, 2000; see also Chapter 4 by Ciarrochi & Godsell).

There is considerable overlap between the constructs of psychological mindedness and EI. Silver (1983), in an early definition of psychological mindedness, suggested that it involved the individual's "desire to learn the possible meanings and causes of his internal and external experiences as well as the patient's ability to look inwards to psychical factors rather than only outwards to environmental factors" (p. 516). A more recent model suggests that psychological mindedness involves several basic mental abilities: having access to one's feelings, a willingness to talk about one's feelings and interpersonal

problems to others, an active interest in the behaviors of others, and a capacity for behavioral change (Conte et al., 1990).

Not surprisingly, individuals with limited psychological mindedness often experience psychotherapy as a confusing and frustrating experience (Piper et al., 1998) and this personality variable has been consistently linked with negative outcomes in psychotherapy (McCallum et al., 1992; McCallum, Piper, Ogrodniczuk, & Joyce, 2003; Piper et al., 1998; Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001). According to Piper et al. (1998), psychological mindedness (PM) "may reflect a useful general ability to analyze conflicts and solve problems, whether the conflicts are internal or external. Thus, PM may be of value to a variety of individual therapies, even those of different theoretical and technical orientations (e.g., cognitive-behavioral therapy)" (p. 565). Clinicians may want to consider assessing their client's level of psychological mindedness at the start of treatment.

13.3 ALEXITHYMIA

Alexithymia is another construct with considerable clinical relevance to EI (Parker, Taylor, & Bagby, 2001; Taylor, 2000; Taylor et al., 1997). Compared to other related constructs, however, alexithymia has generated a vast literature. The abstract database maintained by PsycINFO is a useful tool for tracking the growth of work on alexithymia. Although the concept was not formally introduced until the mid-1970s (Sifneos, 1973), over 1200 papers and chapters (using the words alexithymia or alexithymic in the abstract or title) were included in the database at the end of 2003.

The concept of alexithymia evolved from clinical observations of individuals who responded poorly to psychotherapy. Writing over half a century ago, Ruesch (1948) identified a cluster of personality variables in a subset of his patients who were experiencing various psychosomatic health problems. Many of these individuals seemed to be quite immature and unimaginative in their thinking and had a tendency to use direct physical action for emotional expression. Another contemporary, Karen Horney (1952), described a similar set of characteristics in many of her patients who responded poorly to psychoanalytic intervention: they had a profound lack of emotional awareness, minimal interest in fantasies and dreams, and a very concrete (externalized) style of thinking. Drawing on this early clinical work, as well as his own research on the personality of individuals experiencing various classic psychosomatic diseases (Nemiah & Sifneos, 1970; Sifneos, 1967), Sifneos (1973) coined the word *alexithymia* (from the Greek: a = lack, lexis = word, thymos = emotion) to identify the cognitive and affective characteristics of many of his patients. Over the past three decades alexithymia has come to be defined by the following core features: difficulty identifying feelings and distinguishing between these feelings and the bodily sensations of emotional arousal; difficulty describing feelings to others; constricted imaginal processes; and a stimulus-

bound, externally-orientated, cognitive style (see Taylor, 1984, 2000; Taylor et al., 1997).

In addition to these core parts of the definition, several other common characteristics have been observed in alexithymic individuals that have important clinical implications. Alexithymia has been linked with a limited capacity for empathy (Guttman & Laporte, 2002; McDougall, 1989; Taylor, 1987), problems in processing emotionally-toned or charged information (Stone & Nielson, 2001; Suslow & Junghanns, 2002), as well as difficulties identifying emotions from the facial expressions of others (Lane et al., 1996; Parker, Taylor, & Bagby, 1993). The relationship between dreams and alexithymia has also been of interest to researchers. An early work by Krystal (1979) reported that it was very difficult to work dreams into psychotherapy when treating alexithymic patients. Several different research teams have found empirical evidence that alexithymic individuals have difficulty remembering or recalling dreams (De Gennaro et al., 2003; Krystal, 1979; Nemiah, Freyberger, & Sifneos, 1976). A study by Parker, Bauermann, and Smith (2000) found evidence that the quality of the dreams was also associated with alexithymia. When alexithymic individuals were awakened during REM periods their dream reports were significantly less bizarre and strange than the reports of non-alexithymic individuals.

Since alexithymic individuals often have problems identifying and understanding their emotions, as well as communicating these experiences to others, they are less likely to turn to other people for emotional support. Their limited range of healthy affect regulating abilities also limits the likelihood that alexithymic individuals will regulate emotional distress via daydreams or other imaginative mental activities (Mayes & Cohen, 1992; Taylor et al., 1997). The end result is that these individuals are at an elevated risk for developing a number of clinical disorders:

> It is not surprising that alexithymia has been conceptualized as one of several possible personality risk factors for a variety of medical and psychiatric disorders involving problems in affect regulation. For example, hypochondriasis and somatization disorder might be viewed as resulting, at least in part, from the alexithymic individual's limited subjective awareness and cognitive processing of emotions, which leads both to a focusing on, and amplification and misinterpretation of, the somatic sensations that accompany emotional arousal. (Taylor et al., 1997, p. 31)

Although alexithymia was initially linked with individuals experiencing psychosomatic problems (for a review of this literature see De Gucht & Heiser, 2003), it has become quite evident in the clinical literature that the core features of alexithymia can be observed among patients experiencing a number of psychiatric disorders, such as posttraumatic stress disorder (Badura, 2003; Zlotnick, Mattia, & Zimmerman, 2001), substance use disorders (Cecero & Holmstrom, 1997; Rybakowski, Ziólkowski, Zasadzka, & Brzezinski, 1988), eating disorders (Zonnevijlle-Bender, van Goozen, Cohen-Kettenis, van Elburg, & van Engeland, 2002), and problem gambling (Parker, Wood, Bond, & Shaughnessy, 2005).

For health care professionals, the presence of alexithymia features in their clients has other implications (apart from an increased vulnerability for various psychological disorders). These individuals may be at an increased risk for unnecessary medical consultation and procedures. A recent Finnish study found that alexithymic adults used significantly more health care resources during a 1-year period than non-alexithymic adults (Jyvaesjaervi et al., 1999). The poor communication style of alexithymic individuals, combined with the tendency to somatize their distress (Taylor et al., 1997), may be a contributing factor to this finding. When it comes to medical or psychological health problems, alexithymia may have an important mediating role inhibiting effective diagnosis and patient-physician communication (Tacon, 2001; Williams et al., 2001). Health care professionals generally respond to somatic problems in their patients with tests and interventions. The subsequent failure of these interventions to provide symptom relief often leads to additional tests and interventions being prescribed. The overall effect is that alexithymic individuals are at risk for medical complications or other iatrogenic problems.

Given the widespread health care implications associated with alexithymia, the dramatic increase in empirical work on the construct in the past few decades is not surprising. Another reason for the rapid growth of research must also rest with the proliferation of measures that quickly developed for the construct. Since the mid-1970s a wide assortment of alexithymia measures have been developed: observer-rated questionnaires and interviews (Haviland, Warren, Riggs, & Nitch, 2002; Sifneos, 1973, 1986; Taylor et al., 1997), self-report scales (Apfel & Sifneos, 1979; Bagby, Parker, & Taylor, 1994; Bermond, Vorst, Vingerhoets, & Gerritsen, 1999; Kleiger & Kinsman, 1980; Parker, Taylor, & Bagby, 2003; Sifneos, 1986; Taylor, Ryan, & Bagby, 1986), projective techniques (Acklin & Alexander, 1988; Cohen, Auld, Demers, & Catchlove, 1985), and Q-sort measures (Haviland & Reise, 1996). Although the psychometric properties of these measures vary greatly (for detailed reviews on alexithymia measures, see Taylor, Bagby, & Luminet, 2000; Taylor et al., 1997), researchers interested in alexithymia have been able to choose from a wide range of potential measures (depending on their populations and research questions).

Recent empirical evidence, using different self-report measures for the constructs, indicates that alexithymic individuals score low on measures of EI. Schutte et al. (1998) developed a 33-item self-report scale for EI derived from an early model proposed by Salovey and Mayer (1990). Using the 26-item Toronto Alexithymia Scale (TAS; Taylor et al., 1986), they found a correlation of $-.65$ in a small sample ($N = 25$). More recently, using the same measure of EI, Saklofske, Austin, and Minski (2003) found a similar moderate negative association ($-.52$) between the EI measure and alexithymia using the psychometrically superior 20-item TAS (Bagby et al., 1994). Palmer, Donaldson, and Stough (2002), using the Trait Meta-Mood Scale (TMMS; Salovey, Mayer, Goldman, Turvey, & Palfai, 1995) to measure EI, found a correlation of $-.42$ in a sample of adults using the TAS-20. Using the BarOn Emotional Quotient Inventory (EQ-i; Bar-On, 1997), Dawda and Hart report a correlation of $-.49$ for men and $-.55$ for women between the total EI scale and the TAS-20. Parker

et al. (2001), using a larger sample of adults (N = 734), report a correlation of −.72 between the same two measures. Parker, Hogan, Majeski, and Bond (2004) report a similar high correlation (−.68) between the TAS-20 and the total EI scale on the short form of the EQ-i (i.e., EQ-i: Short, Bar-On, 2002). This consistent pattern of moderate to high correlations is quite remarkable given the different models for EI used in these various studies.

It should be noted, however, that most of the existing empirical work on the relationship between EI and alexithymia has utilized self-report measures. This state of affairs is not surprising, since alternatives to a self-report methodology have only recently been available for the EI construct. Mayer et al. (1999), for example, developed a performance-based measure of EI that asks respondents to solve a variety of different emotion-related problems (Multi-Factor Emotional Intelligence Scale; MEIS). Mayer, Salovey, and Caruso (2002) have since revised the MEIS (now called the Mayer-Salovey-Caruso Emotional Intelligence Test; MSCEIT). Future research needs to explore the empirical relationship between alexithymia and EI using a variety of measurement approaches for both constructs. However, two unpublished studies using the MSCEIT and the TAS-20 provide additional evidence for conceptual overlap between the two constructs (Lumley et al., 2002; Parker, Bagby, & Taylor, 2003). Both studies, using samples of undergraduate students, found moderate negative associations between total scores on the two instruments.

The consistent negative association that has been found between self-report measures of alexithymia and EI is consistent with theoretical work on both constructs. A comparison of the definitions of alexithymia and EI suggests that the two constructs are closely related (Parker et al., 2001; Taylor, Parker, & Bagby, 1999). In an early paper describing their model of EI (see Chapter 2 by Neubauer & Freudenthaler), Salovey, Hsee, and Mayer (1993) conceptualized alexithymia as the extreme lower end of the EI continuum. Thus, while few clinical studies have directly examined the clinical implications of EI, clinicians interested in these implications can turn to the vast literature on alexithymia (given the conceptual and empirical overlap between these two concepts).

As several writers have noted (Krystal, 1982; Taylor, 1987), individuals with high levels of alexithymia, while they may be at risk for developing a variety of physical and mental health problems, are often unsuitable clients for many forms of insight-oriented psychotherapy: Alexithymia may be "the most important single factor diminishing the success of psychoanalysis and psychodynamic psychotherapy" (Krystal, 1982, p. 364). Consistent with Horney's (1952) clinical observations over half a century ago, the psychological problems experienced by many of these individuals may actually be made worse by traditional forms of psychotherapy (Krystal, 1982; Sifneos, 1975; Taylor, 1987; Taylor et al., 1997).

Faced with the problem that conventional forms of psychotherapy might not work, or might make some clients worse, some clinicians have developed a number of therapeutic modifications for working with alexithymic individuals. These modifications contrast with traditional psychotherapy because they attempt

> ...to elevate emotions from a level of perceptually bound experience (a world of sensation and action) to a conceptual representational level (a world of feelings and thoughts) where they can be used as signals of information, thought about, and sometimes communicated to others. (Taylor et al., 1997, p. 252)

In general, these modifications attempt to increase client awareness of problems in the way they process and experience their emotions. The following section describes a number of these therapeutic interventions, as well as some of the empirical literature exploring the clinical benefits.

13.4 PSYCHOTHERAPY AND ALEXITHYMIA

Krystal (1979, 1988) has written some of the most detailed accounts yet on the attempt to modify or adapt traditional forms of psychotherapy for use with alexithymic clients. An important first step in the clinical process, according to Krystal (1979, 1988), is to try and make the client aware that a major cause of their problems is a deficiency in the way he/she understands and communicates emotion. This may prove to be a difficult step to achieve, since many alexithymic individuals give little importance to emotions; many alexithymic patients initially find discussions about emotions and feelings boring and frustrating (Taylor, 1995). A second step in the clinical process, according to Krystal (1979, 1988) is often quite basic and educational. The therapist works to improve basic emotional skills in the client: helping the individual to recognize and correctly label specific emotions, learning to differentiate among different emotional experiences, and learning to better communicate these feelings to others.

This type of modified psychotherapy is often a slow and tedious process (Taylor, 1995). One of the first difficulties the therapist must try to overcome is the alexithymic client's often poor inter-personal skills. These individuals often find close attachments quite difficult (Taylor et al., 1997). With a limited capacity to share personally significant feelings and experiences with others (Fischer & Good, 1997; Mallinckrodt et al., 1998), they are often quite fearful of intimacy. Not surprisingly, alexithymic clients often prevent close emotional relationships from developing with their therapist (Brown, 1985; Taylor, 1987). Although they are quick to assume a dependent patient role, alexithymic individuals often expect that their problems can be "cured" with specific medical interventions. When a quick "fix" is not forthcoming, the client's initial feelings of boredom from individual therapy sessions can quickly escalate to frustration and anger, with an increased risk of treatment being terminated (Taylor, 1995).

13.4.1 Individual Therapy

Using the type of techniques and ideas described in this section, a number of clinicians have written about being able to reduce alexithymic symptoms in

their patients (Krystal, 1988; Taylor et al., 1997). Individuals with problematic levels of alexithymia have learned to have a better understanding of their feelings, a better ability to differentiate between different emotional experiences, and developed a larger repertoire of skills for communicating information about their emotions and feelings. For some individuals it has also been found useful to start the intervention process by combining psychotherapy with behavioral techniques, such as relaxation training or biofeedback (Taylor, 1987; Taylor et al., 1997). These types of behavioral techniques may improve introceptive awareness in alexithymic clients, especially the ability to self-regulate different physiological states. Greenberg and Safran (1987, 1989) have also suggested that the therapist might want to pay more attention to non-verbal expressions of emotion (e.g., body movements, gestures, and sighs) than is usually done during specific therapy sessions. These behavioral events can become important information sources in the process of teaching the client to better communicate their feelings (and to better interpret the internal states in others).

There is also evidence that teaching alexithymic individuals to pay attention to their dreams may improve the progress of psychotherapy (Cartwright, 1993). As tangible mental events, dreams provide the therapist with convenient material for getting the alexithymic individual to focus on inner feelings and experiences. The therapist can also increase the likelihood of developing better emotional skills in alexithymic clients by using their own emotional experiences (generated in specific therapeutic sessions) more than is usually done in traditional insight-oriented psychotherapy (Krystal, 1982; McDougall, 1989; Taylor, 1987). If counter transference problems arise, which often happens with alexithymic clients (Krystal, 1979; Taylor, 1977), the therapist might want to talk about his/her feelings of boredom and frustration with the client. The therapist might also want to share humor and daydreams during individual sessions. All of these forms of communications help the client associate specific interpersonal situations with particular inner experiences.

One of the first studies to examine the benefits of different types of psychotherapy for clients with alexithymia was conducted by Pierloot and Vinck (1977). Outpatients experiencing a variety of different anxiety problems were randomly assigned to one of two different interventions: short-term psychodynamic psychotherapy versus behavior therapy (i.e., systematic desensitization). These authors found that "patients with more alexithymia characteristics are more likely to drop out from psychodynamic therapies, but in systematic desensitization they persist as well as those without alexithymic characteristics" (Pierloot & Vinck, 1977, p. 162). Keller, Carroll, Nich, and Rounsaville (1995) examined responses to different forms of psychotherapy in cocaine abusers who were alexithymic or nonalexithymic. Participants were randomly assigned to four different treatment groups: 1) cognitive-behavioral treatment plus a drug placebo; 2) cognitive-behavioral treatment combined with the tricyclic antidepressant desipramine; 3) clinical management plus a drug placebo; and 4) clinical management combined with the tricyclic antidepressant. The type of clinical management used in the two groups required

little internal focusing on the part of the participant. Individual sessions gave the researchers an opportunity to monitor the individual's clinical status and response to treatment, as well as provide a supportive relationship. The type of cognitive-behavioral therapy used in the study asked participants to identify and communicate internal mental states associated with their drug use, as well as encouraging these individuals to identify, monitor, and analyze their drug cravings. After 12 weeks of treatment the alexithymic and nonalexithymic clients were found to have responded differently to the two types of psychotherapy: nonalexithymic participants had better outcomes with the cognitive-behavioral approach, while the alexithymic participants responded better when treated with clinical management.

13.4.2 Group Therapy

Group therapy has also been suggested as a useful and practical form of intervention for alexithymic clients (Swiller, 1988; Taylor et al., 1997). While individual sessions may be particularly suited for educating alexithymic clients about basic emotional abilities, there are a number of emotional and social competencies that are particularly suited to the use of group intervention. As noted elsewhere:

> While it is essential that the alexithymic patients experience the group as a safe and supportive setting, candid feedback from other group members should be encouraged, to the extent that it does not threaten the patients' self-esteem, as this can help them learn about the impact of their lack of empathy on other people. At the same time, the group therapist can direct an alexithymic patient's attention to communications between other group members that demonstrate more successful and sensitive ways of relating. (Taylor et al., 1997, p. 253-254)

There are, however, some practical issues and concerns that arise when using group therapy with alexithymic individuals. As noted by Swiller (1988), the poor inter-personal skills of alexithymic individuals often generate feelings of boredom and frustration in other group members. Since these negative experiences increase the likelihood that members will drop out of the group, therapists should take care to limit the number of alexithymic individuals included in a group. Swiller (1988) suggests that when there has to be more than one alexithymic client in the group they be selected to be at different stages in their treatment.

Several different groups of researchers have examined the effectiveness of group therapy for reducing alexithymic symptoms. A form of family psychotherapy with a group of alcohol abusers was used by Fukunishi, Ichikawa, Ichikawa, and Matsuzawa (1994). Adults in the study met in small groups (4 to 5 participants) once a week for two hour sessions. After six months of intervention alexithymia levels were significantly lower among family members. Beresnevaite (2000), using a sample of post-myocardial infarction patients, also examined the effectiveness of group therapy for reducing alexithymic symptoms. Participants in the study attended the group therapy session once a

week for 90 minutes. Several different therapeutic techniques were employed over the 4 months of treatment. For example, patients were taught relaxation techniques, as well as being required to participate in various role-playing and nonverbal communication activities. Participants listened to music while in a relaxed state, and were encouraged to write down dreams and fantasies. Alexithymia levels were assessed at several time-points: before the start of treatment, at the end of treatment, six months after treatment, 12 months after treatment, and 24 months after treatment. There was a significant reduction in alexithymia scores following group therapy, which was maintained over the two year follow-up period.

A recent study by Ciano, Rocco, Angarano, Biasin, and Balestrieri (2002) compared the efficacy of two different types of group therapy on reduction of alexithymic characteristics in a small group of patients with binge-eating disorder. One group of patients participated in 14 group psychoanalytic sessions over a 28-week period; the second group participated in 10 psychoeducational sessions over a 10-week period (that focused on providing nutritional information as well as improving the client's communication abilities). When alexithymia levels were compared before and after treatment, there was a significant reduction of alexithymic symptoms only in the group of patients who had received the psychoeducational intervention.

13.5 CONCLUSION

This chapter has described a number of important clinical and therapeutic implications for EI based on the literature related to several overlapping constructs. Several related models have been proposed for the EI construct (e.g., Bar-On, 1997; Mayer et al., 1999), and while this construct has obvious relevance to clinical psychology, it is important to emphasize that virtually all of the existent published research on the construct has examined non-clinical populations. Researchers need to examine the direct relationship between EI and relevant clinical disorders (particularly those that have been found to be associated with alexithymia). There is also the need for clinicians and researchers to explicitly investigate the relationship between EI and various psychotherapy outcome variables, as well as the effectiveness of specific therapeutic interventions for improving specific emotional and social competencies. Of particular importance is that this new research utilizes diverse measurement approaches for the EI construct, rather than focus exclusively on a single approach (e.g., self-report measures). One can expect that many of the EI measures that have only recently been developed will stimulate this new clinical research (e.g., Bar-On, 1997, 2002; Bar-On & Parker, 2000; Mayer, Salovey, Caruso, & Sitarenios, 2003). These new measures may also help in the process of matching clients with appropriate therapeutic interventions, as well as in monitoring the progress of clients during treatment.

Author Note

The writing of this chapter was supported by research grants from the Social Sciences and Humanities Research Council of Canada (SSHRC), the Ontario Government's Premier's Research Excellence Award program, and the Canadian Foundation for Innovation (CFI). The author would like to thank Jennifer Eastabrook and Laura Wood for their help with this chapter.

REFERENCES

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*, 1–33.

Acklin, M. W., & Alexander, G. (1988). Alexithymia and somatization: A Rorschach study of four psychosomatic groups. *Journal of Nervous and Mental Disease*, *176*, 343–350.

Apfel, R. J., & Sifneos, P. E. (1979). Alexithymia: Concept and measurement. *Psychotherapy and Psychosomatics*, *32*, 180–190.

Applebaum, S. A. (1973). Psychological-mindedness: Word, concept, and essence. *International Journal of Psychoanalysis*, *54*, 35–45.

Bachrach, H. M., & Leaff, L. A. (1978). "Analyzability": A systematic review of the clinical and quantitative literature. *Journal of the American Psychoanalytical Association*, *26*, 881–920.

Badura, A. S. (2003). Theoretical and empirical exploration of the similarities between emotional numbing in posttraumatic stress disorder and alexithymia. *Journal of Anxiety Disorders*, *17*, 349–360.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin*, *82*, 738–783.

Bagby, R. M., Parker, J. D. A., & Taylor, G. J. (1994). The Twenty-Item Toronto Alexithymia Scale-I: Item selection and cross-validation of the factor structure. *Journal of Psychosomatic Research*, *38*, 23–32.

Bar-On, R. (1997). *BarOn Emotional Quotient Inventory (EQ–i): Technical manual*. Toronto, Canada: Multi-Health Systems.

Bar-On, R. (2002). *BarOn Emotional Quotient Inventory: Short (EQ-i: S): Technical manual*. Toronto, Canada: Multi-Health Systems.

Bar-On, R., & Parker, J. D. A. (2000). *BarOn Emotional Quotient Inventory: Youth version (EQ-i: YV): Technical manual*. Toronto, Canada: Multi-Health Systems.

Barron, F. (1953). An ego-strength scale which predicts response to psychotherapy. *Journal of Consulting Psychology*, *17*, 327–333.

Beckham, E. (1992). Predicting patient dropout in psychotherapy. *Psychotherapy*, *29*, 177–182.

Beresnevaite, M. (2000). Exploring the benefits of group psychotherapy in reducing alexithymia in coronary heart disease patients: A preliminary study. *Psychotherapy and Psychosomatics*, *69*, 117–122.

Bermond, B., Vorst, H. C. M., Vingerhoets, A. J., & Gerritsen, W. (1999). The Amsterdam Alexithymia scale: Its psychometric values and correlations with other personality traits. *Psychotherapy and Psychosomatics*, *68*, 241–251.

Bloch, S. (1979). Assessment of patients for psychotherapy. *British Journal of Psychiatry*, *135*, 193–208.

Boyatzis, R. E., Goleman, D., & Rhee, K. S. (2000). Clustering competence in emotional intelligence: Insights from the Emotional Competence Inventory. In R. Bar-On & J. D. A. Parker (Eds.), *The handbook of emotional intelligence: Theory, development, assessment, and application at home, school, and in the workplace* (pp. 343–362). San Francisco: Jossey-Bass.

Brown, L. J. (1985). On concreteness. *Psychoanalytic Review*, *72*, 379–402.

Cacioppo, J. T., & Petty, R. E. (1982). The need for cognition. *Journal of Personality and Social Psychology*, *42*, 116–131.

Cartwright, R. D. (1993). Who needs their dreams? The usefulness of dreams in psychotherapy. *Journal of the American Academy of Psychoanalysis*, *21*, 539–547.

Cecero, J. J., & Holmstrom, R. W. (1997). Alexithymia and affect pathology among adult male alcoholics. *Journal of Clinical Psychology*, *53*, 201–208.

Ciano, R., Rocco, P. L., Angarano, A., Biasin, E., & Balestrieri, M. (2002). Group-analytic and psychoeducational therapies for binge-eating disorder: An exploratory study on efficacy and persistence of effects. *Psychotherapy Research*, *12*, 231–239.

Cohen, K. R., Auld, F., Demers, L. A., & Catchlove, R. F. H. (1985). Alexithymia: The development of a valid and reliable projective measure (the objectively scored archetypal 9 test). *Journal of Nervous and Mental Disease*, *173*, 621–627.

Conte, H. R., Plutchik, R., Jung, B. B., Picard, S., Karasu, T. B., & Lotterman, A. (1990). Psychological mindedness as a predictor of psychotherapy outcome: A preliminary report. *Comprehensive Psychiatry*, *31*, 426–431.

De Gennaro, L., Ferrara, M., Cristiani, R., Curcio, G., Martiradonna, V., & Bertini, M. (2003). Alexithymia and dream recall upon spontaneous morning awakening. *Psychosomatic Medicine*, *65*, 301–306.

De Gucht, V., & Heiser, W. (2003). Alexithymia and somatisation: A quantitative review of the literature. *Journal of Psychosomatic Research*, *54*, 425–434.

Fenigstein, A., Scheier, M. F., & Buss, A. H. (1975). Public and private self consciousness: Assessment and theory. *Journal of Consulting and Clinical Psychology*, *43*, 522–527.

Fischer, A. R., & Good, G. E. (1997). Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles. *Psychotherapy*, *34*, 160–170.

Fukunishi, I., Ichikawa, M., Ichikawa, T., & Matsuzawa, K. (1994). Effect of family group psychotherapy on alcoholic families. *Psychological Reports*, *74*, 568–570.

Greenberg, L. S., & Safran, J. D. (1987). *Emotions in psychotherapy*. New York: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. *American Psychologist*, *44*, 19–29.

Guttman, H., & Laporte, L. (2002). Alexithymia, empathy, and psychological symptoms in a family context. *Comprehensive Psychiatry*, *43*, 448–455.

Haviland, M. G., & Reise, S. P. (1996). A California Q-set alexithymia prototype and its relationship to ego-control and ego-resiliency. *Journal of Psychosomatic Research*, *41*, 597–608.

Haviland, M. G., Warren, W. L., Riggs, M. L., & Nitch, S. (2002). Concurrent validity of two observer-rated alexithymia measures. *Psychosomatics*, *43*, 472–477.

Horney, K. (1952). The paucity of inner experiences. *American Journal of Psychoanalysis*, *12*, 3–9.

Horowitz, M. J. (2002). Self- and relational observation. *Journal of Psychotherapy Integration*, *12*, 115–127.

Jyvaesjaervi, S., Joukamaa, M., Vaeisaenen, E., Larivaara, P., Kivelae, S., & Keinaenen-Kiukaanniemi, S. (1999). Alexithymia, hypochondriacal beliefs, and psychological distress among frequent attenders in primary health care. *Comprehensive Psychiatry*, *40*, 292–298.

Keller, D. S., Carroll, K. M., Nich, C., & Rounsaville, B. J. (1995). Alexithymia in cocaine abusers: Response to psychotherapy and pharmacotherapy. *American Journal on Addictions*, *4*, 234–244.

Kleiger, J. H., & Kinsman, R. A. (1980). The development of an MMPI alexithymia scale. *Psychotherapy and Psychosomatics*, *34*, 17–24.

Krystal, H. (1979). Alexithymia and psychotherapy. *American Journal of Psychotherapy*, *33*, 17–31.

Krystal, H. (1982). Alexithymia and the effectiveness of psychoanalytic treatment. *International Journal of Psychoanalysis and Psychotherapy*, *9*, 353–388.

Krystal, H. (1988). *Integration and self-healing: Affect, trauma, alexithymia*. Hillsdale, NJ: Analytic Press.

Lake, B. (1985). Concept of ego strength in psychotherapy. *British Journal of Psychiatry*, *147*, 471–478.

Lane, R., & Schwartz, G. E. (1987). Levels of emotional awareness: A cognitive-developmental theory and its application to psychopathology. *American Journal of Psychiatry*, *144*, 133–143.

Lane, R., Sechrest, L., Reidel, R., Weldon, V., Kaszniak, A., & Schwartz, G. E. (1996). Impaired verbal and nonverbal emotion recognition in alexithymia. *Psychosomatic Medicine*, *58*, 203–210.

Langer, E. (1989). *Mindfulness*. New York: Addison-Wesley.

Luborsky, L., McLellan, A., Woody, G., O'Brien, C., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, *42*, 602–611.

Lumley, M. A., Davis, M., Labouvie-Vief, G., Gustavson, B., Clement, R., Barry, R., et al. (2002, March). *Multiple measures of emotional abilities: Their interrelationships and associations with physical symptoms.* Presentation at the annual meeting of the American Psychosomatic Society, Barcelona, Spain.

Mallinckrodt, B., King, J. L., & Coble, H. M. (1998). Family dysfunction, alexithymia, and client attachment to therapist. *Journal of Counseling Psychology*, *45*, 497–504.

Mayer, J. D., Caruso, D. R., & Salovey, P. (1999). Emotional intelligence meets traditional standards for an intelligence. *Intelligence*, *27*, 267–298.

Mayer, J. D., Salovey, P., & Caruso, D. R. (2002). *The Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT): User's manual*. Toronto: Multi–Health Systems.

Mayer, J. D., Salovey, P., Caruso, D. R., & Sitarenios, G. (2003). Measuring emotional intelligence with the MSCEIT V2.0. *Emotion*, *3*, 97–105.

Mayes, L. C., & Cohen, D. J. (1992). The development of a capacity for imagination in early childhood. *Psychoanalytic Study of the Child*, *47*, 23–47.

McCallum, M., & Piper, W. E. (1997). *Psychological mindedness: A contemporary understanding*. Mahwah, NJ: Lawrence Erlbaum.

McCallum, M., & Piper, W. E. (2000). Pychological mindedness and emotional intelligence. In R. Bar-On & J. D. A. Parker (Eds.), *The handbook of emotional intelligence: Theory, development, assessment, and application at home, school, and in the workplace* (pp. 118–135). San Francisco: Jossey-Bass.

McCallum, M., Piper, W. E., & Joyce, A. S. (1992). Dropping out from short-term group therapy. *Psychotherapy*, *29*, 206–215.

McCallum, M., Piper, W. E., Ogrodniczuk, J. S., & Joyce, A. S. (2003). Relationships among psychological mindedness, alexithymia, and outcome in four forms of short-term psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *76*, 133–144.

McDougall, J. (1989). *Theatres of the body: A psychoanalytic approach to psychosomatic illness*. New York: Norton.

Nemiah, J. C., Freyberger, H., & Sifneos, P. E. (1976). Alexithymia: A view of the psychosomatic process. In O. W. Hill (Ed.), *Modern trends in psychosomatic medicine* (Vol. 3, pp. 430–439). London: Butterworths.

Nemiah, J. C., & Sifneos, P. E. (1970). Affect and fantasy in patients with psychosomatic disorders. In O. W. Hill (Ed.), *Modern trends in psychosomatic medicine* (Vol. 2, pp. 26–34). London: Butterworths.

Owen, P., & Kohutek, K. (1981). The rural mental health dropout. *Journal of Rural Community Psychology*, *2*, 38–41.

Palmer, B. R., Donaldson, C., & Stough, C. (2002). Emotional intelligence and life satisfaction. *Personality and Individual Differences*, *33*, 1091–1100.

Parker, J. D. A., Bagby, R. M., & Taylor, G. J. (2003, August). *Twenty-Item Toronto Alexithymia Scale: Is it distinct from basic personality?* Presentation at the annual meeting of the American Psychological Association, Toronto, Canada.

Parker, J. D. A., Bauermann, T. M., & Smith, C. T. (2000). Alexithymia and impoverished dream content: Evidence from REM sleep awakenings. *Psychosomatic Medicine*, *62*, 486–491.

Parker, J. D. A., Hogan, M. J., Majeski, S. A., & Bond, B. J. (2004). *Assessing emotional intelligence: Reliability and validity of the short form for the Emotional Quotient Inventory.* Manuscript submitted for publication.

Parker, J. D. A., Taylor, G. J., & Bagby, R. M. (1993). Alexithymia and the recognition of facial expressions of emotion. *Psychotherapy and Psychosomatics*, *59*, 197–202.

Parker, J. D. A., Taylor, G. J., & Bagby, R. M. (2001). The relationship between emotional intelligence and alexithymia. *Personality and Individual Differences*, *30*, 107–115.

Parker, J. D. A., Taylor, G. J., & Bagby, R. M. (2003). The Twenty-Item Toronto Alexithymia Scale–III. Reliability and factorial validity in a community population. *Journal of Psychosomatic Research*, *55*, 269–275.

Parker, J. D. A., Wood, L. M., Bond, B. J., & Shaughnessy, P. (2005). Alexithymia in young adulthood: A risk-factor for pathological gambling. *Psychotherapy and Psychosomatics*, *74*, 51–55.

Pekarik, G. (1983). Follow-up adjustment of outpatient dropouts. *American Journal of Orthopsychiatry*, *53*, 501–511.

Pierloot, R., & Vinck, J. (1977). A pragmatic approach to the concept of alexithymia. *Psychotherapy and Psychosomatics*, *28*, 156–166.

Piper, W. E., Joyce, A. S., McCallum, M., & Azim, H. F. (1998). Interpretive and supportive forms of psychotherapy and patient personality variables. *Journal of Consulting and Clinical Psychology*, *66*, 558–567.

Piper, W. E., McCallum, M., Joyce, A. S., Rosie, J. S., & Ogrodniczuk, J. S. (2001). Patient personality and time-limited group psychotherapy for complicated grief. *International Journal of Group Psychotherapy*, *51*, 525–552.

Reder, P., & Tyson, R. (1980). Patient dropout from individual psychotherapy. *Bulletin of the Menninger Clinic*, *44*, 229–252.

Ruesch, J. (1948). The infantile personality. *Psychosomatic Medicine*, *10*, 134–144.

Rybakowski, J., Ziólkowski, M., Zasadzka, T., & Brzezinski, R. (1988). High prevalence of alexithymia in male patients with alcohol dependence. *Drug and Alcohol Dependence*, *21*, 133–136.

Saklofske, D. H., Austin, E. J., & Minski, P. S. (2003). Factor structure and validity of a trait emotional intelligence measure. *Personality and Individual Differences*, *34*, 707–721.

Salovey, P., Hsee, C. K., & Mayer, J. D. (1993). Emotional intelligence and the self-regulation of affect. In D. M. Wegner & J. W. Pennebaker (Eds.), *Handbook of mental control* (pp. 258–277). Englewood Cliffs, NJ: Prentice Hall.

Salovey, P., & Mayer, J. D. (1990). Emotional intelligence. *Imagination, Cognition and Personality*, *9*, 185–211.

Salovey, P., Mayer, J. D., Goldman, S., Turvey, C., & Palfai, T. (1995). Emotional attention, clarity, and repair: Exploring emotional intelligence using the Trait Meta-Mood Scale. In J. W. Pennebaker (Ed.), *Emotion, disclosure, and health* (pp. 125–154). Washington, DC: American Psychological Association.

Saltzman, C., Luetgert, M. J., Roth, C. H., Creaser, J., & Howard, L. (1976). Formation of a therapeutic relationship: Experiences during the initial phase of psychotherapy as predictors of treatment duration and outcome. *Journal of Consulting and Clinical Psychology*, *44*, 546–555.

Schutte, N. S., Malouff, J. M., Hall, L. E., Haggerty, D. J., Cooper, J. T., Golden, C. J., et al. (1998). Development and validation of a measure of emotional intelligence. *Personality and Individual Differences*, *25*, 167–177.

Sifneos, P. E. (1967). Clinical observations on some patients suffering from a variety of psychosomatic diseases. *Acta Medicina Psychosomatica*, *7*, 1–10.

Sifneos, P. E. (1973). The prevalence of "alexithymic" characteristics in psychosomatic patients. *Psychotherapy and Psychosomatics*, *22*, 255–262.

Sifneos, P. E. (1975). Problems of psychotherapy of patients with alexithymic characteristics and physical disease. *Psychotherapy and Psychosomatics*, *26*, 65–70.

Sifneos, P. E. (1986). The Schalling-Sifneos Personality Scale-Revised. *Psychotherapy and Psychosomatics*, *45*, 161–165.

Silver, D. (1983). Psychotherapy of the characterologically difficult patient. *Canadian Journal of Psychiatry*, *28*, 513–521.

Stone, L., & Nielson, K. A. (2001). Intact physiological responses to arousal with impaired emotional recognition in alexithymia. *Psychotherapy and Psychosomatics*, *70*, 92–102.

Sue, S., McKinney, H., & Allen, D. (1976). Predictors of the duration of therapy for clients in the community mental health system. *Community Mental Health Journal*, *12*, 365–375.

Suslow, T., & Junghanns, K. (2002). Impairments of emotion situation priming in alexithymia. *Personality and Individual Differences*, *32*, 541–550.

Swiller, H. I. (1988). Alexithymia: Treatment utilizing combined individual and group psychotherapy. *International Journal of Group Psychotherapy*, *38*, 47–61.

Tacon, A. (2001). Alexithymia: A challenge for mental health nursing practice. *Australian and New Zealand Journal of Mental Health Nursing*, *10*, 229–235.

Taylor, G. J. (1977). Alexithymia and the counter-transference. *Psychotherapy and Psychosomatics*, *28*, 141–147.

Taylor, G. J. (1984). Alexithymia: Concept, measurement, and implications for treatment. *American Journal of Psychiatry*, *141*, 725–732.

Taylor, G. J. (1987). *Psychosomatic medicine and contemporary psychoanalysis*. Madison, CT: International Universities Press.

Taylor, G. J. (1995). Psychoanalysis and empirical research: The example of patients who lack psychological mindedness. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *23*, 263–281.

Taylor, G. J. (2000). Recent developments in alexithymia theory and research. *Canadian Journal of Psychiatry*, *45*, 134–142.

Taylor, G. J., Bagby, R. M., & Luminet, O. (2000). Assessment of alexithymia: Self-report and observer-rated measures. In R. Bar-On & J. D. A. Parker (Eds.), *The handbook of emotional intelligence: Theory, development, assessment, and application at home, school, and in the workplace* (pp. 301–319). San Francisco: Jossey-Bass.

Taylor, G. J., Bagby, R. M., & Parker, J. D. A. (1997). *Disorders of affect regulation*. Cambridge, UK: Cambridge University Press.

Taylor, G. J., Parker, J. D. A., & Bagby, R. M. (1999). Emotional intelligence and the emotional brain: Points of convergence and implications for psychoanalysis. *Journal of the American Academy of Psychoanalysis*, *27*, 339–354.

Taylor, G. J., Ryan, D., & Bagby, R. M. (1986). Toward the development of a new self-report alexithymia scale. *Psychotherapy and Psychosomatics*, *44*, 191–199.

Tolor, A., & Reznikoff, M. (1960). A new approach to insight: A preliminary report. *Journal of Nervous and Mental Disease*, *130*, 286–296.

Williams, K. R., Galas, J., Light, D., Pepper, C., Ryan, C., Kleinmann, A. E., et al. (2001). Head injury and alexithymia: Implications for family practice care. *Brain Injury*, *15*, 349–356.

Zlotnick, C., Mattia, J. I., & Zimmerman, M. (2001). The relationship between posttraumatic stress disorder, childhood trauma, and alexithymia in an outpatient sample. *Journal of Traumatic Stress*, *14*, 177–188.

Zonnevijlle-Bender, M. J. S., van Goozen, S. H. M., Cohen-Kettenis, P. T., van Elburg, A., & van Engeland, H. (2002). Do adolescent anorexia nervosa patients have deficits in emotional functioning? *European Child and Adolescent Psychiatry*, *11*, 38–42.