The management of the alexithymic individual: comorbidity, politics and crime

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This paper refers to the construct of alexithymia, to recent developments about its etiology, its measurement, its comorbidity, therapeutic considerations and its possible association with politics and crime. It concludes with an account on the management of the alexithymic individual. The term alexithymia was developed by the author as a result of his observations, while being in charge of a clinical research with psychosomatic patients in the Harvard Medical School, in the 1960s. Its cardinal features are the following: (1) Inability of the patient to identify, describe emotions and to differentiate them from bodily sensations. (2) Paucity or even absence of fantasies following emotional arousal. (3) Tendency to act impulsively. (4) Utilitarian externally oriented thought content with a vocabulary limited to a description of endless details. In short, one could say that we are confronted with an “absence of words for emotions”. Additionally, it involves an inappropriate affect, lack of sensitivity, chaotic interpersonal relations, and a total inability to understand the meaning of the word “feeling”. There is an absence of dreams, or if dreams occur they are of the wish fulfillment variety. There may exist
anhedonia, rigid postures and facial expression and lack of intonation to their language (“aprosody”). Perhaps it is related to deficits in the connections between the limbic and the cortical areas, deficits in the capacity for symbolization, deficits in the interhemispheric interactions, occurring more in stroke patients with right hemispheric lesions. A recent study utilizing PET methodology, concluded that during emotional recall alexithymic patients utilized different language-related brain regions compared with normal controls. Alexithymic features appear to be present in a variety of psychiatric disorders (somatoforin, panic, anxiety, post traumatic, eating, sexual, suicidal disorders), in patients suffering from chronic pain, masked depression, AIDS, as well as in sociopaths, borderlines, alcoholics, and substance abuse individuals. Since both alcohol and narcotics can cause brain damage, in such alexithymic individuals a vicious cycle may be established. The two instruments that are used to measure alexithymia are the Beth Israel Questionnaire, an evaluator interview assessment, and the Toronto Alexithymia Scale, a self report questionnaire. Therapeutic outcomes are poor, dynamic psychotherapy is contraindicated in alexithymics suffering from medical illness and individual or group supportive psychotherapy in conduction with psychotropic medication can offer more help. A psychoeducational modified intervention should be considered as well. The author describes the characters of the Nazi Rudolf Hoess, commandant of the Auschwitz concentration camp, Adolf Eichmann, officer in charge of transporting prisoners in concentration camps and Adolf Hitler, based on their publications and testimonies and demonstrates the alexithymic features of their character, behaviour and speech. The article concludes with thoughts, clinical examples and considerations about the management of the alexithymic individual. The
only available resource in dealing with them is to provide support, and give
reassurance that one understands their deficits and their difficulties in
communication. There is an ethical problem in dealing with people who are
not patients but occupy powerful positions and can harm to many humans.
The only solution is to identify such individuals before electing or
supporting them.

Key words: alexithymia, comorbidity, politics, crime, management.

Emotional awareness and its expression have always interested
psychosomatic. Alexithymia [from the Greek α for lack, lexis for word, and
thymos for emotion], a term which I introduced thirty years ago, seems to be
associated with defects in the awareness and expression of emotion, and
plays an important role in the understanding of the patients suffering from
psychosomatic disorders.

In this paper, I shall discuss the construct of alexithymia, recent
developments about its etiology, its measurement, its comorbidity,
therapeutic considerations, and its possible association with politics and
crime. Finally, I shall conclude with the description of the problems to the
psychiatrist involved with the management of the alexithymic individual.

While working and being in charge of the Psychiatric Clinic of the
Massachusetts General Hospital, a teaching hospital of Harvard Medical
School, in the 1960’s, I investigated randomly selected psychosomatic
patients. As a result of my observations I was able to develop the construct
of alexithymia and its cardinal features which are the following:
1. The patient is unable to identify, to describe emotions, and to
differentiate them from bodily sensations.
2. There is paucity or even an absence of fantasies following emotional
arousal.
3. One observes a tendency to act impulsively.
4. Finally, one encounters a utilitarian externally oriented thought content
with a vocabulary limited to a description of endless details.
In short, one could say that we are confronted with an “absence of words
for emotions”.
This original description of alexithymia was followed later on by
additional observations which involved an inappropriate affect, lack of
sensitivity, chaotic interpersonal relations, and a total inability to
understand the meaning of the world “feeling”. There was almost
absence of dreams or, if dreams did occur, they were of the wish
fulfillment variety.
Anhedonia as well as an assumption of rigid, frozen wooden like
postures, and facial expressions were commonly encountered. Finally,
patients were unable to modulate and give an intonation to their language
which is called “aprosody”.

In English the words affect, emotion, and feeling are defined
interchangeably, and because confusion might ensue Nemiah and I
decided for purposes of communication to define affect as a general
biopsychological term which includes emotion as its biological
component, and feeling as its experiential psychological one. I shall
therefore use these definitions in this paper.2

Since emotions play an essential role in everyday life in general, and a
special one in medicine in particular early in the last century efforts were
made by neuroscientists and clinicians to investigate its anatomy and
physiology. Here are some examples of the work that was being done.
Bard for instance showed that cats developed furious rage reactions having had their forebrain removed all the way down to the hypothalamus. He called this a “sham rage reaction” since there was no evidence that the animal was experiencing any emotion, because it was also purring at the time.

On the other hand, Kluver and Bucy working on primates produced tameness, oral exploration, lack of fear, and sexual expression by ablating the uncus, amygdale, the hippocampus and its gyrus, and the neighboring cortex. MacLean at about the same time described the visceral brain.³

In the clinical area Ruesch emphasized the importance of what he called the infantile personality, and in Paris, Marty, de M’Uzan, and David demonstrated that psychosomatic patients had a paucity of fantasies and tied to reality almost “fossilized” utilitarian thought content which they called “pensée opératoire”.⁴ Much later Lane and Schwartz described five levels of emotional development.⁵

From all these investigations it was concluded that in the limbic are [amygdale, hippocampus and cingulated cortex] the amygdale was responsible for emotional arousal, but it was not clear that there existed special nuclei for each specific emotion. The amygdale was in turn connected with the hippocampus responsible for past memories, with the hypothalamus, and the cerebral cortex, which in turn exerts an inhibitory activity on the limbic structures, and when it is destroyed, it lives rise to reflex like actions, lack of fear, and hypersexuality. These characteristics were similar to those exhibited by the monkeys of Kluver and Bucy, in leucotomized human beings who had undergone such operations, in order to improve the severe symptoms of their psychiatric illnesses.
In the early 1970’s, a conference in London brought together biological scientists, and clinicians, and came to the conclusion that there was a great need for research in the area of human emotions.

Another international conference was held in Heidelberg in 1976. MacLean presented his work on the “triune brain” [reptilian, limbic and neomammalian]. Hoppe and Bogen reported their findings in intractable epileptic patients who, after a commissurotomy for relief of their seizures, had developed alexithymic characteristics. A genetic model was described by Heiberg and Heiberg who concluded that the alexithymic traits were hereditary in nature. Nemiah favored a structural rather than a psychological model for understanding alexithymia. In sum, the Heidelberg conference established once and for all the importance of alexithymia as a useful construct for the study of psychosomatic disorders as well as for the investigation of affect deficit states.  

Etiological considerations

Although at present the etiology of alexithymia is unknown, it appears that it seems to be associated with a variety of deficit models. Deficits for example in the ascending and/or descending connections between the limbic and the cortical areas, deficits in the capacity for symbolization, deficits in interhemispheric interactions, occurring more in stroke patients with right hemispheric lesions. Finally, deficits in the conscious expression of emotions, which imply that the emotional stimulus is perceived but that the patient is unaware of its existence.  

A recent study by Huber in Cologne utilizing PET methodology concluded that during emotional recall alexithymic somatoform patients
utilized different largely language related brain regions compared with normal controls.

Finally, it is well known that child abuse increases corticotrophin release factor [CRF] which in turn stimulates the release of cortisol. If the excretion of cortisol is prolonged it can be harmful to the brain, as is the case in major depression and possibly in Alzheimer disease. It is conceivable then that it also may play a role in the etiology of alexithymia.

It is clear however that the answer about the cause of the alexithymic characteristics must await the future results of more extensive neuroimaging studies and research.

**Clinical issues and comorbidity**

To the clinician, presents a broad confusing and incomprehensive picture, and because of this I would like to present briefly four cases, three of which I encountered during me psychiatric residency training at the Harvard Medical School’s McLean and Massachusetts General teaching hospitals.

A 28-year-old well-educated housewife was brought to the hospital by her husband because of severe and repeated bouts of alcoholism. She was assigned to me with the recommendation that she should be offered psychotherapy. I found her intelligent and cooperative, but whenever I asked her about her feelings I always hit a brick wall. She always responded by giving me a detailed account of what she did, and when I indicated to her that she had no answered my question she looked surprised. She would then exclaim “But I told you so” and continue to give accurate descriptions of various episodes without saying a word.
about her feelings. Over a period of two years she had several hospitalizations because of severe drinking, and it was clear to me that my psycho-therapeutic efforts had been to no avail, with no beneficial effect whatsoever. Of course the admissions to the hospital temporarily eliminated her need to drink, but as soon as she was discharged she would resume her heavy drinking and her husband would return her to the hospital. After the end of my residency she came to see me in my private office. Each time she was drunk. Unfortunately, her physical condition deteriorated from then on and she died soon after.

The next case involved an 18-year-old student. She was brought to the hospital by her father, because she was refusing to eat and had lost a great deal of weight. When she was seen, she weighed 40 kilos and was of above average height. In other words she looked like a skeleton. Her diagnosis was anorexia nervosa. Every effort that was made to make her eat, was met with total failure. When she was asked to describe how she felt, at first she refused to answer, but when I insisted she told me that she did not understand what I was talking about. The nurses reported that she would stand rigidly for long periods of time in front of a mirror, with a tense look on her face. In desperation because she had lost three more kilos, the decision was reached that she should undergo a unilateral leucotomy, which at the time was used extensively in the United States. The operation was performed by an eminent neurosurgeon. Her right lobe was several at the brain area 10. Immediately after the operation she started to consume enormous amounts of peanuts. She gained rapidly weight and soon reached a respectable 65 kilos. Otherwise her behavior remained unchanged. Her mother had been away in throughout her hospitalization. She came to visit her after her return and when she saw
the patient she exclaimed angrily: “You look as fat as a pig”. The patient did not express any emotion but she again refused to eat, and soon she had lost all her weight, which she had regained. After considerable discussion, it was decided that a second operation on the left hemisphere was the only alternative available. In addition strict orders were given to restrict her mother’s visits. The same series of events took place. She again started to eat and to gain weight, but unfortunately her mother was able to convince her father to have the patient discharged from the hospital against medical advice. Two months later she returned to the hospital, and remained there for several years.

While the first two cases were hospitalized in a mental institution, the third case was about a middle-aged man who was admitted to the Massachusetts General Hospital because of severe ulcerative colitis. He had also a history of mental illness of many years and had received psychotherapy by several senior psychiatrists for many years without much improvement of his psychological problems. As chief resident of the psychiatric service, I first saw the patient after his surgical operation which had removed all his colon, but had left his sigmoid and rectum, which were disease free. The reason for his admission to Psychiatry had to do with his having developed suicidal and paranoid ideas after his operation. When I first met him I was impressed by his intelligence, and by his detailed enumeration of all his needs for medication because of pain, his tirades against the nurses, and his ideas that people were against him. When I mentioned that I understood his angry feelings, he denied that he had any. Although at first he said that he disliked me, because I had replaced the doctor whom he knew, and who had taken care of him in the past; slowly as his psychological state started to improve he
became friendlier and talked at length about his past life. Unfortunately, his physical condition started to deteriorate again because his ulcerative colitis had invaded his sigmoid and rectum. He was therefore transferred to surgery for their resection. Once more he became worse psychologically, and had to return to our Psychiatry service.

This time his physical condition did not improve, and he soon developed massive infections around the permanent ileostomy scar, which were resistant to antibiotics, and as result he developed elephantiasis of both his lower extremities. Since both the internists and surgeons had nothing further to offer and the patient was likely to die, as a last resort, it was thought that anaclitic therapy might help him, although it was known that such a therapy had never before was offered to an adult patient. This therapy which involved giving the patients everything they wanted required an enormous amount of effort, of time, and was extremely expensive.

When I announced to him that we were willing to satisfy all his wishes, he of course was incredulous, but he soon became enthusiastic. At first he demanded to be given expensive food which was followed by request for free narcotics and for alcohol. After some weeks he started to regress, and soon became almost mute, drank only milk from a baby bottle, became incontinent which necessitated to have to wear diapers, and finally his only expressed need was to have me present to hold his hand for long periods of time. This infantile state lasted for several weeks, but my constant presence on his side at hours of day and night, and the use of chloromycetin eliminated his infection, so it was decided to discontinue the anaclitic therapy. He improved rapidly and was discharged after a nine month long and strenuous hospitalization.
It was thought that the anaclitic therapy which involved a physical support of monumental proportions and the antibiotic medication had saved this patient’s life. He lived for four more years and died of a myocardial infarction.

The last case seen some years later involved a young woman who exhibited all the alexithymia characteristics when she was seen at the outpatient clinic. She was to be followed, but she failed to keep her appointment. A few weeks later she was admitted to another Harvard hospital having made a suicidal attempt. The x-rays had revealed that she had a congenital absence of the corpus callosum.

Diverse as the diagnoses of all these cases may appear, alcoholism, anorexia nervosa, ulcerative colitis, and attempted suicide, they all had one feature in common, namely their alexithymic and I discovered that indeed such characteristics did occur in a small percentage in these patients.\(^9\)

At the present time it is documented that alexithymic features appear to be present not only in patients with psychosomatic disorders but also seem to exist in a variety of medical illnesses, such as somatoform, panic, anxiety, post traumatic, eating, sexual, and suicidal disorders. They were also described in patients suffering from chronic pain, masked depressions, and AIDS. Finally, they seem to be present in sociopaths, borderlines, alcoholics, and substance abuse individuals. Although alcohol and drug abuse cases have a variety of etiologies, the individuals who consume them usually are socially isolated, alienated, tense, and impulsive. A certain number of them sometimes have difficulty to identify, and express their emotions, and to use words to describe them.
It is well known that both alcohol and narcotics can cause brain damage, the symptoms of which can be very distressing necessitating self medication. This is turn causes more damage, and a vicious cycle is established, a phenomenon unfortunately only too common these days in the western world.

In sum, then it should be repeated that the by now familiar alexithymic characteristics occur only in a certain percentage in all these disorders.\textsuperscript{6}

The measurement of alexithymia

At the present time, there are two types of instruments that are used to measure alexithymia: evaluator interview assessments and self-report questionnaires.

The BIQ [Beth Israel Questionnaire] which I developed, requires that the evaluator, after interviewing the patient, answer 19 questions, 8 of which denote the alexithymia characteristics. If a positive score of 6 out the 8 is obtained then the patient is considered to be alexithymic. Any score below 5 is considered normal. The BIQ has good interrater reliability but requires an experienced evaluator, familiar with the alexithymia construct. Inexperienced evaluators can have problems and obtain an unreliable evaluation. Other instruments include the SAT 9, which requires the patient to draw pictures of mythical subjects, the SSPS-R [Schalling-Sifneos Personality Scale-revised] which correlates with the BIQ, the MMPI, and the Q set alexithymia prototype, and can be useful in their own ways.

From the self report questionnaires, the TAS [Toronto Alexithymia Scale] is by far the most reliable and well validated instrument with an internal consistency. It has 44 questions and covers most aspects of the
alexithymia construct. It has been revised twice. The most recent revision, the TAS-20 that is widely used, has questions dealing with difficulties to identify and describe feelings and to distinguish them from bodily sensations. It has however eliminated unfortunately the paucity of fantasy item, a key component of the construct. In my opinion, the best way to measure alexithymia at the present time is to use the BIQ in conjunction with the 44-question original TAS.⁶

**Therapeutic considerations**

It should be fairly obvious by now that the problems of the alexithymic individual have to do with the external reality, and not with intrapsychic emotional conflicts which are best dealt with dynamic psychotherapeutic interventions. It is therefore imperative that any form of dynamic psychotherapy should be contraindicated for alexithymic patients suffering from medical illnesses, because the increased tension will give rise to severe medical complications. This actually may be the reason why so many alexithymics have a high drop out rate at psychiatric clinics, as seen also by psychotherapists in private practice. Supportive psychotherapy either of the individual or the group kinds can offer the best help, particularly if they are used in conjunction with psychotropic medication. A modified psychoeducational therapy developed by Krystal is said to provide limited success and should be considered.¹⁰

**Politics and crime**

As it has been mentioned already, alexithymic characteristics can be present in sociopaths, and borderline patients. An important aspect, which to my knowledge has been generally ignored, has to do with
politics and crime. For example, in the media one often reads or hears about criminals who have been given severe sentences but demonstrate no emotion whatsoever. This curious phenomenon raises the question as to their inability to understand the gravity of the situation they find themselves in, or to visualize its long term effects. On the other hand one could argue that because they do not have fantasies associated with their emotional arousal they are unable to consciously express their emotions, a deficit which is considered, as I have reported already, an etiological factor of alexithymia with its lack of language to express feelings. It is of interest that most languages use two words to describe affect. In English we use *emotion* and *feeling*, in French we have *emotion* and *sentiment*, in German we have *Emotion* and *Gefühl*, and in Greek we have *aesthema* and *synaesthema*. The term *syn* implies that something has been added, I think what has been added are the thoughts and fantasies which accompany an emotion which we call feelings and which are absent in the alexithymics.

During the last few years I have studied extensively the publications of three most notorious criminals of the twentieth century.

Rudolf Hoess, the Commandant of the Auschwitz concentration camp between 1941 and 1943, wrote a book while waiting execution in Poland after the war. He describes in great detail the shootings, hangings, gassings, tortures and mass murders of thousands of inmates. He also emphasizes his wish to be alone and avoid contact with people, his ability to be calm and relaxed. He prides himself of having “no sentiments” at the horrors that were taking place all around of which he was responsible. Here is an example: “Gassings always put my mind to rest”. He also mentions seeing children playing unaware of their fate while their
mothers were crying. He does on “I had to act. I nodded to the officer in charge. He picked the children and carried them to the gas chamber. I had no trace of sentiment whatsoever.” A tendency to act rather than to feel we know by now is an alexithymic feature.  

Adolf Eichmann was the SS officer in charge of transporting millions of prisoners to various concentration camps. After his capture by the Israelis in 1960 he was interrogated and a transcript was made of his answers and was later published in book form. Here is an excerpt of what he said when asked about the gassings of the Jews: “I did not give these details any thought. I never discussed these details with anyone. One million or one hundred millions amounted to the same thing. I obeyed and I did my job. The Jews were valuable material because they had money”. 

A videotape was shown on America TV, where one can hear the monotony of his aprosody and see his wooden stiff postures and wooden facies.

Finally there is Adolf Hitler, the politician, the mass murderer, whom Dostoyevsky would have called “The Grand Inquisitor”. Hundreds of books have been written about him, but for me the most extraordinary one is titled “Hitler’s Table Talk”. Published by the Oxford University Press, this 700 page book is a transcription of Hitler’s free association like tirades from 1941 to 1944, all taking place in a relaxed after lunch or dinner atmosphere, and involving mostly a silent audience of party members, military officers, and friends. His secretary Martin Borman was responsible for taking verbatim notes. The well known Oxford professor Trevor Roper in his preface emphasizes that Hitler was “… a systematic thinker with a mind coarse, narrow, rigid, and cruel, as is
seen in these unrehearsed talks which give a vivid and true picture of his mind. These talks were full of materialistic, trivial, half-baked, and disgusting material. There is a yawning emptiness. No word was ever uttered even so much as touched the human spirit. He was rigid without tolerance...” This fine description of alexithymic like thought content was written twenty years before alexithymia was conceptualized. Action predominates throughout. He says: “I will execute all leaders, all commanders irrespective of rank, all concentration inmates and particularly all Jews. Cold reason guides my actions. Sentiment plays no role”. This long and extremely boring book is full of detailed descriptions of military equipment, such as guns, airplanes, tanks, as well as oil, highways, bridges, and so on, and on, without any reference to any feelings. The only one reference to anything implying an emotion was what he said about his mother, whom it was reported by his biographers that he loved, was the following: “She loved her husband and her children. She gave a son to Germany”.

Management of the alexithymic individual

The question that one must raise this point, is how should one manage the alexithymic individual. How can a psychiatrist deal with someone who is usually referred by a member of his or her family, or by a friend, has no medical complaints, is reluctant to cooperate with the evaluation, and proceeds to describe endlessly unrelated episodes or circumstances, and who shows no evidence that he knows or understands what feelings are. If on the other hand such a patient is referred by a physician, the reason for the referral has to do more with the patient’s having no
followed instructions, and has refused to take his medications despite repeated efforts of the referring physician.

I have received many letters from spouses, relatives and fellow doctors complaining about their inability to deal with their alexithymic husbands, wives, friends, or patients.

A wife wrote to me: “My husband is a good man, a fine provider, and an intelligent human being, but throughout our ten years of married life he never said a word about love, sadness, or joy. He does not seem to understand what these words mean, and whenever I bring it up he looks bored or changes the subject”.

Here is what a frustrated internist told me about one of his patients: “This is very peculiar woman. She is a severe diabetic, I have many times explained to her about the importance of her diet, and in particular about her insulin. She always smiles, says she understands, and continues to eat sweets, and avoids her insulin injections with the result that her blood sugar level has skyrocketed. What can I do?”

Another physician send me a patient with severe hypertension, who had a myocardial infarction one year before, who had gained a great deal of weight and refused to do any exercise. He wanted me to see the patient in an effort to convince him to follow the doctor’s recommendations. The patient was extremely obese man who sat rigidly on the chair, told me that he did not want to see a “shrink” [slang for a psychiatrist] because there was nothing wrong with him. When I reminded him of what his internist has said, he smiled and asked me if I was interested in football. O again tried to revert to the original subject, but I was not successful. He got up to leave and said: “I have never worried in my life, I have never got mad or sad. My wife says that I do not know what these words mean.”
Tell me doctor not to worry about me. Tomorrow I am going to watch a fine football game”.

Three months later I received a letter from my internist friend: “Mr. F. had a second coronary and had died three days later. The sad thing is that there seems to be nothing that one can do for such patients”.

It is clear that the only available recourse that one has in dealing with the alexithymic patients is to provide them with support, give them the reassurance that one understands their deficits, their abortive efforts to communicate, and their inability to describe emotions.

Finally, there is the ethical problem of dealing with an important and powerful alexithymic politician, clergyman, industrialist, journalist, publisher, policeman, military officer, actor, lawyer, doctor, or tycoon, who are unaware of any feelings, and proceed with their destructive careers creating havoc, and causing irreparable damage to many other people.

It seems possible that if Hitler’s physicians were able to see through alexithymia instead of blindly obeying his destructive orders, millions of human beings might have been saved, and even the Second World War might have been averted. It might be argued that I am exaggerating but I do not think that this is the case.

Alexithymia’s value lies in its ability to challenge and to cut across our usual nosological boundaries occurring in various percentages not only among medical, and psychiatric patients, but also in different populations. It seems then that it is imperative that we identify individuals who have the potential of causing considerable damage.

Finally, as I have written in a recent article, “We should make sure that those whom we elect to govern us must not only fulfill our own
selfish interests and needs, but also possess the ethical qualifications, as well as the feelings which distinguish us from lower animals, and which are our most striking and precious human characteristic.”

Comments

I would like to make a few brief remarks about a subject very dear to me, because I have spent all my professional life dealing with it, namely the education of medical students in general, and of psychiatrists in particular.

Despite all attempts that have been made over a long period of time to eliminate the dichotomy between body and mind, nevertheless it seems that we have failed in our efforts.

One hears quite often statements such as “this is a biological problem” or “this is a psychological”. For example, what has happened in the United States during the last seventy years was the predominance of psychoanalysis during the 1950s and 1960s, then the emphasis on community mental health during the 1970s, and more recently the preeminence of biological psychiatry and psychopharmacology.

One of the important teaching responsibilities is therefore to eliminate these artificial separations and to emphasize the holistic biopsychosocial model in an effort to help teach our trainees how to understand and treat their patients.

In order to achieve this point of view, at Harvard we rely heavily on individual tutorial instruction. In addition, our students have several supervisors for their clinical cases, and usually by the end of their five year psychiatric training they are ready to treat their patients, as well as to provide valuable consultation to their fellow medical colleagues. It is this
latter task which in my opinion is one of the most important functions and responsibilities of the psychiatrist. For example, one of the commonest request for consultation has to do with a request for the evaluation of a suicidal, or terminally ill patient. The risks involved about a potential suicidal attempt are clearly the responsibility of the psychiatrist to evaluate and to make appropriate recommendations. What to tell on the other hand a terminal ill patient is another matter of the greatest importance. Usually doctors have a tendency to approach the subject in an “either or” way. Either they tell the patient the bad news, or they avoid the subject completely. Instead of evaluating what the patient wants to hear, because the subject is difficult, they decide to deal with it in a black and white way.

For example, if a patient asks the doctor about his or her prognosis, and before hearing the answer starts talking about an unrelated subject, it seems clear that he does not want to hear the bad news. Being told therefore that they might die may have a devastating effect on them. If on the other hand a patient explains that he or she wants to make certain plans about their future or about their family, then giving them the bad news may be the appropriate thing to do.

To conclude this difficult and important discussion, it seems to me that having educated our psychiatric trainees to consider above all the holistic biopsychosocial model and the importance of the “quality of life”, not only they will offer the best care to their patients, but also they will be able to teach their medical colleagues how to do the same.