

The Patient Who Cannot Name What They Feel: Alexithymia and Treatment Response Across Common Mental Disorders

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ABSTRACT

Alexithymia is frequently observed in depression, anxiety-related conditions, trauma-related disorders, and eating pathology, but its value for predicting treatment response remains uncertain. This research uses critical integrative review. The literature did not support alexithymia as a fixed marker of treatment failure. Difficulty identifying feelings appeared more clinically relevant than a high total score, and several associations weakened after baseline depression or general distress was considered. Treatment studies nevertheless suggested that alexithymia could matter when therapy required emotional discrimination, experiential engagement, or verbal use of affect before those capacities were sufficiently available. The synthesis developed emotional access mismatch as a conditional analytical proposition describing a treatment-patient interaction rather than a diagnostic category. Its influence should be weaker when treatment does not initially depend on emotional articulation and should diminish when therapy successfully scaffolds emotional access. Alexithymia may therefore inform formulation and pacing without becoming a reason to exclude patients from evidence-based psychotherapy.



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INTRODUCTION

Patients who struggle to identify feelings rarely describe the problem in those terms. They may speak about exhaustion, pressure in the chest, irritability, arguments that seem to escalate without warning, or a sense that something is wrong without being able to specify what. When a therapist asks about the feeling attached to an event, the answer may remain factual and externally focused. That response is easily interpreted as resistance or limited motivation. Alexithymia offers a different reading. The construct refers mainly to difficulty identifying feelings, difficulty describing them, and an externally oriented style of thinking. None of these implies an absence of emotion. A person can be strongly aroused while having little usable representation of what the arousal means, so bodily sensations and action tendencies reach awareness before a differentiated emotional account does (Luminet et al., 2021). In therapy, this distinction is easy to miss because the patient can appear emotionally flat in language while being physiologically or behaviourally activated. The clinical difficulty lies in access to emotional information, not in assuming that the emotional response is absent.

Alexithymia is elevated across several forms of psychopathology, although the clinical meaning of a high score is not stable. Earlier treatment literature already suggested poorer outcomes in some psychiatric samples, but the association was inconsistent and often entangled with symptom burden (Pinna et al., 2020). Depression is particularly important here. Reduced emotional differentiation, low energy, self-critical appraisal, and general distress can raise alexithymia scores during an acute episode. Recent work continues to show substantial overlap while preserving statistical distinction between the constructs (Kieraitė et al., 2024). A narrative review reached a similar conclusion and warned against treating the two as interchangeable (Sagar et al., 2021). A high intake score can therefore indicate a longer-standing vulnerability, a state-related restriction during acute illness, or some combination of both.

Most treatment studies rely on the Toronto Alexithymia Scale or another self-report measure. Asking people who have difficulty identifying feelings to report on that difficulty is not inherently

invalid, yet the score can absorb current distress, beliefs about emotion, language, and cultural expectations. Chan et al. (2023) found broadly workable measurement across Singaporean and Australian samples while also showing why emotional language cannot be assumed to function identically across settings. Conceptual disagreement adds another layer. Preece and Gross (2023) describe alexithymia through attention and appraisal processes, whereas Taylor and Bagby (2021) caution that a narrower process account may lose clinically important features of the original construct. Taylor et al. (2024) later defended the broader formulation. For treatment research, the practical problem is simple. Studies may use the same total score while implying different psychological processes. This is not a minor psychometric problem. If one study treats alexithymia as poor emotional attention and another treats it as a broader disturbance of affect regulation, an identical association with treatment outcome does not carry the same clinical meaning. Interpretation therefore has to return to the facet and process actually measured rather than relying on the label alone.

Symptom improvement and improved emotional access also need not occur at the same point in therapy. A patient may report fewer panic episodes while still struggling to distinguish fear from bodily illness. Another may become more aware of shame or anger before a global symptom score falls. If outcome is defined only as pre-post symptom change, emotional learning can disappear from the analysis. The reverse problem is equally important. A lower alexithymia score after treatment may simply track improvement in depression rather than show that therapy changed a distinct emotional process. Whether alexithymia is a predictor, a mechanism, or an outcome cannot be decided from one baseline measurement.

The clinical relevance of alexithymia may depend less on its global severity than on what a treatment asks the patient to do with emotion. Cognitive work often assumes that internal shifts can be noticed and linked to appraisals. Exposure depends on sufficient contact with affective and bodily information for new learning to occur. Interpersonal and experiential therapies rely more directly on differentiation and communication of feeling. Those demands are not equivalent. The same patient may therefore encounter difficulty in one phase or treatment format and function adequately in another. This review examines evidence from 2020 to 2026 with particular attention to direct treatment-response studies. Mechanistic and measurement research is used more cautiously to explain why effects might differ. The synthesis develops emotional access mismatch as a proposition about treatment fit, not as a new patient category. Its usefulness depends on whether it can explain variation that a global alexithymia score does not. The proposition therefore has to specify when treatment demands are likely to exceed emotional access and when the same score should have little effect because the intervention does not yet require that operation.

RESEARCH METHODS

A critical integrative review with narrative synthesis was used to examine the relationship between alexithymia and treatment response across common mental disorders. This approach was selected because the available literature includes heterogeneous study designs that cannot be treated as methodologically equivalent or combined into a single pooled estimate. Searches were conducted in PubMed-indexed literature, supplemented by targeted publisher searches and backward and forward citation tracking. Eligible studies were peer-reviewed publications that examined alexithymia in relation to psychotherapy outcomes, treatment processes, changes during intervention, or clinically relevant mechanisms. Studies concerned only with prevalence, neurological alexithymia, or emotional difficulties without a clear measure or conceptualisation of alexithymia were excluded.

Evidence was synthesised according to diagnostic context, alexithymia measurement, treatment or clinical process, study design, and reported outcomes. Greater interpretive weight was given to studies that directly examined treatment response, temporal change, or clinically relevant mechanisms, while correlational and psychometric evidence was used mainly to clarify possible pathways and measurement issues. Because the included studies differed substantially in design and purpose, no single risk-of-bias instrument or meta-analysis was applied. Instead, findings were interpreted according to the inferential limits of each study design, with particular attention to temporal ordering, repeated measurement, potential confounding, and the relevance of the study population to the treatment question.

RESULTS AND DISCUSSION

1. Symptom Severity and the Trait-State Ambiguity of Alexithymia

Difficulty identifying feelings rises with psychopathology, especially depression and general distress. Kieraitė et al. (2024) found substantial association between alexithymia and depression while supporting their distinction at the construct level. That distinction matters in treatment because a score taken during severe depression may partly reflect the episode itself. Low cognitive flexibility, somatic preoccupation, and restricted access to positive emotion can make emotional identification harder at intake. If the score falls as those symptoms improve, the apparent treatment effect on alexithymia may be partly state related. A fixed-trait interpretation is therefore too strong at the moment when the patient is most unwell.

Longitudinal evidence nevertheless suggests that emotional identification difficulty can precede later symptom burden. Brett et al. (2025) found that alexithymia predicted subsequent emotion-regulation difficulties in adolescents, which in turn were related to later depression, anxiety, and stress. The study was not a psychotherapy trial, so it cannot show that alexithymia causes non-response. It does support a vulnerability pathway in which poorly differentiated affect is harder to regulate. Preece et al. (2022) similarly linked alexithymia with affective symptoms through emotion-regulation difficulties. These findings are most useful as mechanism evidence. They explain why an intake score may carry information beyond current symptoms without proving that the score will predict a particular treatment outcome.

Self-harm research gives the same caution from another angle. Norman et al. (2020) found a robust association between alexithymia and self-harm, with difficulty identifying feelings particularly prominent, but much of the evidence was cross-sectional. Among adolescents with major depressive disorder, alexithymia and regulation difficulties were related to the functions served by non-suicidal self-injury (Taş Torun et al., 2022). Shi et al. (2025) later reported mediation involving alexithymia and self-injury functions in the association between childhood maltreatment and NSSI. These studies do not establish that reducing alexithymia will reduce self-harm. They do suggest that behaviour may become a rapid method of changing affective arousal when the state itself has not been clearly identified.

Eating-disorder evidence also points to emotion regulation as an intermediate process. Muir et al. (2024) found that regulation difficulties statistically mediated the association between alexithymia and eating-disorder symptoms. The clinical implication is plausible but narrower than a treatment claim. Restriction, bingeing, or compensatory behaviour may alter arousal before the person can describe the emotional context, yet a mediation model cannot show that emotional identification must be treated first. The same restraint applies to personality pathology. Chaim et al. (2024) found alexithymia widely represented across personality disorders, where shame, dissociation, interpersonal mistrust, and emotional dysregulation can influence self-report. High scores may identify restricted emotional access without establishing the source of that restriction or the therapy most likely to fail.

Across these studies, difficulty identifying feelings appears more clinically consequential than externally oriented thinking, but the difference should not be turned into a universal ranking of facets. The treatment question is whether alexithymia explains variation in response beyond baseline severity and whether the relevant facet is actually required by the treatment task. A global score is useful for identifying possible difficulty. It is much less useful as a stand-alone prognosis.

2. Emotional Demands of Psychotherapy and Differential Treatment Response

Many psychotherapies rely on emotional operations that are not named as techniques. A thought record works better when the patient can notice a shift in internal state and connect it to an appraisal. Exposure requires enough contact with fear-related information for corrective learning to occur. Interpersonal work depends on recognising affective changes within relationships. When emotional information is available only as vague arousal or physical discomfort, the formal technique can still be completed while part of the process it assumes remains inaccessible.

Direct psychotherapy evidence is clearest in trauma treatment. Putica et al. (2024) examined alexithymia during prolonged exposure and found relationships with treatment response and proposed mechanisms, while also showing that patients with elevated alexithymia could improve. Zorzella et al. (2020) likewise reported changes in alexithymia alongside improvements in PTSD symptoms, dissociation, and interpersonal problems during trauma therapy. These results argue against using alexithymia as an exclusion criterion. They instead suggest that emotional engagement can be a variable part of treatment and that alexithymia itself may move during care. Putica (2024) drew a similar clinical

implication for cognitive behavioural treatment of PTSD, proposing greater scaffolding when emotional awareness is limited. The direct evidence remains concentrated in trauma care, which matters for interpretation. Exposure and trauma-focused cognitive work make emotional engagement unusually visible, so an effect detected there cannot simply be transferred to therapies whose early active ingredients are more behavioural. The trauma literature is therefore informative because it shows the interaction clearly, not because it proves a universal treatment rule.

Trauma-exposed adults may also show discordance between subjective reports and other response channels. Putica et al. (2022) linked alexithymia with emotion-response discordance. In practice, low verbal distress does not always mean low activation. A clinician who relies heavily on self-reported emotion may underestimate what is occurring, whereas pushing for stronger emotional activation may overshoot when bodily arousal is already high. This evidence does not validate a specific adaptation, but it supports the broader point that verbal emotional access and emotional activation are not interchangeable.

The therapeutic relationship can be affected before symptom measures reveal a problem. Nunes da Silva (2021) argues that clients with alexithymia may benefit from an active stance that develops emotional skills and protects the alliance from repeated experiences of inadequacy. Broad questions about feeling can be difficult early in therapy, particularly when the patient experiences the question as something they should be able to answer. Starting with a recent episode, bodily change, or action tendency can supply more concrete material. The evidence for such adaptation is still largely clinical and mechanistic rather than trial based, so it is better treated as a testable approach than as established protocol.

Interventions that make emotional skills explicit provide indirect support for modifiability. Atta and El-Gueneidy (2024) found improvement in emotion-regulation difficulties after an intervention for depression, although alexithymia was not necessarily the direct treatment target. Salles et al. (2023) reviewed DBT-based interventions and reported reductions in alexithymia across varied populations. DBT is relevant because observing and labelling internal experience are taught through repeated practice rather than assumed at the outset. The review does not establish that DBT is uniquely effective for alexithymia, but it shows that capacities related to emotional access can change within structured treatment.

Smaller intervention studies support the same possibility with weaker clinical directness. Alexithymia Reduction Treatment produced improvement in university students (Akram & Arshad, 2022), while positive psychotherapy was associated with lower depression and alexithymia among women seeking divorce (Khalili et al., 2022). Psychoeducation studies in adolescents also reported reductions in alexithymia (Bakan et al., 2020; Iuso et al., 2022). These samples do not justify conclusions about routine psychotherapy for diagnosed common mental disorders. Their value is narrower. They show that self-reported alexithymia is not immovable and that emotional identification can respond to structured practice.

Wang et al. (2026) extended this approach through a mechanism-based digital intervention organised around attention, awareness, evaluation, and articulation. The programme reported improvement in alexithymia and related outcomes, although digital delivery and sample characteristics limit generalisation to psychotherapy populations. Its relevance lies in the attempt to separate trainable processes rather than treating alexithymia as one indivisible trait. Cultural differences remain important here. Emotional vocabulary and norms for introspection vary, and Chan et al. (2023) show why a concrete expressive style should not automatically be interpreted as clinical incapacity.

Taken together, the treatment evidence supports adaptation more strongly than pessimism. Elevated alexithymia does not reliably identify patients who will fail psychotherapy. The more defensible proposition is conditional. Problems are more likely when a treatment requires emotional discrimination or communication that the patient cannot yet use, particularly before those operations have been scaffolded. This treatment-patient interaction is what the present review terms emotional access mismatch.

3. Alexithymia as Predictor, Mediator, and Treatment Outcome

Treatment research often measures alexithymia once at intake and then treats it as if it remains unchanged. That assumption is increasingly difficult to defend. Trauma-focused studies show that alexithymia can fall during treatment, while smaller interventions also report change. The temporal

problem is that improvement can be interpreted in several ways. Reduced alexithymia may facilitate symptom change, result from symptom relief, or move alongside another process that therapy affects.

The strongest recent mediation evidence comes from trauma-focused cognitive behavioural therapy in children who experienced sexual abuse. Hébert and Tremblay-Perreault (2026) found that emotional regulation and alexithymia mediated treatment effects on trauma-related outcomes. The design provides stronger temporal evidence than a cross-sectional mediation model, although interpretation still depends on measurement timing and model specification. It supports the possibility that therapy changes access to and regulation of emotion in ways that contribute to symptom improvement rather than merely following it.

Depression-related evidence remains less decisive. Difficulty identifying feelings often moves with depressive symptoms, making it hard to determine which process changes first. Preece et al. (2022) provide a plausible regulation pathway, but their design does not establish whether emotion-regulation change should precede symptom relief. A reciprocal course is credible. Reduced depression may create cognitive room for emotional learning, while improved differentiation may reduce rumination, avoidance, or undirected arousal that maintains distress. Treatment studies need repeated measurements during the period when this interaction is expected to occur.

Facet-level change can also prevent misleading conclusions. Difficulty describing feelings may improve because the patient acquires usable language, while difficulty identifying feelings remains relatively high. Externally oriented thinking may move more slowly or carry less importance in a treatment that begins with behavioural activation. Reporting only a total score can make those trajectories disappear. The same measurement problem is embedded in the conceptual debate between process accounts and the broader original formulation of alexithymia (Preece & Gross, 2023; Taylor et al., 2024). A treatment study should state which component it expects to change and why.

Luminet and Nielson (2025) argue for a more processual affective science in which interventions test specific emotional operations. That direction is more informative than asking whether one global trait predicts success. A patient may become better at noticing arousal without becoming better at interpreting it, or may acquire emotion words without using them in decisions and relationships. Treatment response therefore needs more than one plane of measurement. Symptom change remains central, but repeated assessment of relevant alexithymia facets can show whether emotional-access change preceded, accompanied, or followed it. The role assigned to alexithymia should follow the temporal design rather than the preference of the investigator.

4. Emotional Access Mismatch as a Conditional Treatment-Process Proposition

The apparent inconsistency in this literature becomes less surprising once alexithymia is separated from a fixed patient property. Studies have been asking several different questions under the same label. Some ask whether a high intake score predicts final symptoms. Others ask whether emotional regulation explains concurrent distress, whether alexithymia changes during therapy, or whether a treatment can directly train emotional identification. When those questions are treated as interchangeable, null and positive findings appear contradictory even though they concern different positions in the treatment process. A more useful synthesis keeps those positions separate before asking how they connect. Direct treatment studies do not show a stable rule that high alexithymia predicts failure. Some patients improve substantially, and alexithymia itself can change. Correlational studies, meanwhile, show strong links with distress and emotion-regulation difficulty but cannot establish treatment causality. The pattern is easier to understand as an interaction. A treatment places particular demands on emotional information, and alexithymia matters to the extent that the patient cannot yet supply the kind of discrimination, representation, or communication required at that point in therapy.

Emotional access mismatch is proposed here as an analytical proposition for that interaction. It is not another name for alexithymia and it is not equivalent to emotion dysregulation. Dysregulation concerns what happens when emotion is modified poorly or inefficiently. Emotional access mismatch concerns whether the therapy requires emotional information that is not yet usable in the form the intervention assumes. Nor is it identical to experiential avoidance. A patient may willingly approach internal experience but still be unable to differentiate or describe it. Mentalization difficulties can overlap, especially in interpersonal contexts, yet the present proposition is narrower and tied to a specific treatment demand. These distinctions matter because a new label would add little if it simply renamed established deficits.

The proposition has boundary conditions. It should be strongest when a treatment phase depends directly on emotional discrimination, experiential engagement, or collaborative meaning-making. It should be weaker when early treatment relies mainly on behavioural structure and does not require precise emotional articulation. The mismatch should also shrink if therapy successfully teaches the operations that were initially unavailable. If emotional access improves while treatment response remains poor, the proposition is no longer a sufficient explanation. These conditions make the idea testable. Future studies could examine whether baseline difficulty identifying feelings predicts poorer response more strongly in high-emotion-demand interventions than in treatments whose early mechanisms are primarily behavioural, and whether that moderation weakens after emotional-access skills improve.

Facet differences become clinically useful within this framework. Difficulty identifying feelings is likely to matter when the intervention requires discrimination of internal states. Difficulty describing feelings may be more consequential when treatment relies on disclosure and collaborative verbal formulation. Externally oriented thinking can reduce spontaneous attention to internal experience but may be less disruptive to behavioural learning. These are hypotheses suggested by the literature rather than established matching rules. The current evidence rarely compares therapies directly enough to support prescriptive allocation based on facet scores.

The trait-state problem also becomes less polarised. A vulnerability can be relatively stable and still fluctuate with symptom severity. Clinicians do not need to decide at intake whether a high score is permanently trait-like. Repeated assessment is more informative. A high score during severe depression may justify slower emotional work even if it later falls. Persistent difficulty after remission may point to a residual vulnerability that continues to affect relationships or relapse risk. The clinically relevant outcome is not whether a score crosses a cut-off, but whether the patient can use emotional information more effectively in the tasks that treatment and everyday functioning require.

5. Clinical Implications, Evidential Limits, and Research Priorities

Several adaptations are consistent with this interpretation, although the evidence is not yet strong enough to define a standard alexithymia module. Concrete discussion of a recent episode may be easier than asking for an abstract emotional label. Attention to bodily change can be useful when it is linked carefully to context rather than treated as proof of a particular feeling. Tentative labels can be offered collaboratively rather than as corrections. In trauma treatment, a discrepancy between verbal distress and observed activation may justify checking multiple channels before increasing emotional intensity. These practices fit the mechanisms reviewed here, but direct comparative trials are needed before they can be presented as evidence-based adaptations.

Bodily information requires particular caution. Alexithymia is often discussed as though greater interoceptive attention will automatically improve emotional identification, yet the relation between interoception and anxiety is conditional. Puigcerver et al. (2024) found that interoception moderated the association between alexithymia and anxiety symptoms. For some patients, directing attention inward may provide useful raw material for emotional differentiation. For others, especially when bodily sensations are already interpreted as threat, the same exercise can intensify uncertainty or symptom monitoring. The therapeutic task is therefore not simply to increase attention to the body. Bodily cues become useful when they can be placed in context and compared with action tendencies, appraisals, and subsequent outcomes. This is another boundary on emotional access mismatch. Access that produces more undifferentiated arousal without better appraisal may not improve treatment response. Interoceptive work should therefore be understood as a possible route into emotional information rather than an intervention that is inherently corrective. Its value depends on whether attention to the body becomes more interpretable and usable over time. If inward attention mainly amplifies uncertainty, the treatment demand may have increased before the patient's appraisal capacity has caught up.

Therapeutic stance deserves separate attention. Repeated requests for deeper feeling can become shaming when the patient experiences emotional language as inaccessible, while staying entirely at the level of facts can leave the same difficulty untouched. Nunes da Silva (2021) emphasises alliance-sensitive work in which emotional skills are developed rather than demanded. That stance is compatible with the treatment studies showing modifiability. It also prevents alexithymia from becoming a pejorative explanation for a difficult session. Limited emotional language can be treated as

information about the present therapeutic task without assuming unwillingness or a fixed deficit. This stance also protects the therapist from overinterpreting fluency. A patient who uses sophisticated emotion words may still remain detached from the experience those words describe, while another patient may have limited vocabulary but reliable awareness of changes in action tendency and bodily state. Clinical access cannot be inferred from verbal style alone.

The evidence base remains uneven. Direct psychotherapy studies are concentrated in trauma-related treatment, and common anxiety disorders have much less outcome research than the title of the field might suggest. Many papers use alexithymia as one variable among several, often with self-report measurement at only one or two time points. Small intervention studies commonly lack active controls, and non-clinical samples cannot establish effectiveness in diagnosed disorders. Measurement itself remains contested. A decline in self-reported difficulty describing feelings might reflect genuine access, symptom relief, familiarity with therapeutic language, or a combination of these changes. These limitations are why contextual and mechanistic studies were not given the same evidential weight as treatment-outcome research in this review.

More informative trials would measure alexithymia before treatment and again during the period when process change is expected, rather than only at termination. Facets should be analysed separately where theory predicts different roles. An adapted treatment should be compared with the standard treatment if the claim is that scaffolding emotional access improves response. Qualitative patient accounts could clarify whether lower scores reflect greater experiential access or simply a better vocabulary. The strongest test of emotional access mismatch would be an interaction test linking treatment demand, baseline emotional-access capacity, and subsequent outcome. Without that design, the proposition should remain a clinical formulation generated from converging evidence rather than an established mechanism.

Alexithymia remains transdiagnostic, but transdiagnostic does not mean clinically identical. In depression, current severity can inflate the difficulty and obscure its independent role. Trauma treatment places unusually high demands on experiential engagement and therefore provides a clearer setting for observing mismatch. Eating symptoms and self-harm may serve rapid regulatory functions when affect is poorly differentiated, yet evidence from those literatures is more useful for mechanism than for psychotherapy prognosis. The broad pattern is therefore compatible with diagnosis-sensitive care. A transdiagnostic formulation can guide what the clinician looks for while the pace, risk assessment, and behavioural targets remain specific to the disorder and treatment being delivered.

Emotional responses in alexithymia can be strong even when they are poorly differentiated or difficult to communicate. The clinical task is neither to force emotional expression nor to assume that limited access is immutable. The reviewed evidence supports a more conditional position. Alexithymia may matter because of what a treatment asks the patient to do with emotion at a particular time. When that demand exceeds currently usable emotional access, treatment may slow or become less efficient. When access is scaffolded, the same patient may be able to use the intervention more fully. That claim should remain provisional until comparative treatment studies test it directly, but it is better aligned with the current evidence than treating alexithymia as a stable reason for therapeutic pessimism.

CONCLUSION

Alexithymia is relevant to treatment response across common mental disorders, but the evidence does not support a fixed poor-prognosis interpretation. Part of its association with outcome reflects depression and general distress, while direct treatment studies show that patients with elevated alexithymia can improve and that alexithymia itself may change. Difficulty identifying feelings appears especially important when therapy depends on emotional discrimination or experiential engagement. Emotional access mismatch offers a cautious way to formulate this conditional effect. It describes a treatment-patient interaction in which the emotional operations assumed by an intervention exceed the patient's currently usable access to emotional information.

The proposition remains to be tested directly and should not be used to allocate or deny treatment. Its value is more practical because it directs attention to what therapy is asking of the patient, whether that operation is currently available, and whether early scaffolding changes subsequent response. Future trials with repeated facet-level measurement and explicit tests of treatment demand are needed before this formulation can move from analytical synthesis to established clinical mechanism.

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