EXPRESS OUR EMOTIONS AND FEELINGS?

DO WE SUFFER FROM AN INABILITY TO EXPRESS OUR EMOTIONS AND FEELINGS? A CLINICIAN'S EXPERIENCE IN CONSULTATION ROOM.

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Abstract: The doctors as clinicians are exposed to a variety of client population that have varied presentation towards them in their consultation rooms. The Clinicians are acting not only as medical specialists in their respective fields of expertise but are also regularly exposed to various cultural manifestation that fall in a broad spectrum. These presentations in Psychiatric Clinics include difficulty in accepting and expressing psychiatric symptoms that need an in depth analysis from social and cultural perspective.

Key words: Cultural, Society, Alexithymia, Patient care, Marzi Pura, Clinician's experience, Psychiatric consultations

The word Alexithymia consists of two parts alexis meaning "lack of word" and thymia meaning "emotion".[1] Alexithymia therefore means inability to express feelings or emotions in words. The term was first coined by Dr Peter Sifneos in 1972.[2] Whilst describing people who suffer from Alexithymia Dr Sifenos writes that, "They give the impression of being different, alien beings, having come from an entirely different world, living in the midst of a society which is dominated by feelings". Whilst discussing the topic, Dr Daniel Goleman writes in his book (Emotional Intelligence) that "such people were first noticed by psychoanalysts; puzzled by a class of patients who were untreatable by that method because: they reported no feelings, no fantasies, and colourless dreams-in short no inner emotional life to talk about at all".[3]

The importance of culture whilst approaching the expression of feelings and emotions needs to be appreciated as an important factor determining the presentation of patients in consultation room. Stigma towards mental illness is common and exists in a spectrum of expressions in almost all societies regardless.[4] It can present as denial of mental illness altogether and it's not unusual for mental health professionals to come across clients that have been referred to them with medically unexplained symptoms, where they have undergone extensive investigations and their medical colleagues are scratching their heads thinking if they are missing something here or if the patient's recurrent complaints are indicative of something that needs exploration by their psychiatric counter parts. Language, social framework, family script, symbolic interactionism and psychological and emotional hermeneutics play a pivotal role

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in the choice of expressions that clinicians encounter in their day to day interaction with clients.

Mrs Abdullah (fake name) is a middle-aged lady who is referred to my outpatient clinic by a colleague who is a consultant general surgeon as she has presented with the abdominal discomfort and weight loss. She underwent all formal investigations as a part of regular work up, that were followed by specialist, investigations aimed at finding the reasons for presenting problems. No cause of abdominal discomfort was identified, and the medical and surgical departments were satisfied about the thoroughness of consultations and depth of various assessments that Mrs Abdullah had undergone with them. On my meeting Mrs Abdullah initially expressed the same concern that she had presented to my medical and surgical colleagues in the past. She pointed with one finger (at times two fingers) on a specific point on upper abdomen stating that she has pain at that specific point. Once I offered the reassurance that she has been investigated for this and no medical or surgical reason has been identified for this symptom so far; instead of getting assured she rather presented with helplessness expressing that it's a shame that no one can find the reasons of this persisting problem for so many years. As the initial therapeutic handshake and interaction didn't go very expressive on her part therefore, I instinctively reverted to the basic principles of standard history taking and asked her about the SOCRATES (This is an acronym used for exploring site, onset, character, radiation, association, time course, exacerbating/relieving factors and severity of pain). Notably Mrs Abdullah confirmed that the site of pain is always in the midline and she provided quite vague answers about the aspects of the nature, intensity, severity, associated and relieving factors of pain. Nevertheless, she quite was quite forthcoming in describing that the pain sometimes has a radiating course in her words 'downwards' in midline of the body. She needed prompting and reassuring that as she is describing that the pain radiates downwards therefore,she needs to describe in detail how far down on midline the pain radiates and that how does this affect her. For our discussion to reach this point, so far nearly 45 minutes had passed within the therapeutic interaction and the patient had gained some confidence and had developed some therapeutic alliance (within the setting of a professional consultation). She elaborated that the pain moves to the urethra and that she is worried if she is developing some illness of the urogenital region. On direct questioning when she was enquired that how her monthly periods were, she described that she had been missing them and described a range of symptoms that were suggestive of gradually developing menopause. This was not unlikely given her age. According to her it was the first time that she was able to express those symptoms to anyone. She had been repeatedly describing herself as being thankful, being obedient, being noble, being a non-complainer, being submissive and being a very a supportive house wife.However, it was difficult to establish the relationship of these expressions with the concerns that she had been expressing about pain radiating to her private parts. I acknowledged the expression and encouraged her to tell me about her relationship with her husband as it was established in the beginning that she was married and had three children. She elaborated that her husband had moved out of country some time ago and that she was not sexually active and that she had been

solely responsible for looking after three very young children at home whilst she is trying to support her physically unwell mother in law too at the same time, who had complex caring needs.

The verbal picture painted by the patient started making better sense to me by the later part of our discussion. She had been experiencing an adjustment reaction already due to absence of her husband and the added responsibility that was shifted on to her shoulders. Her description was highly suggestive that the move was made for financial reasons and she is receiving regular share of money to fulfil the needs and demands of daily living. She herself was not a working woman and was a house wife instead. The expressions of being thankful, being grateful, being a supportive wife and being a non-complainer started making more sense to me that as she is receiving a financial share from her expatriate husband therefore if the wheel of social and financial needs is moving successfully(with adequate supply of money) then she should be accepting multiple essential responsibilities that accompany the terms of this tacit bargain without any complaints. Complaining meant challenging or differing with the overall social and financial set up of the family.

It appeared that she had no words to express her love for her husband, to express that she misses her, that she is finding it difficult to manage kids on her own without having any support from the spouse, that she should not be expected to be the only one who should be providing quite demanding care and support to her mother in law (without her own son being in the picture), that her children are downloading and passing all their emotional and psychological difficulties on to her and she has no one in her circle to talk to or share those psychological and emotional difficulties with. An additional factor that was notable in consultation room was that she was always accompanied by her elder brother, whether that be a medical or psychiatric consultation. A little probing on this observation led to the explanation by the patient that she is the only sister of six brothers and that the one who joins her during consultations is like a father figure for her. This fact carried two implications attached with it. One that as she was always accompanied with brother during consultations therefore her choice of avoidance to talk or discuss the sexual issues was understandable and secondly as a cultural expectation (based on common observations and based on individual understandings) sometimes women are expected not to express the problems that they are facing with their in-laws to their parents or parent-figures because this can possibly generate stress or difficulties for them (biological family) that can add up to existing problems of biological parents/ family. Sometimes a woman (daughter/ sister) chooses not to discuss her difficulties or problems that she is facing at her in-law's house because she doesn't want to bother parents or in a different scenario, she doesn't consider them capable enough to contain and tackle these issues.In either case, if such unexpressed emotions and unmet needs are existing then they have the potential to effect and alter patient's presentation in the consultation room with professionals.

"Marzi Pura" is a small town situated in the outskirts of the city of Faisalabad, which is the third biggest city in Pakistan, based on population size. Marzi Pura is thickly populated and is surrounded by two other relatively bigger sized towns one called

"Gulam Mohammad Abad" and the other called "Raza Abad". The combined population of all three areas by a rough estimate would amount to a few hundred thousand people, at least (safely above a few millions). There are some other smaller villages nearby as well towards the 'Ameenpur Bangla' which is the station closest to the motorway. I have been brought up in neighbourhood not far from these towns and it doesn't require me to explore any scientific literature or retrieve data from national statistics department (in context of the subject and purpose of this article) to support or backup the observation that these areas are thickly populated by lower and lower middle-class people who mostly work in the factories and industries situated in this area. We also expect some blue- and white-collar people too who are mostly attached with the same industry directly or indirectly, though labourers outnumber clerical and administration staff members in industries hugely. Driving on the road whilst coming to Marzi Pura one cannot ignore or miss the observation that there is a huge number of repairing workshops around the area in which hard working people can be seen toiling with their sweat. They clearly are noted to be mending and repairing the parts and machineries used in local industry. In the morning majority on roads can be observed riding bicycles and motorbikes carrying usually three to four kids wearing uniforms suggesting they are on their way to schools. Three-wheeler vehicles like autorickshaw and animal driven carts dominate the vehicle population on the road clearly and you come proportionately across one four wheeled cars in comparison to roughly one hundred other small vehicles (less than four wheels or four wheeled public transport vehicles) for a few hundred yards whilst driving towards the main city. The picture changes on roads once you enter main city. Independent Medical College and its allied hospital is situated in Marzi Pura and we obviously see most of the local clients presenting to us mostly in outpatient clinics or in other departments like accident and emergency department. The local population is mostly socioeconomically poor and benefits significantly by the hospital services (sometimes free of cost) that are delivered at their door steps. No such similar facility was existing in the past in this area before establishment of hospital. Mental health services within the institution are available in the form of a 'Behavioural Sciences and Psychiatry Department' that engages in teaching students and providing outpatient assessments. Majority of the patients not only belong to poor socioeconomic status but also have extremely low or negligible educational levels.

Whilst exploring how patients would present to my medical colleagues in non-psychiatric consultation, I met those who are referring patients to Psychiatric Clinic for example I met one of the Consultant Neurologists for a discussion regarding this. The doctor told me that he is regularly receiving patients who come with what he described as psycho-somatic complaints. He had a record book handy in which he was able to show me the diagnoses that he has given to patients in neurological outpatient clinic in last two to three days and according to that list nearly 40 to 50 per cent of patients received a diagnosis of what he described as "Psychosomatic problems". He said that these are 'your patients' presenting in my clinic and I sometimes wonder if my role is that of a Psychiatrist here and not a Neurologist here. Having thanked him for sharing the information with me, I was able to enquire about more specific questions

regarding patient's verbal expression and presentation during consultation when it comes to describing their symptoms. My colleague shared his observations and experience, stating that mostly he doesn't note any difficulty in expression (on patient's part) when patients are describing their physical health symptoms to him. Verbatim, "When I allow them to talk freely, they are quite good in expressing themselves and after a few minutes they are able to conclude the discussion and usually have nothing to add when asked by myself". The Neurologist's perception is that the clients have reasonably good expression and he would not even consider the possibility of Alexithymia if we approach that from a diagnostic consideration point of view.

On reflection I develop the impression that apparently it is not the inability of expression or having a complete lack of feelings and emotions that determine that how a patient presents in psychiatric outpatient clinic, but if limited expression of emotions and feelings is observed then this kind of presentation requires a more detailed analysis. Appreciation of multiple factors that contribute towards doctor-patient therapeutic interaction within a consultation room needs to be appreciated and acknowledged. Thinking aloud, I wonder, if this could be a lack of emotional vocabulary? Could this be cultural driven avoidance or negligence of emotions altogether? Could this be a defence mechanism to avoid emotional and psychological pain? Could this be white coat anxiety? Could this be a personal choice? Or could this be a combination of all these factors.

Culture is sometimes defined as the personality of the society. Culture determinants are varied. Language and symbols contribute significantly towards development of an individual within a society. The language provides building blocks that enable a growing individual to make sense of the world around him/her.The same language is the primary tool that a mother uses to introduce the world to a developing soul. For example, she teaches the child how to ask for food and validate the babbling of mama or baba as an acceptable means by which a baby can get her attention. Some authorities believe that the cultural aspects contribute towards development of brain too.[5] A commonly quoted example is the development of accent in children. The movement of tongue and verbalisation of various vowels and consonants is learnt by a growing baby in first few years of life mostly by copying how their parents verbalise those words that they can copy after hearing them through their ears. By the time a child reaches a certain cut off age, the accent development is complete, and the brain-tongue synchronisation has taken a permanent shape that cannot be altered and changed in life. Every locality, every region and every nation have its own unique accent that is passed on to next generation without any active effort or planned learning process. Likewise, symbols have specific meanings in given cultural contexts.[6] For example, in a religious society the rituals of birth and death are carried out altogether differently compared to the non-religious societies. The same metaphoric symbol of death (its real incident and event for the society though) is interpreted entirely differently in meanings and manifestations that is followed and practised by the members of a given society in significantly unique but varied ways that they choose.

Understanding, appreciating, identifying, expressing, discussing, debating, experiencing and sharing emotions and feelings start from a very early age in life. Non-verbal expression begins as early as birth (if not in-utero) and the verbal expression starts as soon as language skills are acquired during development. The psychological and emotional hermeneutics develop and firm at the same time when the verbal and literal hermeneutics are acquired via active interaction with the surrounding environment. Most of them are not changeable in later life.[7] Let's think of this example that in societies and cultures where war is a routine, survival trumps all other needs and obviously hardly any attention can be spared towards development of emotional intelligence and interpersonal psychological skills. Interestingly emotional expression and intelligence still develops under such very unhealthy circumstances. How this develops is not the subject for this article. If we expect some emotions to dominate in this population of war-stricken areas, they predictably would be those of anger, resentment, paranoia, vengeance and hatred. Obviously, there is lots of modelling around to simply imbibe lots of negativity which is prevailing in the environment, for whatever reasons. A mother would obviously prepare her child to survive, fight, dominate and endure and prepare to disassociate and pay less attention to trauma and pain around her. Let's compare this scenario to a different mother who is raising a baby is stable, comfortable, supportive and loving environment.Here looking after others, basic etiquettes and high standards of emotional intelligence and moralitycan be expected to be taught as a primary part of day to day upbringing. Being clinicians, we would see both of above babies in our clinics at various points in their lives (and during course of our professional careers) and we shall have to tailor our approach towards them according to their needs. Appreciation of feelings and emotions and learning how to express them follow a second to second developmental course in our life and there are multiple number of factors determining that what would be a final interpretative and working model of an individual and how s/he would choose to use that model in interactions with the clinicians in a therapeutic interaction.

If Lev Vygotsky had carried out his observations in Marzi Pura that led him to develop the concept of "zone of proximal development",[8] he would have drawn the same conclusion as he did in 19th century Russia. However, he perhaps would have strongly felt that poverty, illiteracy, unending struggle for meeting the means to manage day to day life, lack of education, overcrowding, limited resources, community shame attached to mental health problems, culture and environment of strong criticism and judgment, parents' own lack of understanding or appreciation of mental health and related issues and a general scarcity of vocabulary to express emotions and feelings are all the contributing factors that a developing baby is receiving in the package of proximal environment in Marzi Pura (And perhaps in most of third world countries with some variations). Freud's pleasure principle[9] or Adler's power dominance struggle[10] obviously would have shown up exactly in the same manner as they were appreciated by them in their areas of observations, but with a different cultural expression. Repressed sexual urges generate sexual neurosis as a rule,[11] but how would you expect a young woman to express and talk about them when she is a part of

family of ten who are sharing a two-bedroom house and her mother is not interested in talking about this subject. If Victor Franklhad visited Marzi Pura he would have smiled and said, look didn't I tell you that the pursuit of meanings and purpose trumps seeking power or pleasure.[12] Perhaps he would have said that look at thousands and millions of people who are surviving and managing at a family income below £100 per month but still have reasons to be happy and continuing. Happiness is ensued nor pursued, Victor might had added.

In conclusion we own and accept every child in Marzi Pura, in Faisalabad, in Pakistan and in the world. We don't need to return the clock, find a time machine and go back in time to rewrite the entire subject of Psychology and Behaviourism in the language of Marzi Pura in order to help and support our patients here. All we need to do is to commit to learn and connect with our clients, appreciate their language, their expression and their body language. We need to appreciate that what they can express and what they cannot express. A great psychologist once said that I wish we could communicate with one another in the language or our feelings. Marzi Pura residents presents with a variety of feelings and emotions, I don't observe them lacking ability to express themselves, though they have their own unique ways of expressions that don't mostly match the text books that we studied in medical school. This part of our leaning can happen only in the clinics and this competency (of developing the therapeutic alliance and offering culturally appropriate treatment) can only be gained by continued regular interaction with local population. When the clients seek our help and support, they have already taken initial steps to explore the pathway to find solutions to their problems.Our challenge (as clinicians) in consultation rooms comprises of tailoring and adjusting our set of expertise, our style, our knowledge and the medical terminology that we have acquired in a different language, to the needs of the patients in order to help and support them the best. Every child is important. Every client is precious and deserves the best of our efforts, nonetheless it would be worth remembering the fact that the research studies confirm the relationship between Alexithyia and Somatic Symptoms reporting.[13]

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