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Considerations on emotional development: to be aware of or else holding back emotions among inflammatory bowel disease patients

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Summary

This cross-sectional study was conducted in an inflammatory disease group comprised of 59 patients, 22 men and 37 women, and aimed to explore the possible influences of familial interactions in affect regulation. Probably benefiting from a more caring upbringing and environment, the last born express his emotions outwardly in contrast to the eldest child who has such tendency decreased. In turn, parental separation is associated with lower positive affect and sensation seeeking. However, from another perspective, positive affect and exploratory behaviour tends to increase with the time period of adulthood separation from the nuclear family of origin. Finally, those who were raised as an only child within the family are more anxious, have greater difficulty in describing feelings and tend to be included among more severely ill patients. These findings are consistent with the importance attributed to environmental conditions regarding alexithymia and related constructs.

Key-words*: Alexithymia, Emotional control, Disorders of the affect regulation.*

INTRODUCTION

Starting with a seething cauldron[1], we devise the epigenetic character of emotional development[2] through a mutual recognition process[3] between the child in early infancy and its key relationships; that is the caretaker, just to borrow Engel's words in reference to ulcerative colitis patients' compensatory dependency[4]. Residing in a pattern recognition capacity, this development process eventually provides consistency to the significant objects invariant behaviour; thus allowing the emergence of a representational model structure that provides security as immanent of a predictable world.

This way, influenced by the child's behaviour, the mother's attuned response in affect sharing – as evidenced by mirroring affective expression –, gives trust opportunity; while integrating affects and cognition. And this is the indispensable basis for the resolution of the transition from a symbiotic attachment style to individuation. Thus obviating, as it would result from an aggravated develop-

ment crisis, to an avoidant functioning ego defect characterised by insecure-ambivalent attachment style and even autistic isolation. In this later case, non-symbolic, concrete thinking, and reported extensive use of projective identification [5-7], may be viewed as a disturbance of the person's adaptive capacity characterised by withdrawal and regression. In an integrative perspective, McLean[8] and Nemiah[9] postulated that this affect regulation malfunction, with difficulty verbalising feelings and limited fantasy, might occur as a result of some sort of disconnection between neocortex and limbic systems.

But while resulting from disturbances in the earliest dyadic relationship, assumed here as a fundamental requirement in order to bring about a traceable neural morphogenesis, we would better go back to the Kleinian theory on functioning in the paranoid/schizoid position. Since emotions are yet to be organised at this preconceptual level[10] contrasting with the use of the cognitive functioning on the depressive position level. As a matter of fact, to conciliate pleasure and painful anxiety feelings – outgrowing from deprivation/ /frustration –, she conceived ego splitting, in order to reduce dissonance between retaining the first ones – the oral incorporation traceable in addictions –, while discharging the unbearable others into the object through projective identification [2].

Mother as a container[11] acts by processing cognitively and emotionally her infant's raw projected feelings of distress – alpha function, *rêverie* –, thus transforming, giving them meaning, and sending them back in a more bearable form. This way, with the object's help, the infant progresses in order to tolerate, accept, and finally possess its own feelings; accomplishment that will eventually lead him to the depressive position.

The self-doubt's archaic level[12] assumed in this conceptual model of the psychosomatic functioning, clearly contrasts with some like Fonseca's affective equivalents[13,14] and others. For these rely upon Freud's pioneer work on repression and somatic conversion, and this is an ulterior inhibitory process upon which reside some other psychopathological phenomena that we'd rather qualify as expressive. Meaning that, although they must not be simply disregarded since they are somatic amplificators, the latter would better be understood as a neurotic function that in some sort might be reduced to a mere self-monitoring of the anticipated reaction to the environment. Coherence between ideas and behaviours is displaced here to an emotional investment in relationships with others. Extraverted, sociable, mimicking others with no mental dissonance restraint, this is a character that behaves in a pragmatic manner, frequently compromising and adopting ethical relativism towards utilitarian positions. And this expressi-veness[15, 16] simply cannot be mistaken for the primal blockade presiding behaviour of those who act in conformity, both internally and

regarding norms. Nonetheless this simply doesn't exclude the important secondary role of environmental influences as previously reported regarding sociodemographic variables [15, 17].

Aims

The aim of the present study, in order to clarify the possible role on affect regulation of some empirical assumptions about parental attitude during emotional development, was to analyse the association between those family/environment conditions and a few other emotions and health related constructs.

MATERIALS AND METHODS

Subjects

The sample is comprised of 59 inflammatory bowel disease (IBD) patients (42 diagnosed as ulcerative colitis and 17 as Crohn's disease), 22 men and 37 women, who were attending the gastroenterology outpatient clinic of a major metropolitan hospital covering a large northern region of Portugal (with circa one thousand identified patients). Patients were invited to participate in the study if they had a diagnosis of IBD established both clinically and by means of radiological, endoscopic, and/or histologic examination. The mean age is 37.05 years (SD = 13.54) and the mean duration of illness is 9.79 years (SD = 7.34).

Measures

All subjects were given a structured interview, which included a small adjective checklist (Annexe). This was intended to elicit a very short description of the main personality features, both of oneself and of one's parents. This interview also included questions aimed at evaluating indirect signs of dysphoria, the APGAR[18], and family support, namely throughout life cycle:

01. Is it difficult for you to fall asleep?
02. Do you sometimes take psychotropic drugs (hypnotics, minor tranquillisers) by self-initiative?
03. Do you usually get up easily?
04. a) Are you the only child?
    b) Are you the eldest child?
    c) Are you the younger child?
05. Did your parents ever separate from each other?
06. How long has it been (yr.) since you became independent from your family of origin?

Severity/activity level of IBD was established by **Survey CDAI (SCDAI)** score[19] and cross-validated by the gastroenterologist's ratings on a five point scale ranging from 1 (for remission) to 5. Resulting from three of the CDAI variables – abdominal pain, liquid or very soft faeces, and general well being –, SCDAI permits to establish a relatively safe severity distribution crossing categories of mild, moderate and severe cases. Having in mind to render interpretations easier, the authors convert their index into CDAI equivalents as proposed by Best *et al*[20], thus becoming an ade-

quate mean of assessment, whose weighted scores are equivalent to those resulting from CDAI ($r = 0.866$, $p < 0.0001$). The remaining question that has already been addressed by various authors is to known how valid it is to use an index arisen from Crohn's disease to also assess ulcerative colitis. Like we do, some of them think that although not correspondent strictly speaking, it is irrelevant, as this does not include any symptoms specific to either nosographic group[21,22].

The Multiple Affect Adjective Check List (MAACL), used here in its trait form, is a 132 adjective checklist which has been widely used over the past 30 years. It yields scores on five scales – Anxiety, Depression, Hostility; and Positive Affects and Sensation Seeking –; these may be further grouped into two main categories: dysphoria and positive affects and sensation seeking. Previous investigations of some of the psychometric properties of the MAACL within a Portuguese context [23,24] have confirmed its originally proposed factorial structure[25,26], and revealed some minor semantic differences. These differences were not sufficient to invalidate the already available standard data[26].

Alexythymia was assessed with a Portuguese translation[15] of the reliable and well-validated self-report **Twenty-Item Toronto Alexithymia Scale (TAS-20)**. This instrument uses a five-point Likert rating scale, and provides a global alexithymia score resulting from three major scores capturing its most prominent characteristics: difficulty identifying feelings, difficulty describing feelings, and externally oriented thinking [27,28]. Previous testing of the psychometric properties for the Portuguese TAS-20 has demonstrated an overall internal consistency/Cronbach alpha coefficient of 0.78.

The Emotional Expression and Control Scale (EEC) is an 18-item scale with a 4-point Likert rating format which was developed by Bleiker *et al*[29] to assess how individuals generally act when they are angry, anxious, or depressed. Based in part on Spielberger's State-Trait Anger Expression Inventory[30] and the Courtauld Emotional Control Scale devised by Watson and Greer[31], the EEC comprises three six-item subscales: emotional expression-in (EEI), emotional expression-out (EEO), and emotional control (EC). These EEC subscales have demonstrated adequate internal consistency and test-retest reliability[29].

RESULTS

The mean scores and standard deviations used to compare the *yes* and the *no* responders on the structured interview, whenever they differ significantly, are presented in Table 1. In yet another perspective, patients descriptions of their own personality, as well as of their parents, also result from the statistically significant differences that stand out when comparing means in both – *yes* and *no* responders – groups.

Difficulty to get asleep is more common among patients with higher scores in depression (MAACL) and who regard their families as dysfunctional (APGAR). Both these sleeping problems and self-medication with psychotropics are associated with lower scores in emotional control (EEC). Patients who get up easily, on the other hand, are less frequently depressed (MAACL), have lower disease activity (SCDAI), and do rely on their family's support (APGAR).

The only child, as compared to others, portrays him or herself as authoritative; the father as distrustful and stiff, and the mother as joyless. This child scores significantly higher on anxiety (MAACL) and on difficulty describing feelings (TAS--20), while having a higher disease activity (SCDAI). The eldest child tends to see the mother as a not tender person, and to have lower scores in emotional expression out (EEC). The younger child, on the other hand, sees the father as gentle and the

Table 1. **Mean scores and standard deviations for the subgroups of the *Yes* and the *No* responders on the structured interview items**

Question	*Significant items*	*Yes*	*No*		
		Mean ± SD	*Mean ± SD*	*[df]*	*p*[1]
01.	MAACL: Depression	02.91±003.18	01.28±001.67	55	0.024
	EEC: Emotional Expression Control	13.03±004.12	15.92±005.23	55	0.023
	Family APGAR	07.16±002.87	08.73±002.00	56	0.022
02.	EEC: Emotional Expression Control	11.86±004.59	15.02±004.64	56	0.030
03.	MAACL: Depression	01.54±002.03	03.13±003.32	56	0.028
	SCDAI: Activity	130.00±109.05	213.52±128.30	57	0.009
	Family APGAR	06.87±002.22	02.48±002.90	57	0.016
04. a)	MAACL: Anxiety	04.14±000.71	02.02±002.32	36	0.051
	TAS-20: Difficulty Describing Feelings	13.97±002.83	02.43±004.00	36	0.020
	SCDAI: Activity	375.50±072.83	159.00±114.99	36	0.013
b)	EEC: Emotional Expression Out	10.26±003.75	13.57±004.26	36	0.015
c)	EEC: Emotional Expression Out	13.88±004.36	10.33±003.62	36	0.009
05.	MAACL: Positive Affects	05.20±003.90	10.60±005.28	55	0.031
	MAACL: PA + Sensation seeking	10.60±004.45	16.78±006.26	55	0.036

[1] *Student t*

Table 2. **Correlation between emotionality and duration of life apart from origin family (structured interview question 3)**

(N = 43) Correlation	*p* [1]	
MAACL: Positive Affects	0.45	0.002
MAACL: Positive Affects + SS	0.41	0.006

[1] *Pearson r*

mother as a non-authoritative person and scores higher in emotional expression out (EEC).

Finally the patient whose parents separated from each other describes him or herself more frequently as a tender person, with a joyful father and an affectionate, tender and joyful mother, while scoring significantly lower in positive affects and sensation seeking (MAACL). Positive affects and sensation seeking (MAACL) scores also have a significant relationship with duration of living apart from the family of origin (Table 2).

DISCUSSION

In accordance with empirical assumptions that have been prodigally reported, sleep disturbances proved here once again to be clearly associated with depression, while the sleep repairing action, assessed through the inherent easier awakening, is associated with its absence. This occurs in the same way regarding the patients' perception towards, respectively, the worst or the better quality of the available family support. Difficulties in sleeping, as well as taking psychotropic pills without prescription, are also symptomatically associated with a weaker control of the emotional expression behaviour.

In regards to parental attitude, assumed from parent-child interactions, this turns out to clearly influence emotional life in its various forms of finding a way into a more or less adaptive action. First of all, the patient who is raised as the only child retains a memory of a rejecting father and a gloomy mother, somehow assuming himself to mimic an authoritative behaviour. In fact he is a person with a low arousal threshold, who finds it difficult to describe his feelings. This falls perfectly into the alexithymia model since he is somehow deprived of a cognitive regulatory feedback, and not surprisingly finds himself among patients with a higher degree of disease activity.

Considering yet another aspect, to be raised as the eldest or the youngest child has a clear repercussion on the way the patient expresses his emotions outwardly, for this tends to accentuate among the last in a row. This probably results from the benefit of more caring parents than did those who were born first, who display a significant decrease of that tendency.

Finally, separated parents are nevertheless described later by their children as joyful, tender, and

affectionate. But while this patient also describes himself as a tender person, he also reflects some lack of autonomy encouragement while scoring significantly lower on positive affects and sensation seeking. Surprisingly or not, the longer the period since the patient became apart from its family of origin, the higher he scores in these same aspects. The important supportive role of the family attachment during development thus seems to turn into a serious drawback to achieve fulfilment if it persistently prolonged during later life.

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Annexe. **Personality Checklist**

How would you describe [you/your father/your mother] as a person? Would you say [you/your father/ your mother] are/is (please check with an X if you think so):

Affectionate	____
Gentle, Tender	____
Joyful	____
Popular	____
Fighter	____
Shy	____
Reserved	____
Suspicious	____
Authoritative	____
Strict, Stiff	____

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