Mishandelende moeders hebben moeite met emotieherkenning

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'Richt interventies rondom kindermishandeling meer op het verbeteren van emotieherkenning en begrip om sensitief ouderschap te verhogen.' Dit adviseert Laura Compier-de Block naar aanleiding van haar onderzoek naar moeders die hun kind verwaarlozen. Zij promoveerde eerder deze maand aan de Universiteit Leiden.

Herkennen van emoties

Uit haar onderzoek blijkt dat moeders die hun kind verwaarlozen, problemen hebben met het herkennen van emoties en vooral van angst. Ook hebben zij moeite met het verwerken van deze emoties en het reguleren van de reacties op de signalen van hun kind. Een andere uitkomst van het onderzoek was dat de verwaarlozende moeders in een laboratoriumtest minder goed in staat waren om het gebruik van fysieke kracht onder controle te houden.

Compier-de Block onderzocht voor haar onderzoek 43 mishandelende en 40 niet-mishandelende moeders. Ouders die zelf fysiek en emotioneel mishandeld zijn, zijn eerder geneigd hun kinderen fysiek en emotioneel te mishandelen, terwijl fysiek en emotioneel verwaarloosde ouders hun kinderen eerder verwaarlozen.

Advies

Naast haar oproep om interventies meer te richten op het verbeteren van emotieherkenning, pleit Compier-de Block voor biofeedbacktraining. Hiermee kunnen ouders die hun kracht niet onder controle kunnen houden, zich bewuster worden van hun gedrag waardoor zij dat beter kunnen sturen.

Alexithymie (emotieblindheid): symptomen en behandeling

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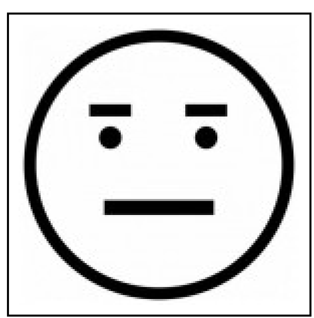


Alexithymie verwijst naar mensen die moeite hebben met het identificeren en beschrijven van emoties en die de neiging hebben om emotionele ervaringen te minimaliseren en de aandacht extern te richten. Alexithymie betekent letterlijk 'geen woorden hebben voor emoties'. Alexithymie is niet geclassificeerd als een psychische stoornis in de DSM-5, een classificatiesysteem waarin internationale afspraken zijn gemaakt over welke criteria van toepassing zijn op een bepaalde psychische stoornis op basis van (nieuwe) wetenschappelijke inzichten. Alexithymie wordt gezien als een persoonlijk probleem dat verschilt van persoon tot persoon. Het bestaan van alexithymie kan gemeten worden door middel van een schaal, zoals de Toronto Alexithymia Scale (TAS). De TAS is een instrument met 20 items dat een van de meest gebruikte maten van alexithymie is.

- Wat is alexithymie of emotieblindheid?
- Definitie en betekenis
- Waar komt de term vandaan?
- Een nog weinig onderzocht fenomeen
- Hoe vaak komt het voor?
- Symptomen
- Ontwikkeling en beloop
- Vroege kindertijd
- Doelgericht
- Lichaam reageert wel
- Interpersoonlijke problemen
- Lichamelijke sensaties verkeerd interpreteren
- Associatie met andere problematiek
- Link met autisme
- Andere psychische problemen
- Chronische pijn
- Oorzaken van alexithymie
- Onderzoek en diagnose
- Behandeling van alexithymie

Wat is alexithymie of emotieblindheid?

Definitie en betekenis

Alexithymie of emotieblindheid is een persoonlijkheidstrek die wordt gekenmerkt door moeilijkheden in het beschrijven en onderscheiden van gevoelens, een beperkt fantasieleven en een denken dat voornamelijk gericht is op de buitenwereld en minder op de innerlijke beleving.

Alexithymie houdt in dat je je emotionele toestand moeilijk kunt begrijpen / Bron: MissLunaRose12, Wikimedia Commons (CC BY-SA-4.0)

Waar komt de term vandaan?

De term alexithymie werd bedacht door Peter Sifneos, hoogleraar psychiatrie aan de Harvard Medical School, die het fenomeen in de jaren zeventig vaststelde bij epileptici

die na een lobotomie emotioneel afgestompt leken. Emotieonderzoekers noemen dit fenomeen emotioneel analfabetisme of emotionele blindheid, want als zulke mensen over gevoelens praten, klinkt het alsof blinde mensen beschrijven hoe mooi een sterrenhemel is. Emotioneel blinde mensen voelen meestal geen verdriet of vreugde en deze gelijkmoedigheid is voor de sociale omgeving erg moeilijk te verdragen.

Een nog weinig onderzocht fenomeen

Alexithymie is een fenomeen dat anno 2024 nog weinig is onderzocht in de psychologie. Er wordt vaak onderscheid gemaakt tussen verschillende graden van expressie, omdat er enerzijds alexithymische mensen zijn die er geen moeite mee hebben, anderzijds zijn er alexithymische mensen die zowel fysieke als psychologische pathologische symptomen vertonen. Het ene onderzoeksgebied houdt zich vooral bezig met representatieve studies naar de prevalentie van alexithymie in de populatie, terwijl andere meer gericht zijn op getroffenen die te maken hebben met problemen in verband met alexithymie, waarbij altijd eerst moet worden opgehelderd in hoeverre alexithymie lijden veroorzaakt bij deze mensen.

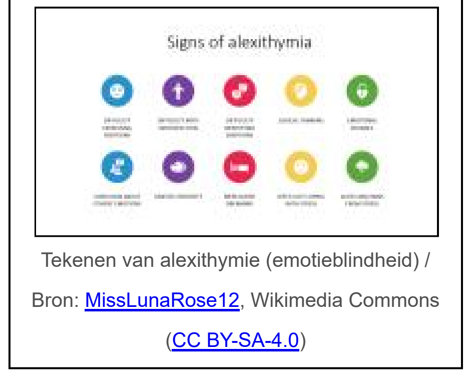
Hoe vaak komt het voor?

Alexithymie is geen ziekte of stoornis in de strikte zin van het woord, maar een persoonlijkheidskenmerk dat bij ongeveer tien procent van de bevolking wordt aangetroffen. De meeste (representatieve) populatieonderzoeken komen uit Scandinavië, waarin de TAS-20-vragenlijst wordt afgenomen als meetinstrument voor alexithymie. De resultaten laten zien dat meer mannen, maar ook meer mensen met een lage sociaaleconomische status, mensen met een lage opleiding en ouderen ermee behept zijn. In de klinische praktijk zijn er echter meer vrouwen dan mannen, vooral in verband met pijnstoornissen, terwijl er meer mannen worden aangetroffen bij sommige ziekten die vermoedelijk door alexithymie worden veroorzaakt, vooral verslavingen.

Symptomen

Symptomen en kenmerken van alexithymie zijn onder meer:

- moeilijkheden bij het identificeren van gevoelens en emoties
- problemen om onderscheid te maken tussen emoties en lichamelijke gewaarwordingen die verband houden met die emoties
- beperkt vermogen om gevoelens aan anderen over te brengen
- moeilijkheden bij het herkennen van en reageren op emoties bij anderen, waaronder de stemtoon en gezichtsuitdrukkingen
- een gebrek aan fantasie en verbeeldingskracht
- een logische en rigide denkstijl met een neiging tot zwart-wit denken die geen rekening houdt met emoties
- slechte copingvaardigheden als het gaat om het omgaan met stress
- zich minder altruïstisch gedragen dan anderen
- afstandelijk, star en humorloos overkomen
- ontevredenheid met het leven
- mnadruk op externe gebeurtenissen in plaats van interne emoties
- sterkere verbinding met lichamelijke sensaties dan emotionele toestanden
- relatieproblemen: uitdagingen bij het begrijpen van emotionele behoeften van anderen
- moeilijkheden in therapie: belemmering bij emotionele verkenning en groei tijdens therapie



Tekenen van alexithymie (emotieblindheid) / Bron: MissLunaRose12, Wikimedia Commons (CC BY-SA-4.0)

Ontwikkeling en beloop

Vroege kindertijd

Als persoonlijkheidskenmerk verschijnt alexithymie meestal vroeg in de kindertijd, blijft het in de loop van de tijd stabiel en is het van invloed op het sociale gedrag, zoals de studie-, beroeps- en partnerkeuze. Gevoelens leren waarnemen en uiten is een langdurig sociaal geïnduceerd leerproces in de menselijke ontwikkeling, waarin veel mis kan gaan. Een persoon die last heeft van emotieblindheid, heeft als kind waarschijnlijk niet alle noodzakelijke ontwikkelingsstappen doorlopen, waardoor de meeste ongewenste ontwikkelingen terug te voeren zijn op de sociale interacties tussen het kind en zijn omgeving.

Doelgericht

Mensen met alexithymie denken zeer doelgericht, bijvoorbeeld als de potentiële partner of schoonvader veel geld heeft, is dit een argument om een partnerschap aan te gaan. Als de vrouw eruitziet alsof ze geen problemen veroorzaakt, is dat ook een rationeel argument om een relatie aan te gaan. Zij nemen dus niet per se verkeerde beslissingen in het leven, maar ze maken ze anders.

Lichaam reageert wel

Mensen met alexithymie zijn niet volledig verdoofd. Integendeel, hun lichaam reageert op dezelfde manier in situaties die negatieve gevoelens bij anderen oproepen, maar ze zijn zich minder of niet bewust van de bijbehorende gevoelens. Zij hebben minder toegang tot hun gevoelens, maar in wezen hebben zij niet minder gevoelens dan anderen, doch hun gevoelens zijn eerder minder gedifferentieerd en zij kunnen ze niet zo goed van elkaar onderscheiden.

Interpersoonlijke problemen

Omdat ze niet alleen hun eigen gevoelens niet tot nauwelijks kunnen waarnemen en identificeren, maar ook die van andere mensen niet goed kunnen aflezen en voelen, kunnen zich in de interpersoonlijke sfeer ook problemen voordoen. Velen leren daarom snel om datgene te doen wat anderen in het dagelijks leven van hen verwachten. Als ze lachen, is dat vooral omdat ze weten dat de omstandigheden dat wel van hen zal vragen, maar het lachen komt niet van binnenuit. Mensen met alexithymie zijn in die zin meestal erg goede acteurs. Toch komen ze vaak wat stijfjes over en hun gezichtsuitdrukkingen en gebaren zijn veelal niet erg uitgesproken. Een naar buiten gerichte denkstijl is ook typerend voor alexithymie, dat wil zeggen dat zij meer gericht zijn op het feitelijke, terwijl de verbeelding en fantasie weinig betekenis heeft en vaak wordt gezien als een zinloos tijdverdrijf, zodat ze er een negatieve houding tegenover ontwikkelen en daarmee het fictieve maar ook het creatieve wordt afgewezen.

Lichamelijke sensaties verkeerd interpreteren

Omdat alexithymes hun lichamelijke reacties niet zo goed aan gevoelens kunnen toewijzen, maar ze wel kunnen voelen, interpreteren ze bijvoorbeeld hartkloppingen niet als een signaal van angst, maar als een symptoom van een hartaandoening. Mensen die lijden aan emotieblindheid maken veel meer fouten bij het vinden van de oorzaak van lichamelijke gewaarwordingen. Zo worden over het algemeen meer lichamelijke afwijkingen zoals pijn gerapporteerd, maar ook omdat negatieve gevoelens geïsoleerd worden ervaren en niet in verband kunnen worden gebracht met de onderliggende sociale stresssituatie. Zij hebben vaker last van lichamelijke klachten zonder organische oorzaak zoals het prikkelbare darmsyndroom of andere pijnklachten.

Associatie met andere problematiek

Link met autisme

Alexithymie heeft een sterke associatie met autismespectrumstoornis (ASS). Dit blijkt uit een onderzoek uit 2018 die aangeeft dat ongeveer de helft van de mensen met ASS waarschijnlijk alexithymie heeft. Het komt vooral voor bij mensen met complexe ASS.[1]

Ander onderzoek suggereert dat de sociale en emotionele moeilijkheden die mensen met ASS ervaren (empathische tekortkomingen, problemen met het herkennen van emoties), misschien niet zozeer een kenmerk zijn van autisme, maar eerder van gelijktijdig voorkomende alexithymie.[2]

Andere psychische problemen

Psychische problemen worden ook vaak geassocieerd met alexithymie. Mensen met alexithymie reguleren hun gevoelens eerder door alle emotionele impulsen te onderdrukken, wat sociale contacten bemoeilijkt en kan leiden tot negatieve (interpersoonlijke) ervaringen en dus tot nog meer onzekerheid. Het is bekend dat praten over gevoelens een belangrijke uitlaatklep is om op de lange termijn geestelijk gezond te blijven en mensen met alexithymie hebben deze optie niet of beheersen deze niet voldoende. In talloze onderzoeken hebben onderzoekers verbanden aangetoond tussen alexithymie en psychische problemen zoals eetstoornissen,

middelenmisbruik, depressie en angststoornissen.

Hoewel emotieblindheid officieel geen ziekte is, kan het je leven behoorlijk bemoeilijken en de kwaliteit van leven aantasten. Alexithymie is een risicofactor wanneer er stressvolle levensgebeurtenissen zijn waarbij een adequate omgang met gevoelens noodzakelijk is. De betrokkene heeft in dat geval meer kans op het ontwikkelen van een depressie of een angststoornis.

Chronische pijn

Aalexithymie komt ook vaak voor bij mensen met niet-gediagnosticeerde chronische pijn.

Oorzaken van alexithymie

De oorzaken van alexithymie zijn anno 2024 nog niet duidelijk onderzocht. Het is mogelijk dat traumatische ervaringen tijdens de (vroege) kinderjaren kunnen leiden tot emotieblindheid. Het onvermogen om gevoelens waar te nemen kan echter ook het gevolg zijn van emotionele verwaarlozing in de vroege kinderjaren, aangezien kinderen van hun ouders leren hoe ze gevoelens kunnen waarnemen en uiten.

Het is mogelijk dat het deels genetisch bepaald is.

Alexithymie kan echter ook het gevolg zijn van hersenschade aan de insula, een gedeelte van de hersenen onder de laterale sulcus. Dit deel van de hersenen staat bekend om zijn rol in sociale vaardigheden, empathie en emoties, en sommige onderzoeken associëren schade aan de insula-laesies met apathie en angst.

Onderzoek en diagnose

Mensen met alexithymie belanden weinig in de spreekkamer bij de psychiater. Ze klagen namelijk niet over hun gevoelens of emoties. Vaker belanden ze op het spreekuur van de huisarts met onbegrepen lichamelijke klachten.

Alexithymia wordt gediagnosticeerd door een professional in de geestelijke gezondheidszorg (ggz). Het wordt niet officieel erkend door de vijfde editie van de Diagnostic and Statistical Manual of Mental Disorders (DSM-5). De hulpverlener zal vragen stellen en een diagnose stellen op basis van je antwoorden. Het bestaan van alexithymie kan gemeten worden door middel van de Toronto Alexithymia Scale (TAS). Dit is een instrument met 20 items dat een van de meest gebruikte maten van alexithymie is.

Een andere mogelijke test is een MRI die wordt uitgevoerd door een neuroloog. Dit levert beelden op van de insula in de hersenen. Het kan vaak even duren voordat de juiste diagnose is gesteld.

Behandeling van alexithymie

Aangezien alexithymie anno 2024 nog steeds weinig onderzocht is, zijn er niet veel bewezen behandelingsopties beschikbaar. Een op (sociale) vaardigheden gebaseerde interventie lijkt echter een effectieve methode om alexithymie te behandelen. Een mentaliseren bevorderende therapie (MBT) lijkt ook zijn vruchten af te werpen. Mentaliseren betekent dat je het gedrag van jezelf en anderen kan begrijpen en verklaren vanuit achterliggende gevoelens, gedachten en motivatie. Een op mentaliseren gebaseerde behandeling helpt patiënten hun eigen gedachten en gevoelens te scheiden van die om hen heen. Deze behandeling is relationeel en richt zich op het verkrijgen van een beter begrip en gebruik van mentaliserende vaardigheden.

Noten:

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Bronnen en referenties

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Relation of Child Maltreatment and Alexithymia

A summary of the pooled correlations between child maltreatment types and alexithymia is provided in **Table 1**. The meta-analysis revealed that greater exposure to child maltreatment is associated with greater levels of adult alexithymia: child emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect were all associated with adult alexithymia (see **Table 1**). Notably, emotional abuse, emotional neglect, and physical neglect were the strongest predictors. In terms of the specific dimensions of alexithymia, we found that higher exposure to all child maltreatment types was associated with increased adult difficulty identifying feelings and difficulty describing feelings (see **Table 1**). Finally, higher exposure to child maltreatment in general and child emotional neglect, and physical neglect specifically, were associated with higher levels of adult externally oriented thinking (see **Table 1**).

Child Maltreatment and Alexithymia

In our study, overall child maltreatment was found to correlate with adult alexithymia. As caregivers play a crucial role in the cognitive–emotional development of a child, their ability to identify their own and others' emotional states translates to the child's capacity to do the same (Mason et al., 2005). This translated capacity can be seen through the lens of gene–environment processes in which biological caregivers provide both their children's genotypes and environment, enhancing the correlation between the two (Dick, 2011; Jaffee & Price, 2007). Given that caregivers are often the primary example for children in developing their emotional responses (Ogren & Johnson, 2021), maltreatment by caregivers—the most common perpetrators (Finkelhor et al., 2014; United Nations Children's Fund, 2003; Yampolskaya et al., 2009)—decreases the number of positive examples and opportunities for the modeling and reinforcement of appropriate coping strategies and emotional expressiveness (Brown et al., 2016; Gaher et al., 2015). This can cause children who experience maltreatment to grow up with difficulties processing their emotional reactions to negative emotional stimuli (Dvir et al., 2014), which in turn increases the likelihood of developing alexithymia in adulthood (P. D. Parker et al., 2005; Pollatos et al., 2008; Starita et al., 2016).

Our findings revealed that childhood emotional abuse as well as emotional and physical neglect were the strongest predictors of adult alexithymia. This is in line with meta-analytic findings by Khan and Jaffee (2022) who found alexithymia to be more strongly associated with neglect than physical or sexual abuse. These findings might be explained by the implicit nature of these types of maltreatment as compared to physical or sexual abuse. As emotional maltreatment and physical neglect are harder for others to recognize, they are less frequently reported (Chamberland et al., 2011; Garland et al., 1996). This may contribute to a longer maltreatment duration. In contrast to physical and sexual abuse, even victims themselves struggle to recognize their experiences of emotional abuse and neglect as maltreatment (Goldsmith & Freyd, 2005); therefore, they may seek help less frequently and may not employ the same conscious psychological processes to heal from the emotional damage.

Further, emotional neglect and physical neglect commonly occur together (Glaser, 2002), and both involve not meeting a child's needs. These unmet needs and a child's likely lack of vocabulary and ability to identify and describe their needs create emotional discord. Without guidance in managing the resulting feelings, this may translate into the development of adult alexithymia, exhibiting those exact inabilities.

One useful lens for considering the link between child emotional maltreatment and physical neglect, on the one hand, and adult alexithymia, on the other, is Bowlby's attachment theory. According to this theory, emotional maltreatment can obstruct the development of a secure attachment when caregivers fail to meet the child's emotional needs (Bowlby, 1958), and this lack of secure attachment formation can last into adulthood (Aust et al., 2013). In fact, maltreatment during childhood can predict attachment disorganization in infants (Ludmer et al., 2018) and unresolved attachment in adulthood (Bailey et al., 2007). On the other hand, secure attachment consists of three components, one of which is "self-awareness or the capacity to be aware of one's own opinions, wishes, and needs, and the capacity to express these in social interactions" which overlaps with the dimensions of alexithymia (Bekker et al., 2007, p. 509). Evidently, the fulfillment of emotional needs in childhood is crucial to healthy emotional development. Maltreatment or a deficiency in emotional support may lead to an understanding that emotional expression is unacceptable and will be punished (Goldsmith & Freyd, 2005; Paivio & McCulloch, 2004). In an attempt to adjust to emotional maltreatment, children may learn

to distance themselves from their emotional needs. Estranging themselves from their emotions may ultimately lead to poor emotional awareness in adulthood, and this may manifest as alexithymia (Brown et al., 2016).

This distancing from emotional needs ties to another potential explanation for the strength of alexithymia's association with emotional and physical neglect—the role of dissociation. Dissociation is a process in which the individual becomes detached from behaviors, thoughts, memories, and feelings (Kluft, 1990b; O'Neil, 2009; Spiegel & Cardeña, 1991; Vaillant, 1994). Research has shown that childhood dissociation is most strongly related to the unavailability of caregivers, closely aligned with emotional and physical neglect (Schimmenti, 2017). Maltreated children are likely to dissociate as a defense mechanism when maltreatment is too overwhelming to fully experience the depth of their emotional distress (Boysan et al., 2009; Dalenberg et al., 2012; Hariri et al., 2015; Schore, 2009). This defense mechanism may be the most available coping strategy for neglected children as self-regulation abilities are limited during childhood, particularly in the absence of healthy role models. Neglectful and abusive parenting has indeed been shown to lead children to a constant and excessive use of dissociation to escape from unbearable mental states arising from maltreatment (Bromberg, 1998; Chefetz, 2015; Kluft, 1990a, 2000; Schimmenti & Caretti, 2016; van der Kolk, 2014). In practice, frequent dissociation can reinforce alexithymic tendencies (Craparo, 2011; Craparo et al., 2014; Schimmenti, 2017). There also exists a positive correlation between alexithymia and dissociation, particularly in the dimensions of difficulty identifying and describing feelings (Mason et al., 2005) with both clinical and nonclinical populations (Grabe et al., 2000). Interestingly, research has found that experience of child maltreatment is related to both alexithymia and dissociation in that maltreated children have been observed to experience both (Berenbaum & James, 1994; McFarlane et al., 1990; Terr, 1991). This coincides with our findings of stronger associations between overall child maltreatment and difficulty identifying and describing feelings.

The present study revealed that the greater an individual's exposure to physical or sexual abuse, the greater their symptoms of alexithymia in adulthood. According to Güleç et al. (2013), these results may be explained by the strong association of physical and sexual abuse with various forms of psychopathology. Studies that exclude participants based on these psychopathologies may therefore not account for participants with significant levels of physical abuse and sexual abuse, causing a potential underestimation of the link between alexithymia and physical as well as sexual abuse. Additionally, it is important to mention that the co-occurrence of multiple types of child maltreatment is alarmingly high (Daro, 2015; Herrenkohl & Herrenkohl, 2009; Kim et al., 2017). A review by Herrenkohl and Herrenkohl (2009) on this co-occurrence found rates of co-occurrence from 33% to 94% across samples. The extent to which overlap between subtypes occurs is difficult to ascertain, as findings differ based on data source and analysis method (Debowska et al., 2017; Edwards et al., 2003). Adding to the complexity, research shows that coexisting forms of maltreatment may have additive effects on adjustment outcomes (Kim et al., 2009). Thus, co-occurrence is associated with the most adverse outcomes, especially when the overlap included sexual abuse (Edwards et al., 2003).
The magnitude of associations found in the present study is worth considering. Our study found a significant positive relationship between levels of child maltreatment and alexithymia as well as the different child maltreatment subtypes, exhibiting similar magnitudes to the relations found by Khan and Jaffee (2022). The average correlation found (r = .23) was close to both Cohen's (1988) value for a "medium" effect size (r = .30) and Lipsey and Wilson's (1993) empirical value for the 75th percentile in the social sciences (r = .30). According to the Promising Practices Network (2014), a correlation of r = .12 is a benchmark value for effects considered significant, important, notable, or consequential (Promising Practices Network, 2014), and the correlation we found surpasses this benchmark. The average correlation we found is similar to that of child maltreatment and emotion dysregulation (r = .28) found in a recent meta-analysis (Gruhn & Compas, 2020). A recent study on alexithymia and emotional well-being found a negative correlation between the two to a similar degree (r = −.32; Myles & Merlo, 2021), indicating a corresponding trend among child maltreatment, alexithymia, and emotional regulation. Another recent study on child maltreatment and adult mental disorders found a positive correlation between child maltreatment and depression (r = .49) and child maltreatment and anxiety (r = .44; Struck et al., 2020). This is comparable to a meta-analysis on alexithymia and depression which found a similar magnitude of association (r = .46; S. Li et al., 2015). While our effect size is smaller than the associations found with child maltreatment or alexithymia and psychopathology, our results still demonstrate a significant link between the two constructs, especially in comparison to the findings regarding emotion processing. Although all of these findings are consistent with the narrative of adverse outcomes and correlates of both child maltreatment and alexithymia, the prediction intervals indicate that negative associations between child maltreatment and alexithymia cannot be ruled out for future studies.

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Child Maltreatment and Alexithymia: A Meta-Analytic Review

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Alexithymia refers to difficulties identifying and describing one's emotions. Growing evidence suggests that alexithymia is a key transdiagnostic risk factor. Despite its clinical importance, the etiology of alexithymia is largely unknown. The present study employs meta-analytic methods to summarize findings on the role of one hypothesized antecedent of adult alexithymia, namely child maltreatment. We obtained effect size estimates from 99 independent samples reported in 78 unique sources that reported both child maltreatment history and adult levels of alexithymia. These studies involved a total of 36,141 participants. Using correlation coefficients as our effect size index, we found that child maltreatment was positively related to overall adult alexithymia (r = .23 [.19, .27]). Notably, emotional abuse (r = .18 [.13, .23]), emotional neglect (r = .21 [.16, .26]), and physical neglect (r = .18 [.15, .22]) were the strongest predictors. Effects were moderated by gender, affiliation with clinical versus nonclinical samples, and publication status. Overall results were robust to publication bias and the presence of outliers. These findings contribute to a more nuanced understanding of the complex connection between different types of child maltreatment and alexithymia, providing greater insight into the early environmental influences on alexithymia.

Public Significance Statement
This meta-analysis reveals that adult alexithymia, which is defined by difficulties identifying and describing one's emotions, is linked to child maltreatment. These effects are strongest when individuals experience emotional abuse, emotional neglect, or physical neglect as children.

Keywords: alexithymia, child maltreatment, emotional abuse, emotional neglect, meta-analysis

Supplemental materials: https://doi.org/10.1037/bul0000391.supp

> I don't know what I feel, it's like my head and body aren't connected. I'm living in a tunnel, a fog, no matter what happens it's the same reaction-numbness, nothing. Having a bubble bath and being burned or raped is the same feeling. My brain doesn't feel.
>
> —W. H., posttraumatic stress disorder patient suffering from alexithymia (Frewen, Lanius, et al., 2008, p. 177)

Emotions help us act, make decisions, and understand others (Shariff & Tracy, 2011). Emotions also help other people understand us (Shariff & Tracy, 2011). Some people, however, have great difficulty knowing what emotion they are experiencing. They are not able to tell if they are sad, angry, or happy. Their world is one-, maybe two-dimensional, one that is deprived of the fullness of feelings (Taylor et al., 1997). That is the world in which a person with alexithymia lives.

First described by Sifneos in 1973, alexithymia literally means "no words for feelings." It is defined by (a) difficulty identifying and describing feelings; (b) difficulty differentiating between emotional states and physiological sensations; and (c) a concrete, externally oriented cognitive style (Bermond et al., 2007; Preece et al., 2017; 2020; Watters et al., 2016). Alexithymics' difficulty

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The data set and code used during the present study are available on the Open Science Framework repository at https://osf.io/mr8u9/?view_only=6ee7458747014980ba1a82f1a956869a.

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in distinguishing affective from somatic states manifests itself in their frequent use of physical sensations to describe emotions (Bagby et al., 1994; Taylor et al., 2003). They focus on the physiological component of emotional arousal, experiencing emotions as amplified cognitive feeling states (Aleman, 2005; Taylor & Bagby, 2000). Individuals with high levels of alexithymia tend to feel physically uncomfortable when they are emotional but are not able to describe the nature or source of this sensation (van der Kolk, 2014). They cannot describe what they feel because they cannot identify what their physical sensations mean or what might make them feel better or worse.

Alexithymia as a Personality Trait

While alexithymia was initially conceptualized as a psychosomatic disorder, it is now widely recognized as a personality trait (Martínez-Sánchez et al., 1998; Picardi et al., 2005; Salminen et al., 2006; Taylor & Bagby, 2012) with a high degree of relative stability (Martínez-Sánchez et al., 1998; Mikolajczak & Luminet, 2006; Saarijärvi et al., 2006; Salminen et al., 2006). Taxometric evidence strongly supports the theoretical view of alexithymia as a continuous personality dimension (Keefer et al., 2019; Primmer, 2013; Taylor & Bagby, 2012; Watters et al., 2016) that is normally distributed in the general population (J. D. A. Parker et al., 2008). Clinically speaking, the prevalence of clinically significant levels of alexithymia in the general population is estimated at approximately 13% (Franz et al., 2008; Honkalampi et al., 2000; Joukamaa et al., 2007; Mason et al., 2005; Salminen et al., 1999).

As male gender and advanced age correspond with increased alexithymia (Franz et al., 2008; Levant et al., 2009; Mattila et al., 2006), the rates of clinically relevant alexithymia among men are almost twice (17%) as high as among women (10%; Salminen et al., 1999). The dominant theoretical perspective posits that societal forces differentially shape boys and consequently men to restrict emotionality, leading to increased alexithymia (Levant et al., 2009). Additionally, alexithymia levels have been shown to differ between regions and cultures (Dere et al., 2012; Le et al., 2002; Levant et al., 2003), reflecting cultural differences in experience and expression of emotions (Le et al., 2002).

Alexithymia further corresponds to impairments of emotional processing (Suslow & Junghanns, 2002) and difficulties in identifying facial expressions (Grynberg et al., 2012; Jongen et al., 2014; Lane et al., 1996, 2000; Parker et al., 1993). Researchers have also confirmed alexithymia as an important risk factor for a range of psychopathologies (Zackheim, 2007) including affective disorders (Honkalampi et al., 2020; Kajanoja et al., 2020; Kefeli et al., 2018), nonsuicidal self-injury (Lüdtke et al., 2016; Sleuwaegen et al., 2017), personality disorders (Sleuwaegen et al., 2017), and eating disorders (Mazzeo & Espelage, 2002). Moreover, the consequences of alexithymics' emotional deficits extend beyond intrapersonal difficulties. Alexithymia interferes with individuals' interpersonal relationships as they exhibit shortcomings in understanding and relating not only to their own emotions but also to the emotions of others (Humphreys et al., 2009; Moriguchi et al., 2007). These limited socioaffective skills result in difficulties interacting with their social environments. In fact, Vanheule et al. (2007) found patterns of cold and distant social functioning and detachment from others among high alexithymia scorers. Their decreased capacity for empathy (Bird et al., 2010; Bird & Viding, 2014; Guttman & Laporte, 2002; Moriguchi et al., 2007; Valdespino et al., 2017) results in them experiencing less distress at seeing others in pain and thus behaving less altruistically (Feldmanhall et al., 2013). Additionally, individuals with high alexithymia tend to avoid close social relationships, and if they do relate to others, the relationship tends to remain superficial. Chaotic interpersonal relations have also been observed (Sifneos, 1996), as well as a lack of differentiation between self and other (Blaustein & Tuber, 1998; Saito et al., 2016; Taylor et al., 1997). In line with these observations, alexithymia is linked to avoidant-dismissing attachment (De Rick et al., 2009; Taylor, 2000; Verhaeghe, 2020).

Given its clinical relevance, there is considerable interest in the etiology of alexithymia. While biological models associate increased alexithymia with altered functioning of specific brain structures (Aleman, 2005; Tabibnia & Zaidel, 2005; van der Velde et al., 2013) or genetics (Kano et al., 2018), these approaches provide little information about the trait's origin. One area of research that could elucidate the etiology of alexithymia is the field of developmental traumatology. Indeed, some authors have suggested that alexithymia may develop in response to extreme trauma to protect individuals from experiencing painful affect (Krystal, 1982; Shipko et al., 1983; van der Kolk, 2014). Consistent with this perspective, victims of traumatic events, such as concentration camp survivors (Yehuda et al., 1997), combat veterans (Frewen, Dozois, et al., 2008; Shipko et al., 1983), victims of sexual assault (Zeitlin et al., 1993), and individuals with a history of child abuse (Chung & Chen, 2020), experience an increased disconnect from their emotions. This suggests that alexithymia might develop as a reaction to an acute and severe traumatic event or in the presence of early life stress, including child maltreatment (Aust et al., 2013; Bermond et al., 2008; Wingenfeld et al., 2011; Zlotnick et al., 2001). Thus far, however, findings have been inconsistent as to which forms of child maltreatment contribute to the subsequent development of alexithymia and how strong these contributions are. This underscores the need for a systematic investigation of child maltreatment as a precursor to alexithymia.

Child Maltreatment and Alexithymia

Child maltreatment has been acknowledged as a global public health and social welfare risk (Carr et al., 2020; Finkelhor et al., 2015; Gilbert et al., 2009; Norman et al., 2012; Peterson et al., 2018; Wegman & Stetler, 2009). It includes active (i.e., abuse) and passive (i.e., neglect) forms, as well as physical, emotional, and sexual dimensions. Due to the lack of social, cultural, and legal consensus over what child-rearing practices are harmful or unacceptable (Barnett et al., 1993; Herrenkohl, 2005; Manly, 2005), there has been considerable debate about how to define child maltreatment. While various classifications exist, a distinction between emotional, physical, and sexual abuse as well as emotional and physical neglect is widely accepted (Herrenkohl, 2005; Manly, 2005). For the purpose of the present meta-analysis, we thus adopted this classification.

In the United States alone, an estimated 656,000 children suffered from maltreatment over the course of 2019 (U.S. Department of Health & Human Services, Administration for Children & Families, Administration on Children, Youth & Families, Children's Bureau,

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2021). Internationally, one in four children experiences child maltreatment (Ajilian Abbasi et al., 2015; Stoltenborgh et al., 2015). Accounting only for reported cases, these figures underrepresent the true extent of child maltreatment (Sedlak et al., 2010; U.S. Department of Health & Human Services, Administration for Children & Families, Administration on Children, Youth & Families, Children's Bureau, 2021). Given its high prevalence worldwide, child maltreatment constitutes a severe public health burden. It is among the most influential risks for adverse mental health outcomes: Children who experience maltreatment are 3 times more likely to experience psychopathology than their peers without child maltreatment history (Green et al., 2010; Li et al., 2016). Ultimately, child maltreatment experiences have been found to significantly account for the development of approximately half of psychological disorders (Green et al., 2010; Li et al., 2016; Zeanah & Humphreys, 2018). Further, psychopathology is quickly becoming the leading burden of disease (World Health Organization, 2012), making it a significant economic burden worldwide (Tiainen & Rehnberg, 2010). With its potential to substantially derail survivors' developmental trajectories across various domains throughout life (Cicchetti & Toth, 2016), understanding the processes in which child maltreatment impacts survivors is thus of vital importance.

Accumulating research on the short- and long-term consequences of child maltreatment underscores its contribution to disturbances in one such domain: cognitive–affective functioning, including alexithymia (Aust et al., 2013; Berenbaum, 1996; Berenbaum et al., 2003; Wingenfeld et al., 2011; Zlotnick et al., 2001). According to developmental models, emotional awareness and expression undergo development within the context of attachment relationships, and traumatic childhood experiences and neglect may disturb this natural development, resulting in increased adult alexithymia (Frewen, Dozois, et al., 2008). Further, children growing up in abusive or neglectful homes may develop a sense of powerlessness that elicits negative emotions (Gómez, 2011; Katz, 2013; Kernsmith, 2006; Saradjian & Hanks, 1996). These emotions are frequently ignored or invalidated (Paivio & McCulloch, 2004). Additionally, maltreated children often lack positive models for developing effective coping strategies and emotional self-awareness (De Young et al., 2011; Moriguchi et al., 2006). Experiencing higher levels of negative emotion in conjunction with receiving less modeling of healthy patterns of emotion experience and expression could lead to deficits in emotional awareness and expression. Supporting this theory, maltreated children produce less recognizable emotional expressions and show lower accuracy in their recognition of emotional expressions as compared to their nonmaltreated counterparts (Camras et al., 1988). Similarly, adults with maltreatment histories have been found to experience greater difficulty identifying their emotions than those without such histories (Berenbaum, 1996).

The Present Study

Significant relations between a history of child maltreatment and adult alexithymia have been demonstrated within various populations (e.g., Hahn et al., 2016; Hund & Espelage, 2006; Paivio & McCulloch, 2004; Zlotnick et al., 2001). However, it is not clear which forms of child abuse and neglect contribute to the development of adult alexithymia, and no consensus exists as to how strong these contributions are (Gaher et al., 2015). While only about 120 articles were published on alexithymia by the mid-1980s (Taylor & Bagby, 2004), a recent search of the APA PsycInfo database revealed almost 5,000 journal articles on alexithymia. Nearly 200 of these articles included child maltreatment.

A synthesis of the evidence is necessary to inform etiological models of alexithymia which will supply a basis for approaches of prevention and intervention. Such a meta-analytic exploration has the advantage of drawing conclusions based on the multitude of findings to date while also identifying areas that have not received much scholarly attention. To our knowledge, only one recent meta-analysis has integrated the literature on associations between alexithymia and all forms of child maltreatment (Khan & Jaffee, 2022). The recent study by Khan and Jaffee (2022) constitutes a noteworthy addition to the existing body of literature in the field. However, its methodology is beset by several shortcomings that necessitate a more robust meta-analytic examination of the phenomenon in question. One major limitation is the lack of consideration given to the frequent overlap between subtypes of child maltreatment. The authors conducted separate analyses for each type of maltreatment, rendering it inappropriate to compare the average associations of the different forms of maltreatment with alexithymia. To overcome this limitation, a more appropriate analytical approach that takes into account the multiple effect sizes derived from multiple forms of maltreatment is imperative.

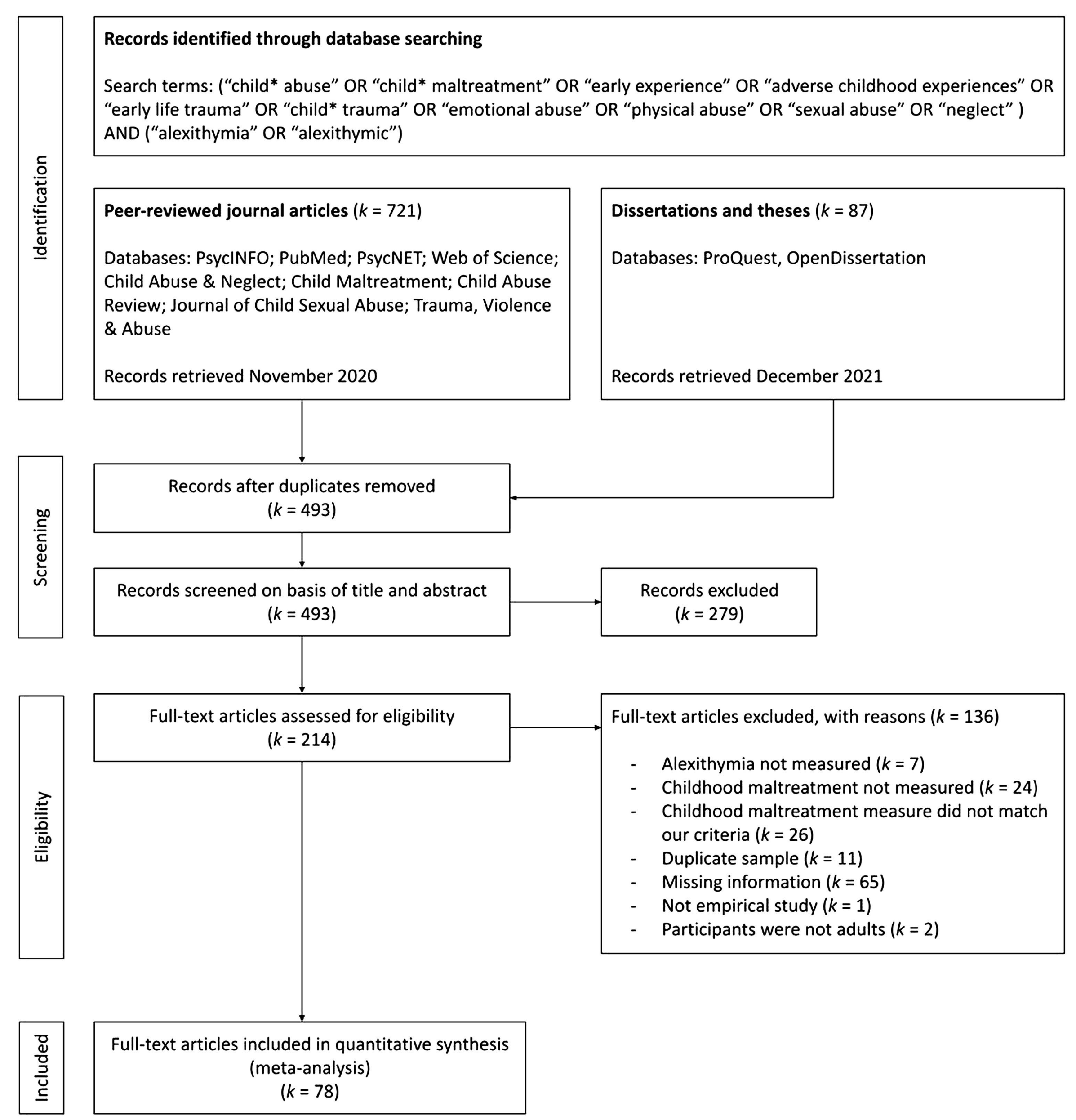
The present meta-analytic review aims to synthesize the empirical evidence on the relation between child maltreatment and alexithymia, with a specific focus on individual subtypes of child maltreatment (i.e., emotional abuse, physical abuse, sexual abuse, physical neglect, and emotional neglect). Through a rigorous and systematic examination of the existing literature, this study contributes to a comprehensive understanding of the relationship between child maltreatment and alexithymia, while taking into account the frequent co-occurrence of child maltreatment subtypes, and to establish the robustness of these associations. The findings of this meta-analytic review will thus advance knowledge in the field and inform future research directions.

Method

Selection of Studies

We conducted the present meta-analysis strictly adhering to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols (PRISMA) statement. In November 2020, a systematic search of relevant studies was undertaken in APA PsycInfo, Pubmed, APA PsycNet, and Web of Science as well as in the scientific journals *Child Abuse and Neglect*; *Child Maltreatment*; *Child Abuse Review*; *Journal of Child Sexual Abuse*; and *Trauma, Violence, and Abuse*. We applied the following search terms: "child* abuse," "child* maltreatment," "early experience," "adverse childhood experiences," "early life trauma," "child* trauma," "emotional abuse," "physical abuse," "sexual abuse," "neglect," "alexithymia," and "alexithymic" (see Figure 1). We identified studies satisfying the following criteria: (a) Studies were published in peer-reviewed journals, (b) studies were published in English, (c) studies recruited adult participants, and (d) studies

Figure 1
PRISMA Flowchart of Literature Search and Inclusion/Exclusion Decisions



Note. PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols.

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reported the correlations of child abuse and alexithymia (or provided data to calculate them). In December 2021, an additional systematic search of relevant articles was undertaken in ProQuest and Open-Dissertations to include studies that were not published in peer-reviewed journals and thus minimize the potential for publication bias. Our final selection criteria included (a) English studies, (b) studies with adult participants, and (c) studies that reported or provided data to calculate correlations of child abuse and alexithymia.

Studies were included in the meta-analysis if they examined the relation between child maltreatment and adult alexithymia and if the effect size (Pearson's r) of that relation was provided directly or could be computed from other statistics. When studies lacked sufficient information to be included (k = 136), authors were contacted to obtain the relevant information. The authors of studies which included only some correlations between types of child maltreatment and the dimensions of alexithymia were also contacted to retain more complete data. If they did not respond to our first request, two more reminders were sent and a deadline was given. Thirty-six authors (26.47%) responded by providing their results or raw data, while 28 publications as well as all 14 unpublished studies had sufficient information provided in the articles themselves.

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Together, the publications and unpublished studies produced a final sample of 78 studies (see Figure 1).

The studies of authors who did not provide relevant data and which lacked information to extract or compute the relation between child maltreatment and adult alexithymia (Pearson's r) were coded as missing information and were excluded. Studies were also excluded if their child maltreatment measure did not match our criteria. Since our primary outcome of concern was the relation between child maltreatment and adult alexithymia, child maltreatment measures that did not allow for calculating this correlation were excluded. For example, binary measures of child maltreatment were excluded as those did not lend data comparable with continuous data.

Data Extraction

Three independent researchers screened the studies and extracted the data using a standardized form. Relevant data included overall levels of child maltreatment and alexithymia as well as the levels of their respective subtypes and dimensions. Types of child maltreatment included physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect. This classification was chosen based on consensus among previous literature (Herrenkohl, 2005; Manly, 2005). Dimensions of alexithymia involved (a) difficulty identifying feelings, (b) difficulty describing feelings, and (c) externally oriented thinking. These specific dimensions reflected the most commonly used measures of alexithymia which had subscales of each dimension (Bagby et al., 1986; Taylor et al., 1988). Types of child maltreatment and dimensions of alexithymia were coded accordingly during extraction.

Each article was screened by at least two researchers. Discrepancies were resolved through discussion, and if necessary, referred to a fourth researcher. Study authors were contacted to provide information that was unclear or in the publications or unpublished studies. If studies reported on the same or overlapping samples, the study providing the maximum information, namely, correlation coefficients for the individual types of child maltreatment and alexithymia's dimensions, was included to ascertain the independence of samples and the inclusion of every participant only once. When a study separately reported child maltreatment and alexithymia relations for more than one sample, these subsamples were treated as independent studies.

Study Characteristics

Participant Characteristics

Gender. We coded the gender distribution of samples used in included studies. As such, we calculated the percentage of female participants when possible. If studies did not report sufficient information, we contacted the authors and requested it.

Age. We coded the mean age of participants.

Population. We coded whether studies recruited clinical (i.e., psychiatric), nonclinical, or mixed samples.

Geographic Location. We coded the continents in which the included studies were conducted.

Source Characteristics

Year. We coded the year the study was published.

Publication Status. Publication status (peer-reviewed publications or unpublished studies) was coded to assess the possibility of publication bias. More formal tests were also employed (see Analytical Approach section below). Our results were not significantly affected by including unpublished studies in our analyses.

Analytical Approach

Relation of Child Maltreatment and Alexithymia

We conceptualized both child maltreatment and alexithymia as continuous variables. The present meta-analytic review thus used correlation coefficients as its effect size index. We conducted the analyses using random-effects models with robust variance estimation and subgroup correlated effects working model (Pustejovsky & Tipton, 2022) using the metafor (W. Viechtbauer, 2010) and clubSandwich (Pustejovsky, 2022) packages in R (R Core Team, 2020).

Each correlation coefficient was Fisher's z-transformed (Gleser & Olkin, 2009) and weighted by the inverse of its variance before pooling. This was necessary as the correlation coefficient is not normally distributed unless the population correlation coefficient is equal to zero. The weighting resulted in larger studies receiving more weight in the pooling process. Further, we investigated outliers by calculating studentized residuals and by running the leave-one-out sensitivity analyses, which identified effect sizes that disproportionately contributed to the overall heterogeneity and the results (Viechtbauer & Cheung, 2010).

In many cases, articles reported more than one relevant effect size for our analyses. In these instances, correlation coefficients for multiple types of child maltreatment were reported (see Supplemental Tables S1 and S2). As articles reported effect sizes for multiple subtypes of child maltreatment, the conventional meta-analytic assumption of effect size point estimates being independent (Hedges et al., 2010) was violated. We thus calculated robust variance estimates and confidence intervals (CIs; Hedges et al., 2010; Tipton, 2013, 2015) and used the subgroup correlated effects working model that allowed for dependencies across subgroups (child maltreatment types and alexithymia dimensions), while preserving the conceptual clarity of subgroup analysis. The subgroup correlated effects working model combines the principles of separate metaregression analyses into a working model for the full data. Thus, accounting for the dependence of the effect sizes, we ran a single meta-analytic model for both the global association between overall child maltreatment and alexithymia and the different associations between child maltreatment subtypes and specific alexithymia dimensions.

Next, we calculated the prediction intervals for the mean correlations to address the heterogeneity of the pooled effect sizes of the associations between child maltreatment and alexithymia (Borenstein et al., 2017; Riley et al., 2011). The prediction intervals present where the true effect size in 95% of all comparable populations would fall. We intended to present the pooled effect sizes of the associations between child maltreatment and alexithymia, as well as the prediction intervals, as correlation coefficients. Thus, we retransformed the Fisher's z into correlation coefficients.

Publication Bias

We examined possible publication bias for all associations separately. We used the recommended adapted Egger's regression test to

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handle the dependence of the effect sizes (multi-level meta-analysis; Rodgers & Pustejovsky, 2020). Additionally, we inspected the funnel plots.

Moderator Analysis

Finally, to examine potential moderators that may influence the association between child maltreatment and alexithymia, we ran 144 separate moderator analyses (i.e., 24 types of associations between child maltreatment and alexithymia and six moderators) on the global association between overall child maltreatment and alexithymia and the different associations between child maltreatment subtypes and specific alexithymia dimensions. We used the omnibus F test to test whether the factors (e.g., published vs. unpublished studies) provide evidence of moderating effect. The omnibus F test is used to test the null hypothesis that states the predictor as unrelated to the effect sizes. To account for Type I error for multiple comparisons (e.g., testing six different moderators on the same dataset) that is frequent in meta-analyses (Cafri et al., 2010), we adjusted probability values using Bonferroni correction (Abdi, 2007). Next, we determined whether a specific moderator influenced the child maltreatment and alexithymia associations by interpreting the significance of the regression coefficients. A significant omnibus F test for the continuous variable indicates a significant association between the continuous variable (e.g., percentage of females) and the mean effect of child maltreatment on adult alexithymia. A significant omnibus F test for categorical variables (e.g., type of sample) indicates the significant difference from the comparison category. Next, we considered the association between child maltreatment and alexithymia as significantly different in one subgroup from other subgroups if CIs of the difference between effect sizes in a given moderator subgroup did not include zero. We interpreted the mean effect of the moderator category when there were at least three studies per category.

Transparency and Openness

We followed the PRISMA-P checklist when preparing the protocol, and we followed PRISMA reporting guidelines for the final report (Moher et al., 2015). All meta-analytic data, analysis code, and research materials (including our coding scheme) are available at https://osf.io/mr8u9/?view_only=c51dbaddba6b4db49f69acd9080484dd. This project was not preregistered.

Results

Study Characteristics

Our database search identified a total of 808 records. After excluding duplicates and applying exclusion criteria, $k = 78$ studies with a total of $N = 36{,}141$ participants were identified (see Figure 1). Sixty-four included studies were published in peer-reviewed journals, and 14 were unpublished. All publications and unpublished studies were published between 1996 and 2021. The average age of participants ranged from 18.0 to 50.5 years.

Our primary outcome was the association between the forms of child maltreatment (i.e., physical, emotional, sexual abuse, and physical and emotional neglect) and alexithymia. All included studies reported child maltreatment and alexithymia as continuous outcomes and were included based on operational definitions of the terms. To assess child maltreatment, 56 studies (72%) used the Childhood Trauma Questionnaire or its short form (Bernstein et al., 1994, 2003), eight studies (10%) used the Child Abuse and Trauma Scale (Sanders & Becker-Lausen, 1995), and the remainder used other child maltreatment measures, summarized in Supplemental Table S1. As shown in Supplemental Table S1, 76 studies (97%) assessed alexithymia using the Toronto Alexithymia Scale (TAS-20; Bagby et al., 1994) and two studies (3%) used the Bermond–Vorst Alexithymia Questionnaire (Vorst & Bermond, 2001).

The majority of studies were conducted in North America ($k = 39$; 50%) and Europe ($k = 26$; 33%). Ten studies (13%) were conducted in Asia, two in Australia (3%), and only one in Africa (1%). Thus, we only included studies from North America, Europe, and Asia in the moderator analysis. Of the samples, 64% were nonclinical (i.e., nonpsychiatric), while 29% were psychiatric clinical samples, and 7% of samples were mixed.

We identified 21 effect sizes as problematic, with all studentized residuals $Zs > 3.00$. We double-checked the effect sizes and included them in further analyses, as these effect sizes represent the field, despite their extreme values. The analyses without the problematic effect sizes are presented in the online Supplemental Materials (Tables S3 and S4). We did not find significant heterogeneity across permutations (see Table 1). This suggests that no individual study had undue influence on the pooled effect sizes.

Relation of Child Maltreatment and Alexithymia

A summary of the pooled correlations between child maltreatment types and alexithymia is provided in Table 1. The meta-analysis revealed that greater exposure to child maltreatment is associated with greater levels of adult alexithymia: child emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect were all associated with adult alexithymia (see Table 1). Notably, emotional abuse, emotional neglect, and physical neglect were the strongest predictors. In terms of the specific dimensions of alexithymia, we found that higher exposure to all child maltreatment types was associated with increased adult difficulty identifying feelings and difficulty describing feelings (see Table 1). Finally, higher exposure to child maltreatment in general and child emotional neglect, and physical neglect specifically, were associated with higher levels of adult externally oriented thinking (see Table 1).

Publication Bias

We examined the possibility of publication bias for all associations between child maltreatment types and alexithymia dimensions separately. Inspection of funnel plots and almost all adapted Egger's regression tests indicated no evidence of publication bias (see Table 1 and Supplemental Figure S1).

Moderator Analysis

We explored potential moderators of the link between child maltreatment types and alexithymia dimensions. We found that the strength of the link between child maltreatment types and alexithymia dimensions was not affected by most variables that were tested as potential moderators (see Table 2, for a summary). After adjusting for Bonferroni correction, we only found a few individual moderators (six out of 136 moderators) that influenced the mean associations between child maltreatment types and alexithymia dimensions.

Table 1
Summary of Meta-Analytic Statistics

	Pooled effect size			Heterogeneity		Adapted Egger's test			
Link	*k*	*r*	95% CI	τ	PI	Intercept	Slope	Slope *SE*	*p*
Child maltreatment									
Alexithymia	75	0.28	[0.17, 0.39]	0.37	−0.66, 0.88	0.33	−0.39	0.70	.71
Difficulty identifying feelings	51	0.18	[0.12, 0.23]	0.11	−0.19, 0.50	0.22	0.12	0.47	.40
Difficulty describing feelings	51	0.22	[0.16, 0.28]	0.14	−0.22, 0.59	0.16	0.28	0.42	.25
Externally oriented thinking	51	0.07	[0.02, 0.11]	0.09	−0.25, 0.37	0.08	−0.15	0.38	.65
Emotional abuse									
Alexithymia	55	0.21	[0.13, 0.28]	0.20	−0.39, 0.68	0.24	−0.39	0.54	.77
Difficulty identifying feelings	54	0.15	[0.10, 0.19]	0.10	−0.20, 0.46	0.22	−0.17	0.40	.66
Difficulty describing feelings	54	0.20	[0.16, 0.25]	0.11	−0.15, 0.51	0.15	0.03	0.39	.47
Externally oriented thinking	52	0.01	[−0.03, 0.05]	0.08	−0.27, 0.28	−0.01	0.28	0.36	.22
Physical abuse									
Alexithymia	55	0.13	[0.06, 0.21]	0.19	−0.41, 0.61	0.11	0.23	0.50	.33
Difficulty identifying feelings	52	0.10	[0.06, 0.14]	0.08	−0.19, 0.37	0.11	0.20	0.37	.30
Difficulty describing feelings	52	0.12	[0.08, 0.16]	0.08	−0.17, 0.39	0.06	0.63	0.37	.05
Externally oriented thinking	51	0.03	[0.00, 0.06]	0.06	−0.19, 0.25	0.04	−0.21	0.33	.74
Sexual abuse									
Alexithymia	60	0.14	[0.09, 0.20]	0.14	−0.30, 0.54	0.14	0.09	0.43	.42
Difficulty identifying feelings	53	0.10	[0.06, 0.13]	0.06	−0.12, 0.31	0.16	0.01	0.59	.49
Difficulty describing feelings	53	0.16	[0.08, 0.24]	0.21	−0.44, 0.66	0.06	0.57	0.32	.04
Externally oriented thinking	52	0.02	[−0.03, 0.06]	0.09	−0.28, 0.31	0.01	0.16	0.37	.33
Emotional neglect									
Alexithymia	55	0.23	[0.14, 0.32]	0.23	−0.43, 0.73	0.22	0.21	0.59	.36
Difficulty identifying feelings	48	0.15	[0.10, 0.21]	0.12	−0.22, 0.49	0.17	0.22	0.46	.32
Difficulty describing feelings	48	0.18	[0.12, 0.23]	0.13	−0.23, 0.53	0.15	0.14	0.45	.38
Externally oriented thinking	48	0.08	[0.03, 0.13]	0.10	−0.25, 0.39	0.13	−0.62	0.41	.93
Physical neglect									
Alexithymia	51	0.20	[0.11, 0.28]	0.19	−0.38, 0.66	0.19	0.16	0.54	.39
Difficulty identifying feelings	47	0.12	[0.07, 0.17]	0.09	−0.18, 0.40	0.12	0.61	0.50	.11
Difficulty describing feelings	47	0.16	[0.10, 0.23]	0.14	−0.29, 0.55	0.10	0.36	0.40	.19
Externally oriented thinking	47	0.08	[0.03, 0.12]	0.08	−0.20, 0.34	0.08	−0.03	0.38	.53

Note. k = number of studies; r = mean correlation coefficient; CI = confidence interval; τ = tau; PI = mean correlation coefficient prediction interval; *SE* = standard error.

Source Characteristics

Publication Status

We found that publication status (i.e., publications or unpublished studies) moderated the relation between overall child maltreatment and externally oriented thinking (Δr = .08, 95% CI [.04, .13]) with unpublished studies presenting weaker associations.

Year

We did not find any moderating effects of studies' publication year on the relation between child maltreatment types and alexithymia dimensions.

Participant Characteristics

Gender. We found that studies with a higher percentage of female participants exhibited stronger associations between emotional neglect and general alexithymia (β = .004, 95% CI [.001, .006]).

Age. We did not find any moderating effects of participants' age on the relation between child maltreatment types and alexithymia dimensions.

Population. We found the association between emotional neglect and general alexithymia to be stronger in nonclinical samples (Δr = .13, 95% CI [.21, .06]) as compared to clinical samples.

Geographic Location. We found that studies conducted in Europe indicated weaker associations between overall child maltreatment and general alexithymia (Δr = −.15, 95% CI [−.24, −.06]), overall child maltreatment and difficulty describing feelings (Δr = −.12, 95% CI [−.19, −.09]), and emotional abuse and externally oriented thinking (Δr = −.08, 95% CI [−.13, −.03]), than studies conducted in North America. Furthermore, studies conducted in Europe indicated weaker associations between emotional abuse and externally oriented thinking (Δr = −.12, 95% CI [−.20, −.04]), than studies conducted in Asia.

See the online Supplemental Materials for a summary of the analyses without outliers (Table S4) and detailed results of the analyses of potential moderating effects on the relation of child maltreatment types and alexithymia's dimensions (including studies identified as outliers, Table S5).

Discussion

Research on alexithymia is advancing rapidly. Highlighting its clinical importance, alexithymia has been linked to mental disorders such as depression (S. Li et al., 2015), dissociative experiences (Mason et al., 2005), somatic disorders (Myles & Merlo, 2021), and atypical interoceptive sensitivity (Murphy et al., 2017). Still, there is

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Table 2
Results of the Moderator Analyses for Associations Between Child Maltreatment and Alexithymia

	Percentage of females		Age		Sample		Location		Publication year		Status	
Link	*F*	*df*	*F*	*df*	*F*	*df*	*F*	*df*	*F*	*df*	*F*	*df*
Child maltreatment												
Alexithymia	0.96	1, 48	3.72	1, 40	2.95	2, 52	$\mathbf{6.25}^{**}$	2, 50	0.68	1, 54	0.13	1, 54
Difficulty identifying feelings	0.38	1, 32	5.85^{*}	1, 28	2.10	2, 35	4.65^{*}	2, 33	4.46^{*}	1, 37	0.15	1, 37
Difficulty describing feelings	1.05	1, 32	4.93^{*}	1, 28	1.81	2, 35	$\mathbf{6.56}^{**}$	2, 33	2.99	1, 37	0.06	1, 37
Externally oriented thinking	0.46	1, 32	2.65	1, 28	1.31	2, 35	3.47^{*}	2, 33	3.11	1, 37	$\mathbf{13.43}^{***}$	1, 37
Emotional abuse												
Alexithymia	2.23	1, 35	0.16	1, 29	0.82	2, 38	2.24	2, 36	0.02	1, 39	2.02	1, 39
Difficulty identifying feelings	2.42	1, 35	0.45	1, 28	1.89	2, 38	1.85	2, 36	2.84	1, 39	6.84^{*}	1, 39
Difficulty describing feelings	1.11	1, 35	1.18	1, 28	1.47	2, 38	2.39	2, 36	4.34^{*}	1, 39	0.10	1, 39
Externally oriented thinking	3.72	1, 33	2.94	1, 27	0.77	2, 36	$\mathbf{6.62}^{**}$	2, 34	3.67	1, 37	N/A	N/A
Physical abuse												
Alexithymia	0.73	1, 35	0.89	1, 27	0.02	2, 38	0.80	2, 36	0.47	1, 39	0.21	1, 39
Difficulty identifying feelings	0.02	1, 34	0.05	1, 26	0.03	2, 36	1.11	2, 34	2.55	1, 37	1.40	1, 37
Difficulty describing feelings	0.00	1, 34	0.02	1, 26	0.27	2, 36	0.54	2, 34	2.81	1, 37	0.03	1, 37
Externally oriented thinking	0.05	1, 33	0.11	1, 26	2.94	2, 35	0.69	2, 33	3.83	1, 36	N/A	N/A
Sexual abuse												
Alexithymia	2.45	1, 38	0.27	1, 33	1.95	2, 43	0.78	2, 41	0.20	1, 44	0.56	1, 44
Difficulty identifying feelings	0.02	1, 35	0.02	1, 30	0.09	2, 38	0.09	2, 36	0.09	1, 39	N/A	N/A
Difficulty describing feelings	1.22	1, 35	0.15	1, 30	1.77	2, 38	0.70	2, 36	5.76^{*}	1, 39	0.38	1, 39
Externally oriented thinking	0.01	1, 34	1.37	1, 29	2.32	2, 37	3.21	2, 35	2.59	1, 38	0.00	1, 38
Emotional neglect												
Alexithymia	$\mathbf{8.14}^{**}$	1, 36	1.02	1, 30	3.25^{*}	2, 38	0.67	2, 36	0.55	1, 39	1.00	1, 39
Difficulty identifying feelings	4.61^{*}	1, 30	2.97	1, 24	3.63^{*}	2, 32	4.12^{*}	2, 30	7.79^{*}	1, 33	N/A	N/A
Difficulty describing feelings	7.65^{**}	1, 30	4.07	1, 24	$\mathbf{7.75}^{**}$	2, 32	4.86^{*}	2, 30	2.57	1, 33	N/A	N/A
Externally oriented thinking	1.79	1, 30	0.00	1, 24	1.95	2, 32	3.23	2, 30	1.51	1, 33	N/A	N/A
Physical neglect												
Alexithymia	0.91	1, 32	0.11	1, 26	1.07	2, 34	1.97	2, 32	0.59	1, 35	0.49	1, 35
Difficulty identifying feelings	0.00	1, 29	0.13	1, 23	0.23	2, 31	0.33	2, 29	3.81	1, 32	N/A	N/A
Difficulty describing feelings	0.28	1, 29	0.32	1, 23	1.90	2, 31	0.71	2, 29	1.61	1, 32	N/A	N/A
Externally oriented thinking	1.97	1, 29	0.67	1, 23	0.53	2, 31	0.68	2, 29	0.09	1, 32	N/A	N/A

Note. Each row and column presents a separate moderator analysis. Bolded values indicate significance at adjusted p level for Bonferroni correction as less than three studies were included in the comparison category (e.g., published vs. unpublished studies). Significance asterisks are based on unadjusted p values. N/A = not available.
$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

considerable uncertainty concerning alexithymia's etiology (Gaher et al., 2015). Synthesizing conflicting findings is necessary for a more nuanced understanding of the complex connection between the different types of child maltreatment and alexithymia. Our results demonstrate that, regardless of its nature, child maltreatment correlates positively with adult alexithymia. This association was strongest in cases of emotional abuse, emotional neglect, and physical neglect. We found some evidence that specific associations between the child maltreatment and alexithymia dimensions were moderated by gender, existence of psychopathology (clinical vs. nonclinical samples), geographic location, and publication status, but not by age and publication year.

Child Maltreatment and Alexithymia

In our study, overall child maltreatment was found to correlate with adult alexithymia. As caregivers play a crucial role in the cognitive–emotional development of a child, their ability to identify their own and others' emotional states translates to the child's capacity to do the same (Mason et al., 2005). This translated capacity can be seen through the lens of gene–environment processes in which biological caregivers provide both their children's genotypes and environment, enhancing the correlation between the two (Dick, 2011; Jaffee & Price, 2007). Given that caregivers are often the primary example for children in developing their emotional responses (Ogren & Johnson, 2021), maltreatment by caregivers—the most common perpetrators (Finkelhor et al., 2014; United Nations Children's Fund, 2003; Yampolskaya et al., 2009)—decreases the number of positive examples and opportunities for the modeling and reinforcement of appropriate coping strategies and emotional expressiveness (Brown et al., 2016; Gaher et al., 2015). This can cause children who experience maltreatment to grow up with difficulties processing their emotional reactions to negative emotional stimuli (Dvir et al., 2014), which in turn increases the likelihood of developing alexithymia in adulthood (P. D. Parker et al., 2005; Pollatos et al., 2008; Starita et al., 2016).

Our findings revealed that childhood emotional abuse as well as emotional and physical neglect were the strongest predictors of adult alexithymia. This is in line with meta-analytic findings by Khan and Jaffee (2022) who found alexithymia to be more strongly associated with neglect than physical or sexual abuse. These findings might be explained by the implicit nature of these types of maltreatment as compared to physical or sexual abuse. As emotional maltreatment and physical neglect are harder for others to recognize, they are less

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frequently reported (Chamberland et al., 2011; Garland et al., 1996). This may contribute to a longer maltreatment duration. In contrast to physical and sexual abuse, even victims themselves struggle to recognize their experiences of emotional abuse and neglect as maltreatment (Goldsmith & Freyd, 2005); therefore, they may seek help less frequently and may not employ the same conscious psychological processes to heal from the emotional damage.

Further, emotional neglect and physical neglect commonly occur together (Glaser, 2002), and both involve not meeting a child's needs. These unmet needs and a child's likely lack of vocabulary and ability to identify and describe their needs create emotional discord. Without guidance in managing the resulting feelings, this may translate into the development of adult alexithymia, exhibiting those exact inabilities.

One useful lens for considering the link between child emotional maltreatment and physical neglect, on the one hand, and adult alexithymia, on the other, is Bowlby's attachment theory. According to this theory, emotional maltreatment can obstruct the development of a secure attachment when caregivers fail to meet the child's emotional needs (Bowlby, 1958), and this lack of secure attachment formation can last into adulthood (Aust et al., 2013). In fact, maltreatment during childhood can predict attachment disorganization in infants (Ludmer et al., 2018) and unresolved attachment in adulthood (Bailey et al., 2007). On the other hand, secure attachment consists of three components, one of which is "self-awareness or the capacity to be aware of one's own opinions, wishes, and needs, and the capacity to express these in social interactions" which overlaps with the dimensions of alexithymia (Bekker et al., 2007, p. 509). Evidently, the fulfillment of emotional needs in childhood is crucial to healthy emotional development. Maltreatment or a deficiency in emotional support may lead to an understanding that emotional expression is unacceptable and will be punished (Goldsmith & Freyd, 2005; Paivio & McCulloch, 2004). In an attempt to adjust to emotional maltreatment, children may learn to distance themselves from their emotional needs. Estranging themselves from their emotions may ultimately lead to poor emotional awareness in adulthood, and this may manifest as alexithymia (Brown et al., 2016).

This distancing from emotional needs ties to another potential explanation for the strength of alexithymia's association with emotional and physical neglect—the role of dissociation. Dissociation is a process in which the individual becomes detached from behaviors, thoughts, memories, and feelings (Kluft, 1990b; O'Neil, 2009; Spiegel & Cardeña, 1991; Vaillant, 1994). Research has shown that childhood dissociation is most strongly related to the unavailability of caregivers, closely aligned with emotional and physical neglect (Schimmenti, 2017). Maltreated children are likely to dissociate as a defense mechanism when maltreatment is too overwhelming to fully experience the depth of their emotional distress (Boysan et al., 2009; Dalenberg et al., 2012; Hariri et al., 2015; Schore, 2009). This defense mechanism may be the most available coping strategy for neglected children as self-regulation abilities are limited during childhood, particularly in the absence of healthy role models. Neglectful and abusive parenting has indeed been shown to lead children to a constant and excessive use of dissociation to escape from unbearable mental states arising from maltreatment (Bromberg, 1998; Chefetz, 2015; Kluft, 1990a, 2000; Schimmenti & Caretti, 2016; van der Kolk, 2014). In practice, frequent dissociation can reinforce alexithymic tendencies (Craparo, 2011; Craparo et al., 2014; Schimmenti, 2017). There also exists a positive correlation between alexithymia and dissociation, particularly in the dimensions of difficulty identifying and describing feelings (Mason et al., 2005) with both clinical and nonclinical populations (Grabe et al., 2000). Interestingly, research has found that experience of child maltreatment is related to both alexithymia and dissociation in that maltreated children have been observed to experience both (Berenbaum & James, 1994; McFarlane et al., 1990; Terr, 1991). This coincides with our findings of stronger associations between overall child maltreatment and difficulty identifying and describing feelings.

The present study revealed that the greater an individual's exposure to physical or sexual abuse, the greater their symptoms of alexithymia in adulthood. According to Güleç et al. (2013), these results may be explained by the strong association of physical and sexual abuse with various forms of psychopathology. Studies that exclude participants based on these psychopathologies may therefore not account for participants with significant levels of physical abuse and sexual abuse, causing a potential underestimation of the link between alexithymia and physical as well as sexual abuse. Additionally, it is important to mention that the co-occurrence of multiple types of child maltreatment is alarmingly high (Daro, 2015; Herrenkohl & Herrenkohl, 2009; Kim et al., 2017). A review by Herrenkohl and Herrenkohl (2009) on this co-occurrence found rates of co-occurrence from 33% to 94% across samples. The extent to which overlap between subtypes occurs is difficult to ascertain, as findings differ based on data source and analysis method (Debowska et al., 2017; Edwards et al., 2003). Adding to the complexity, research shows that coexisting forms of maltreatment may have additive effects on adjustment outcomes (Kim et al., 2009). Thus, co-occurrence is associated with the most adverse outcomes, especially when the overlap included sexual abuse (Edwards et al., 2003).

The magnitude of associations found in the present study is worth considering. Our study found a significant positive relationship between levels of child maltreatment and alexithymia as well as the different child maltreatment subtypes, exhibiting similar magnitudes to the relations found by Khan and Jaffee (2022). The average correlation found ($r = .23$) was close to both Cohen's (1988) value for a "medium" effect size ($r = .30$) and Lipsey and Wilson's (1993) empirical value for the 75th percentile in the social sciences ($r = .30$). According to the Promising Practices Network (2014), a correlation of $r = .12$ is a benchmark value for effects considered significant, important, notable, or consequential (Promising Practices Network, 2014), and the correlation we found surpasses this benchmark. The average correlation we found is similar to that of child maltreatment and emotion dysregulation ($r = .28$) found in a recent meta-analysis (Gruhn & Compas, 2020). A recent study on alexithymia and emotional well-being found a negative correlation between the two to a similar degree ($r = -.32$; Myles & Merlo, 2021), indicating a corresponding trend among child maltreatment, alexithymia, and emotional regulation. Another recent study on child maltreatment and adult mental disorders found a positive correlation between child maltreatment and depression ($r = .49$) and child maltreatment and anxiety ($r = .44$; Struck et al., 2020). This is comparable to a meta-analysis on alexithymia and depression which found a similar magnitude of association ($r = .46$; S. Li et al., 2015). While our effect size is smaller than the associations found with child maltreatment or alexithymia and psychopathology, our results still demonstrate a significant link between the two constructs, especially in comparison to the findings regarding emotion

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processing. Although all of these findings are consistent with the narrative of adverse outcomes and correlates of both child maltreatment and alexithymia, the prediction intervals indicate that negative associations between child maltreatment and alexithymia cannot be ruled out for future studies.

Moderating Factors

The moderation analysis revealed only a few individual moderators influencing specific associations, providing no support for any consistent moderating effects of potential predictors. The future high-powered secondary analysis could examine the moderating effects that we identified in the present review.

We found no population effects of participants' age on the association between child maltreatment and alexithymia. While increasing age has been found to correlate with higher alexithymia scores (e.g., Mattila et al., 2006; Onor et al., 2010), our results suggest that the link between child maltreatment history and alexithymia is not affected by age. In contrast, we found that studies with a higher percentage of female participants exhibited stronger associations between emotional neglect and general alexithymia. While many studies have found the presence of alexithymia to be more robust in male populations (Levant et al., 2009) and boys are less frequently emotionally neglected than girls (Moody et al., 2018), our results indicate the role of other moderating factors in the relation of gender, child maltreatment, and alexithymia.

We found no population effects of clinical versus nonclinical or mixed samples on associations between alexithymia and overall child maltreatment, emotional abuse, physical abuse, sexual abuse, or physical neglect. There was, however, a significant moderating effect on the link between general alexithymia and emotional neglect. As many of our clinical samples were recruited as part of in-patient treatment, this may be explained by their previous and present counseling and psychotherapy experience. As part of psychotherapy, patients are required to interact emotionally with their therapist, practicing to identify and describe their feelings. This practice has been shown to decrease potential levels of alexithymia (Beresnevaite, 2000; Cameron et al., 2014). Additionally, we categorized clinical samples as psychiatric ones in order to account for the impact of psychopathology (Russotti et al., 2021). Therefore, nonclinical samples included participants with somatic disorders. Alexithymia has been associated with various physical outcomes including dermatological, gastrointestinal, and cardiovascular conditions (Myles & Merlo, 2021). One of these conditions is atypical interoception, defined as an impaired ability to perceive the physiological state of the body (Murphy et al., 2017; Shah et al., 2016). Related structural changes in the interoceptive regions of the brain, for example, the insula and anterior cingulate cortex, have been shown to be the results of child maltreatment experiences (e.g., Teicher et al., 2014). Simultaneously, they are also linked to alexithymia (Murphy et al., 2017). Due to this overlap of physical conditions and alexithymia, potential population effects may be revealed with further analysis based on recategorization of the available samples.

We found geographic effects that moderated the relationship between alexithymia, some of its dimensions, and overall child maltreatment as well as child maltreatment subtypes. These significant moderation effects may be attributed to international discrepancies in access to psychological treatment (e.g., Demyttenaere et al., 2004; Priebe & Wright, 2006; Wedding, 2007), social and child protective services (Connolly & Katz, 2019; Freymond, 2006; Parton, 2017; Spratt et al., 2015), as well as cultural variance between and within these continents concerning alexithymia (Dere et al., 2012; Le et al., 2002; Levant et al., 2003; Lo, 2014) and attitudes toward child maltreatment (e.g., Akmatov, 2011; Gelles & Cornell, 1983; Maul et al., 2019; McCartan et al., 2020). Further investigation is required to confirm these results and identify contributing factors to the geographic differences in the link between alexithymia and child maltreatment, particularly considering the dominance of studies from Northern America and Europe.

Finally, we found little evidence that for some associations between child maltreatment and alexithymia dimensions, the effects were weaker in unpublished studies. The year of publication did not moderate the relation between child maltreatment and alexithymia.

Strengths and Limitations

Our study has several strengths. First, our analyses accounted for the intercorrelation and co-occurrence of child maltreatment types. In addition, the present study was able to include a comparatively high number of primary studies. Therefore, our results are grounded on a large body of literature. Further, we limited our inclusion criteria to validated measures of child maltreatment which yield continuous data. This strengthens the precision and reliability of the included effect sizes. Our meta-analysis thus ensures high construct validity for child maltreatment. Last, our meta-analysis did not only investigate the relation between general alexithymia and the individual types of child maltreatment (as seen in Khan & Jaffee, 2022) but also synthesized the evidence of this relation for the alexithymia dimensions. This is particularly valuable for clinical practice as it can inform targeted interventions.

Despite the many strengths of the present study, there are some limitations worth noting. First, our inclusion criteria ensured that the articles involved only adult participants and were empirical studies written in English. Restricting our inclusion criteria in this way may introduce a monolingual bias that fails to consider studies written in other languages, therefore, limiting the generalizability of our results (Johnson, 2021). Considering the richness of English-authored data included, the present meta-analysis reflects psychology's overreliance on WEIRD samples (i.e., Western, educated, industrialized, rich, and democratic; see Henrich et al., 2010). Although the majority of published scientific literature is written in English (Ammon, 2010; Hamel, 2007; Ramírez-Castañeda, 2020), excluding studies that report data in other languages skews results toward WEIRD samples and precludes us from confidently making determinations about non-WEIRD samples. As shown in Table 2, our analyses revealed some differences between European and Asian samples. A more complete database using non-English studies would be useful in further exploring potential contributing cultural differences.

We further limited measures of child maltreatment and alexithymia to continuous measures to maintain the highest level of consistency. As a result, studies that discussed the relationship between child maltreatment and alexithymia, but did not meet our inclusion criteria, were excluded from our data analysis. Second, retrieval of the initially identified research was incomplete as many authors no longer had access to the needed data or did not respond when we inquired about their studies. Both stringent inclusion criteria and

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missing data reduced the number of included studies and thus may have introduced bias.

Another common limitation in research regarding child maltreatment is the underreporting of child maltreatment due to victims' shame of stigma as well as factors such as denial or minimization of their own experiences (Chandran et al., 2020). Our results could be impacted by the underreporting of child maltreatment occurrence and severity, as that discrepancy decreases the generalizability of our findings.

Furthermore, we did not account for the potential effects of varying durations of child maltreatment. Few of the included studies provided information on the duration, onset, or frequency of child maltreatment, all of which are important factors. Most measures used to recount the history of maltreatment did not specify the developmental timing of the maltreatment. The age of onset and developmental span of the maltreatment could create variance in the consequences experienced during adulthood (Russotti et al., 2021). Due to the absence of this information in the included articles, our findings are unable to account for these nuances. The duration, onset, or frequency of child maltreatment could also contribute to the formation of posttraumatic stress disorder or complex posttraumatic stress disorder (McLean et al., 2006; McLean & Gallop, 2003), and their presence may lead to a higher level of alexithymia (Zlotnick et al., 2001). We could not specifically account for duration, onset, and frequency in our analyses, and so our results may not fully reflect the association between child maltreatment and alexithymia.

Moreover, one potential shortcoming of this study concerns the measurement of child maltreatment as all included studies investigated child maltreatment through retrospective self-report. The available evidence on retrospective reports of child maltreatment indicates that while well-operationalized retrospective self-report measures exhibit sufficient validity and positive reports are likely to be correct, they are simultaneously likely to provide underestimates of the incidence of child maltreatment (Baldwin et al., 2019; Hardt & Rutter, 2004).

Additionally, although considered the most reliable way to measure alexithymia, the TAS-20 still has limitations in its capabilities. By nature, alexithymia is characterized by a lack of emotional insight. Thus, asking those with alexithymia to reflect on their emotional experiences becomes a cyclical problem. As a self-report measure, the TAS-20 can only depict what participants are able to express. Considering the common source of child maltreatment and alexithymia information, self-report, it is important to note that some portion of the association between the two may be due to shared-reporter variance.

Also, while we believe our findings point to promising directions regarding the role that child maltreatment plays in adult alexithymia, it is worth considering the notable unexplained noise in our data. Despite reporting significant results between these variables, it is important to pay heed to external factors that we did not consider in this meta-analysis, but which can also contribute to the significance of this association. This may suggest that the developmental sequelae are complex and perhaps more idiographic than addressed typically in the field.

We found that the associations between alexithymia and child maltreatment are moderately heterogeneous. The usual way to address effect size heterogeneity is to test variables as potential moderators. Contrary to our expectations, we did not identify many factors significantly influencing the associations between alexithymia and child maltreatment. This does not necessarily mean that there are no moderators of the associations between alexithymia and child maltreatment. The posteriori power analysis showed that we could detect small-sized effects, with more than 80% power in the sample and observed distribution of effect sizes for the comparison between two or three groups (Griffin, 2021). However, we were not able to include all potential moderators in a single model to provide more robust support for the moderator analyses as it is suggested to have at least 10 studies for each moderator (Deeks et al., 2022). Thus, our moderator analyses may provide an insight into the size of the differences between conditions, but their significance should be interpreted cautiously.

Finally, it should be noted that our study compiled correlational data and thus cannot be used to make causal inferences. While our results constitute a foundation for further investigation of the potential pathways that lead from child maltreatment to adult alexithymia, more definitive evidence is needed to establish a causal connection between the two. Such evidence should include multilingual, multimeasure, and longitudinal investigations of both child maltreatment and alexithymia.

Conclusion

This meta-analysis aimed to provide an overview of the available literature on links between child maltreatment and adult alexithymia. Overall, all types of child maltreatment appear to be related to adult alexithymia, with emotional abuse, emotional neglect, and physical neglect emerging as the strongest predictors. This meta-analysis thus highlights the long-term implications of child maltreatment for the etiology of alexithymia. A better understanding of the early environmental influences on alexithymia can allow for targeted alexithymia-focused approaches of prevention and intervention that can recognize and address adverse childhood experiences as antecedents of this clinically important trait.

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Childhood maltreatment, shame, and self-esteem: an exploratory analysis of influencing factors on criminal behavior in juvenile female offenders

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Abstract

Objective This study aimed to investigate the relationships between childhood maltreatment, shame, and self-esteem among juvenile female offenders and to explore the potential influencing factors on their criminal behavior.

Methods Using a stratified cluster sampling method, 1,227 juvenile female offenders from 11 provinces in China were surveyed using the Childhood Trauma Questionnaire (CTQ), Self-Esteem Scale (SES), and a self-developed Shame Questionnaire for Juvenile Offenders. Data were analyzed using descriptive statistics, correlation analysis, chi-square tests, t-tests, and structural equation modeling with mediation analysis.

Results (1) Childhood maltreatment have a significant potential influencing factors on criminal behavior; (2) Childhood maltreatment was positively correlated with self-esteem($\beta = 0.351$, $p < 0.001$); (3) shame ($\beta = 0.042$, $p < 0.001$) mediate the relationship between Childhood maltreatment and self-esteem (childhood maltreatment → shame → self-esteem (95% CI: 0.033, 0.052)).

Conclusion This study demonstrates that childhood maltreatment is a significant predictor of criminal behavior among juvenile female offenders. childhood maltreatment can directly influence of self-esteem, which can also affect juvenile female offenders'self-esteem indirectly through shame. The findings suggest that shame are important variables that mediate the effect of the juvenile female offenders'childhood maltreatment on their self-esteem.

Keywords Childhood maltreatment, Shame, Self-esteem, Criminal behavior, Female juvenile offenders

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Introduction

Child maltreatment remains a pervasive global issue with far-reaching impacts that extend into every corner of society. juveniles, the future of our society, are influenced by a multitude of factors in their growth and development, one of which is their early life experiences. As emphasized by the World Health Organization, child maltreatment includes physical, emotional, and sexual abuse, neglect, and exploitation, all potentially harmful to a child's overall health [1]. Moreover, maltreatment of children is not just about acts of commission; it also involves acts of omission, which include neglecting the emotional and physical needs of children [2]. The impact of child maltreatment on society becomes particularly evident in the context of criminal behavior. Notably, a link between experiencing abuse during childhood and delinquent behavior in adolescence has been observed [3]. According to existing literature, such traumatic experiences during formative years lead to challenges in interpersonal relationships and might result in maladaptive behaviors [4, 5]. These experiences of abuse can have lasting impacts on a child's psychological and emotional health [6]. For instance, children who are frequently abused may exhibit serious mental problems, such as psychological trauma, depression, anxiety, suicidal tendencies, violent tendency, and aggression. Among those with a history of abuse, behaviors such as school absenteeism, risky behaviors, and even physical altercations become more prevalent [7, 8]. Simultaneously, these behaviors might be their way of coping with traumatic experiences.

In China, childhood maltreatment is a significant influencing factor in juvenile criminal behavior [9, 10]. Studying the relationship between childhood maltreatment and criminal behavior in the Chinese context is unique and necessary, mainly reflected in three aspects. First, the collectivistic cultural characteristics of China may make childhood maltreatment more easily concealed, and victims are less willing to seek help, leading to more severe psychological consequences and criminal risks. Second, China's relatively inadequate laws and policies in preventing and dealing with childhood maltreatment may exacerbate victims' psychological trauma and criminal risks. Finally, China's rapid social transformation and modernization may increase the risk of childhood maltreatment while bringing more uncertainties and challenges to juveniles, increasing their psychological vulnerability and criminal risks. Research shows that among juvenile offenders, theft, group fighting, provocative disturbance, robbery, rape, and intentional injury are the most common criminal behaviors, accounting for 76.5% of all criminal behaviors [11]. Therefore, conducting research on the relationship between childhood maltreatment and criminal behavior in the Chinese context can reveal the influence of cultural characteristics, legal policies, and social transformation factors, providing important theoretical and practical basis for improving relevant policies, preventing and intervening in childhood maltreatment and its resulting criminal behavior. At the same time, it also helps to fill the research gap in this field in China and provide empirical evidence from a Chinese perspective for cross-cultural research. However, when studying juvenile delinquency, few studies focus on female juvenile offenders. They may have unique experiences and challenges that differ from male offenders [12]. The under-representation of female juvenile offenders in scholarly research is a significant gap that our study aims to address. Historically, the majority of studies in juvenile delinquency have centered on male populations, leading to a skewed understanding of the factors contributing to criminal behavior and the effective interventions needed for rehabilitation. This gender bias overlooks the unique socio-cultural, psychological, and environmental factors influencing female adolescents' pathways into criminal behavior. Female juvenile offenders often face distinct challenges and vulnerabilities compared to their male counterparts. Research indicates that girls are more likely to experience certain forms of trauma, such as sexual abuse, which can have profound impacts on their psychological development and lead to different coping mechanisms, including delinquent behavior [13, 14]. Furthermore, societal norms and gender expectations can exacerbate the stigma and shame associated with female delinquency, influencing their self-esteem and identity formation [15]. Understanding the specific needs and experiences of female juvenile offenders is crucial for developing targeted interventions that address the root causes of their criminal behavior and support their rehabilitation and reintegration into society.

In recent years, there has been an increasing focus on understanding the specific relationship between childhood maltreatment and juvenile delinquency. Research findings indicate a positive correlation between these two factors, with individuals who experienced physical abuse during childhood being more likely to exhibit aggressive behavior during adolescence [16]. This highlights the importance of prevention and intervention measures targeting childhood physical abuse to mitigate its impact on later criminal activities. Related studies have explored the relationship between early traumatic experiences and criminal behavior, primarily focusing on male prisoners. However, their research findings suggest that the impact of early trauma may also have significant implications for criminal behavior among female juveniles [17]. Some researchers investigated the link between childhood emotional abuse and potential aggressive behavior in early adulthood. Their study emphasizes the importance of mentalization abilities as a mediating factor in this relationship. Mentalization refers to the ability to

understand the mental states underlying human behavior, which may be crucial for female juveniles in processing the impact of emotional abuse and avoiding the development of criminal behavior [18]. Furthermore, research has highlighted the role of gender in the impact of abuse, as female participants exhibited BDSM-type sexual addiction, self-attacking behaviors, and alcohol abuse [19]. This case study emphasizes the need for gender-specific interventions and support systems for female juveniles who have experienced abuse and violence. The "life course perspective" model suggests that childhood abuse indirectly increases the propensity for criminal behavior later in life by exacerbating juvenile delinquency. When juvenile offenders are labeled by society, this initial deviance may be reenacted in later life, leading to the recurrence of criminal behavior [20].

The process of being socially labeled intensifies feelings of social exclusion, thereby reducing opportunities for behavioral correction or reintegration into society [21]. This negative cycle makes it more likely for abused juveniles to continue engaging in criminal activities in adulthood. While the life course perspective model emphasizes the indirect pathway from childhood abuse to criminal behavior in adulthood through juvenile delinquency, we must recognize that various factors can mediate the direct link between these two variables. Individual coping mechanisms, the presence of social support systems, and access to effective interventions can all play a role in mitigating the long-term negative effects of abuse [22]. This implies that not all individuals who experience childhood maltreatment will follow a criminal trajectory, as positive factors at the societal, familial, and individual levels can intervene and alter the course of criminality. The relationship between childhood maltreatment and criminal behavior among female juveniles is a complex process involving the interaction of multiple factors, encompassing both direct influences and indirect effects through juvenile delinquency. The studies reviewed in this literature review highlight the importance of considering the specific forms of maltreatment, such as physical and emotional abuse, as well as the role of gender in shaping the psychological and behavioral outcomes of maltreatment. Consistent with the proposal, we formed our hypothesis 1 as follows: Childhood maltreatment is an important influencing factor in the criminal behavior of juvenile female offenders.

Childhood maltreatment, including various forms of abuse and neglect, is considered a significant risk factor for a range of adverse outcomes, including low self-esteem. Self-esteem is defined as an individual's overall subjective evaluation of their own worth and plays a crucial role in psychological well-being and social functioning. Shen (2009) investigated the combined impact of interparental violence and child physical abuse on juvenile self-esteem, and the results showed that both forms of abuse experienced during childhood had long-term detrimental effects on self-esteem in adulthood [23]. This finding highlights the compound impact of various forms of abuse on an individual's self-perception and worth, emphasizing the need for comprehensive interventions targeting multiple forms of maltreatment. Additionally, The study sampled emerging adults from low socioeconomic backgrounds and examined the relationship between childhood maltreatment and various adverse psychological outcomes, including reduced self-esteem [24]. Their research adds to the literature linking childhood maltreatment to negative psychological outcomes, highlighting the importance of considering socioeconomic factors when examining the impact of abuse on self-esteem. Furthermore, study found a negative correlation between childhood maltreatment and self-esteem [25]. Researchers further explored the correlation between self-esteem and child abuse. The study found that psychological abuse and neglect were negatively correlated with self-esteem, which in turn was associated with various forms of internalizing and externalizing behavior problems [26–28]. In addition, study explored the protective role of self-related resources, such as self-esteem and self-compassion, in the relationship between childhood maltreatment and subjective well-being in early adulthood [29]. Collectively, the research findings emphasize the significant impact of childhood maltreatment on self-esteem. Based on the above discussion, by combining the aforementioned hypotheses, this study proposes the following hypothesis 2: Childhood maltreatment has a significant impact on self-esteem in juvenile female offenders.

In recent years, research on childhood shame has become increasingly rich, with numerous studies demonstrating that experiences of shame have profound effects on individual psychological health and self-perception, and are also closely related to childhood maltreatment. A study investigated the direct link between childhood maltreatment and the development of shame, demonstrating that these experiences largely contribute to subsequent shame [30], And further explored the relationship between childhood maltreatment and shame by examining how maladaptive schemas mediate this link [31]. Their research findings suggest that maladaptive schemas formed due to abuse heighten sensitivity to shame and guilt, which in turn affects emotion regulation and self-esteem. Some researchers explored the psychological pathways from childhood maltreatment to depression and crime, highlighting the process of juvenile shame transforming into guilt and self-blame [32, 33]. There are also some studies explored the broader societal impact of shame, examining its relationship with racism, social anxiety, and bullying victimization [34,

35]. These studies indicate that shame not only stems from direct abuse but can also be exacerbated by social threats to an individual's relationships and status, further impacting self-esteem and psychological well-being. This research emphasizes the importance of considering the social context in which shame arises and its far-reaching effects on individual well-being. Several studies focused on specific populations, such as individuals with psychosis, investigating the impact of socially induced shame, self-blame, and low self-esteem [36, 37]. These studies provide deeper insights into how internalized shame and self-esteem mediate the relationship between stigma, emotional distress, and recovery in individuals with psychosis, highlighting the central role of shame in the experience of mental health challenges. The reviewed research suggests that shame plays a crucial role in the relationship between childhood maltreatment and various psychological outcomes, including self-esteem. The internalization of shame often stems from maladaptive schemas and social pressures, significantly impacting an individual's self-esteem, emotional well-being, and behavioral patterns. Recognizing the central role of shame in these dynamics is essential for developing targeted interventions to mitigate the long-term effects of childhood maltreatment and promote resilience and recovery. Based on the above analysis, we propose hypothesis 3: Shame mediates the relationship between childhood maltreatment and self-esteem in juvenile female offenders.

In summary, this study aims to uncover childhood maltreatment as an important influencing factor in juvenile female offenders' criminal behavior, as well as its relationship with self-esteem and shame, and to examine the mediating effect of shame in the relationship between childhood maltreatment and self-esteem, thereby analyzing the sociopsychological mechanisms of juvenile female offenders' criminal behavior. This study plans to establish a mediation model to deeply explore the influence of sociopsychological mechanisms such as childhood maltreatment, self-esteem, and shame on the criminal behavior of juvenile female offenders. The research results will help provide targeted recommendations for the prevention and intervention of childhood maltreatment and reduce the long-term negative impact of abuse. Additionally, the research results will provide a basis for the psychological treatment and rehabilitation of female offenders, aiding in the design of intervention programs focusing on self-esteem and shame. Furthermore, this study will also provide references for reducing the risk of recidivism among female offenders and formulating effective rehabilitation and re-socialization strategies.

Method

Participants and procedure

China contains 681 prisons, due to the large number of prisons this study randomly selected 11 provinces prisons, which contain 3 prisons in west of China,4 prison in east of China prison and 4 central prisons of China. From June to July 2023, Paper questionnaires were distributed to juvenile female offenders in these 11 provinces, yielding a total of 1,321 responses. All of the questionnaires are received back, after selected all those questionnaires 1,227 valid responses were obtained, resulting in a questionnaire validity rate of 92.88%, the invalid questionnaires contains unclear answers and blurry messages, and deleted all those questionnaires.

Among the participants, the majority were non-only children (84.27%), with most having an educational level of junior high school or below (59.90%). The majority resided in rural areas (48.90%), came from families where the parents were in their first marriage (68.05%), and had moderate family economic conditions (56.07%). The most common offenses were sexual crimes and fraud (19.64% and 23.88%, respectively), with the majority of crimes being committed in groups (60.64%).

Before the study, informed consent was obtained from departmental and prison leaders as well as the juvenile female offenders themselves. The survey was conducted in a group format, led by two psychology postgraduate students in each prison area. A standardized introduction was used to ensure all participants clearly understood the purpose and process of the survey. The entire survey took approximately 15 min to ensure necessary information was collected efficiently. This study was approved by the Ethics Review Committee of Nanshan Hospital of Shandong Province (Approval Number: [2023-07-X105]). All of the procedures were performed in accordance with the Declaration of Helsinki and relevant policies in China. All participants agreed to participate voluntarily, with informed consent when they fled in the survey.

Measure

Demographic questionnaire

We used a self-compiled demographic questionnaire to survey: Only child status (Yes/No), Place of origin, Education Level, Type of Residence, Parental Marital Status(Intact/Remarried/Single Parent), Types of Crime(Property Crime/ Violent Crime/ Sexual Crime /Other), Family's Economic Status in the Local Area(Better Off/Average/Below Average/Poor).

Childhood trauma questionnaire (CTQ)

The Childhood Trauma Questionnaire (CTQ) developed by Bernstein (1998) [38] and later translated and modified into Chinese by Zhao Xingfu (2004) [39] was used. Designed to measure maltreatment experiences before

the age of 16, this questionnaire serves as a screening tool to identify individuals with childhood abuse and neglect experiences. The questionnaire comprises five sub-questionnaires with five items each: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. Scoring ranges from “never"=1 to “always"=5. Out of 28 questions, 25 assess the questionnaire’s main components, and 3 identify individuals denying childhood issues. The total score of the sub-questionnaires ranged from 0 to 25, with higher scores indicating more severe abuse. The Cronbach’s alpha coefficients of the subscales ranged from 0.79 to 0.92, indicating good reliability.

Self-esteem scale (SES)

The Self-Esteem Scale (SES), developed by the Rosenberg, is used to assess juveniles’ overall sense of self-worth and self-acceptance. It consists of 10 items, each rated on a four-point scale: 1 indicates “strongly agree,” 2 indicates “agree,” 3 indicates “disagree,” and 4 indicates “strongly disagree.” Items 3, 5, 8, 9, and 10 are reverse-scored. The total score ranges from 10 to 40, with higher scores indicating higher levels of self-esteem [40]. In this study, the Cronbach’s alpha coefficient for the scale was 0.86.

Shame questionnaire for juvenile offenders

The Shame Questionnaire for Juvenile Offenders, a self-developed questionnaire, was used in this study. The questionnaire consists of 17 items, each rated on a 5-point scale ranging from 1 (completely disagree) to 5 (completely agree). It includes three dimensions: cognitive shame, emotional shame, and behavioral shame. Higher scores indicate higher levels of shame among juvenile female offenders. In this study, the fit indices of a confirmatory factor analysis model of the scale were RMSEA = 0.06, TLI = 0.90, and CFI = 0.91. The Cronbach’s alpha coefficients for the overall questionnaire and its three dimensions were 0.86, 0.82, 0.81, and 0.72, respectively. The split-half reliabilities were 0.71, 0.78, 0.77, and 0.81, respectively.

Table 1 Descriptive statistics of crime types and risk factors

	Variable	Frequency	Percentage
Types of Crime	Property Crime	417	33.98
	Sexual Crime	325	26.49
	Violent Crime	97	7.91
	Other	388	31.62
Risk Factors	Family	Present 712	58.03
		Absent 515	41.97
	School	Present 674	54.93
		Absent 553	45.07
	Economy	Present 650	52.97
		Absent 577	47.03

Note: Crimes are categorized into four types based on the nature of the object harmed by the criminal activity: property crimes, violent crimes, sexual crimes, and others. Property crimes include theft, robbery, fraud, embezzlement of funds, etc.; sexual crimes encompass rape, prostitution, organizing prostitution, etc.; violent crimes cover intentional injury, murder, etc.; others include crimes such as using cult organizations to obstruct law enforcement, drug trafficking, illegal collection of public deposits, bribery by non-governmental personnel, organizing and leading pyramid schemes, using superstition to disrupt law enforcement, causing traffic accidents, provoking trouble, and other similar offenses

Statistical analysis

This study has adopted IBM SPSS22.0 statistical software for all data analyses. After the questionnaires were collected, all the data have been processed as follows: (1) Exploratory factor analysis was performed on all scales by SPSS22.0; (2) internal consistency was tested for all scales by SPSS22.0; (3) the Harman single-factor method has been adopted for the common method deviation test; (4) descriptive statistics, such as statistical means (M), standard deviations (SD), maximum and minimum values, and the Cronbach'salpha were computed; (5) Pearson correlation analysis to explore the relationship between childhood maltreatment, shame, and self-esteem; (6) T-tests were used to analyze relationship between the types of crime committed and the types of childhood maltreatment experienced, chi-square analyses were performed; (7) a Structural Equation Modelling (SEM) approach was employed to test the theoretical model in the current study. PROCESS version 3.3 macro was used to construct the structural equations and to test the mediating effects [41]. The accepted level of significance was $p < 0.05$.

Results

Data processing and common method bias test

In this study, common method bias was controlled through anonymous surveys and reverse scoring of some items. To further assess this bias, Harman’s single factor analysis method was used. The analysis revealed five factors without rotation, accounting for 59.95% of the total variance. The first factor explained 33.41% of the variance, below the 40% threshold, indicating that the data were not significantly affected by common method bias [42].

Descriptive statistics of variables

The study participants consisted of 1,227 female juveniles deprived of liberty due to various criminal offenses, as recorded in the reviewed files. Table 1 reveals that the most common type of offense was property crime, accounting for 33.98% (n = 417), followed by sexual crimes at 26.49% (n = 325), violent crimes at 7.91% (n = 97), and other types of crimes at 31.62% (n = 388). However, the majority of these juveniles were exposed to negative elements within their marginalized family and educational environments. As depicted in Table 1, the

Table 2 Descriptive statistics of types of childhood maltreatment

Variable	Min	Max	M	SD	Skew	Kurt
Emotional Abuse	5	25	8.39	3.97	1.720	3.148
Physical Abuse	4	25	6.56	3.21	2.681	7.514
Sexual Abuse	5	25	7.29	2.17	2.261	10.328
Emotional Neglect	5	25	11.35	5.60	0.593	-0.708
Physical Neglect	5	25	8.89	3.93	1.015	0.454
Childhood Maltreatment	28	113	49.88	13.04	1.430	2.270

Table 3 Analysis of differences between types of crime and types of childhood maltreatment

Variable	Types of Crime						
	Property Crime (n=417)	Violent Crime (n=97)	Sexual Crime (n=325)	Other (n=388)			
	M	M	M	M	F	*P*	η^2
Emotional Abuse	7.88	9.09	8.99	8.16	6.116	0.000	0.015
Physical Abuse	6.30	6.91	7.03	6.40	3.374	0.018	0.008
Sexual Abuse	7.18	7.60	7.22	7.26	1.661	0.174	0.004
Emotional Neglect	10.73	12.19	12.23	11.11	4.907	0.002	0.012
Physical Neglect	8.55	9.53	9.33	8.72	3.659	0.012	0.009

Note: *$p<0.05$;**$p<0.01$; ***$p<0.001$; η^2 is an indicator for measuring effect size

percentage of family context issues (parental marital status and domestic abuse) was higher than other contexts. This was followed by school educational context (dropout rates), and lastly socio-economic context (poor economic conditions and living in marginalized and inappropriate environments), indicating that these risk factors contribute to the criminal behavior among female juvenile offenders.(Table 1).

Types and degrees of childhood maltreatment in female juvenile offenders

Table 2 presents the percentage distribution of types of childhood maltreatment based on the degree experienced by the female juvenile offenders studied. Significant percentages were observed at moderate and high levels, indicating the presence of maltreatment among these juveniles. Indeed, in Table 2, it can be seen that there is a prevalence of moderate to high degrees of emotional abuse, sexual abuse, physical neglect, and emotional neglect among the female juvenile offenders.

Comparison between types of crime and types of childhood maltreatment

Table 3 presents the results of the analysis of differences between types of crime and types of childhood maltreatment. Significant differences were found among the four groups in terms of emotional abuse ($p<0.001$), physical abuse ($p<0.05$), emotional neglect $p<0.01$), and physical neglect ($p<0.05$). However, no significant difference was observed for sexual abuse ($p>0.05$). The effect sizes ($\eta 2$) for these differences were small, ranging from 0.004 to 0.015. The violent crime group had the highest mean scores for emotional abuse, physical abuse, emotional neglect, and physical neglect compared to the other crime type groups.

Table 4 Chi-square analysis of self-esteem, shame, and crime types among juvenile female offenders

Variable	Property Crime	Sexual Crime	Violent Crime	Other	*t*
	M ± SD	M ± SD	M ± SD	M ± SD	
Self-Esteem	21.21 ± 5.28	22.14 ± 4.97	22.56 ± 4.46	21.39 ± 5.18	4.36**
Shame	19.19 ± 6.87	20.03 ± 6.71	20.94 ± 6.69	19.16 ± 8.42	3.59**

Note: *$p<0.05$;**$p<0.01$; ***$p<0.001$

Chi-square analysis of self-esteem, shame, and crime types

Table 4 presents the results of the chi-square analysis of self-esteem, shame, and crime type among juvenile female offenders. The participants were categorized into four groups based on their crime types. Significant differences were found among the four groups in terms of self-esteem (t=4.36, $p<0.01$) and shame (t=3.59, $p<0.01$). The violent crime group had the highest mean scores for both self-esteem and shame compared to the other crime type groups. The property crime group had the lowest mean scores for self-esteem and shame. The results suggest that juvenile female offenders who committed violent crimes tend to have higher levels of self-esteem and shame compared to those who committed other types of crimes.

Correlation analysis of childhood maltreatment, self-esteem, and shame

Table 5 presents the results of the correlation analysis of childhood maltreatment, self-esteem, and shame among juvenile female offenders. The analysis revealed

Table 5 Correlation analysis of childhood maltreatment, self-esteem, and shame among juvenile female offenders

Variable	1	2	3	4	5	6	7
1 Emotional Abuse	-						
2 Physical Abuse	0.661***	-					
3 Sexual Abuse	0.146***	0.247***	-				
4 Emotional Neglect	0.483***	0.391***	-0.185***	-			
5 Physical Neglect	0.583***	0.484***	-0.053	0.776***	-		
6 Childhood Maltreatment	0.802***	0.760***	0.263***	0.760***	0.824***	-	
7 Self-Esteem	0.341***	0.221***	-0.027	0.332***	0.331***	0.351***	-
8 Shame	0.351***	0.247***	0.063*	0.224***	0.252***	0.330***	0.414***

Note: *$p<0.05$;**$p<0.01$; ***$p<0.001$

Table 6 Mediation effect analysis

Path	Effect	SE	Boot LL CI	Boot UL CI	Relative mediation effect
Mediating effect	0.042	0.005	0.033	0.052	18%
Direct effect	0.093	0.011	0.072	0.014	41%
Total effect	0.135	0.011	0.114	0.114	59%

significant positive correlations among various types of childhood maltreatment. However, sexual abuse was negatively correlated with emotional neglect (r = -0.185, $p<0.001$) and not significantly correlated with physical neglect (r = -0.053, $p>0.05$). Childhood maltreatment was positively correlated with self-esteem ($r=0.351$, $p<0.001$) and shame ($r=0.330$, $p<0.001$). Self-esteem was also positively correlated with shame ($r=0.414$, $p<0.001$). These findings suggest that juvenile female offenders who experienced higher levels of childhood maltreatment tend to have higher levels of self-esteem and shame. The results also indicate that different types of childhood maltreatment are interrelated, and they collectively contribute to the development of self-esteem and shame among juvenile female offenders. This result confirms Hypothesis 2.

Mediation analysis

The analysis of the mediation effects of exercise imagery showed that the mediation effect of shame was 0.042, and its bootstrap 95% confidence interval did not contain 0 (0.033, 0.052), which indicates that its mediation effect was significant (see Table 6; Fig. 1), This result confirms Hypothesis 3.

Discussion

Child abuse, encompassing neglect and harm to children under 18, includes emotional abuse, physical abuse, neglect, and sexual abuse. Emotional neglect occurs when a child's emotional and relational needs are unmet due to a lack of attention. Emotional abuse involves inappropriate behaviors that disrespect a child's relationships with others, potentially negatively impacting their psychological and emotional development. Additionally, physical neglect includes inadequate and unsafe supervision of minors, potentially placing them in danger and even predisposing some juveniles to criminal pathways [43]. This study conducted an explorative analysis of 1,227 female juveniles deprived of liberty for various offenses, aiming to explore the relationship between their experiences of childhood maltreatment and subsequent criminal behavior. The study found a close association between childhood experiences of maltreatment, particularly emotional abuse, physical abuse, and emotional

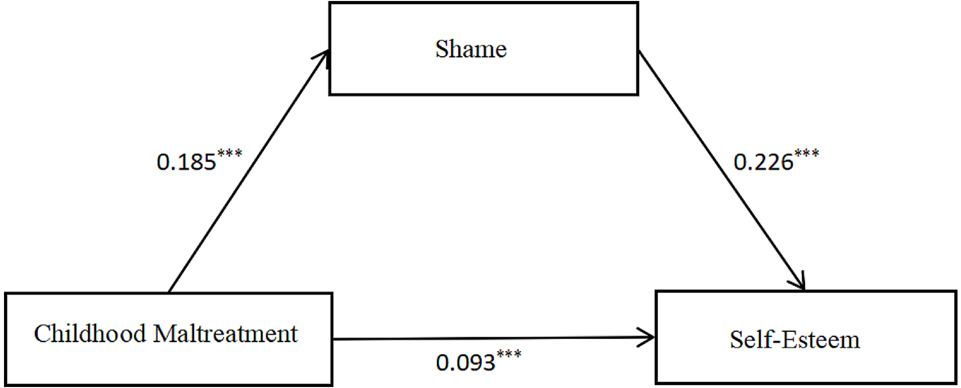

Fig. 1 Diagram of structural equation model

neglect, and criminal behavior in juvenile females. Significant differences were observed in the levels of emotional abuse, physical abuse, and emotional neglect across different types of criminal activities, indicating that the severity of maltreatment may influence the inclination of young women to commit various types of crimes. Specifically, property crimes, violent crimes, and other types of offenses showed significant correlations with all forms of childhood maltreatment. These findings align with domestic and international research [44–46], further confirming the impact and formation process of childhood maltreatment on juvenile criminal behavior.

The results of this study indicate that different types of childhood maltreatment experiences are prevalent among juvenile female offenders. Emotional neglect had the highest mean score, suggesting that this type of maltreatment was the most common in the sample. The positive skewness of all maltreatment types indicates that most participants reported lower levels of maltreatment experiences, while a few individuals experienced more severe maltreatment. Sexual abuse had the highest skewness and kurtosis values, indicating that the distribution of sexual abuse experiences was more uneven compared to other types of maltreatment, with a few participants reporting extremely high levels of sexual abuse. These findings are consistent with previous research, demonstrating that childhood maltreatment is common among female offenders [47]. Studies have also shown that different types of maltreatment may have distinct impacts on an individual's developmental trajectory [48]. For example, sexual abuse may be associated with more severe mental health problems and a higher risk of criminal behavior [49]. Therefore, it is crucial to consider the maltreatment experiences of female offenders and their potential differential effects when working with this population.

This study found significant differences in the types and severity of childhood maltreatment experienced by juvenile female offenders across different crime types. The violent crime group had the highest mean scores on most maltreatment types, suggesting that this group may have experienced more severe maltreatment. This finding is consistent with previous research indicating an association between childhood maltreatment experiences and violent offending [50]. Violent offenders may have internalized aggressive behavior through social learning processes, or maltreatment experiences may have led to difficulties in emotion regulation and impulse control, increasing the risk of violent behavior [51]. However, no significant differences were found in sexual abuse, which is inconsistent with some previous studies that have shown an association between sexual abuse and sexual offending [52]. This discrepancy may be due to differences in sample characteristics or measurement methods. Future research should further explore the relationship between sexual abuse and sexual offending and the potential moderating factors that may influence this relationship. Although there were significant differences between crime type groups, the effect sizes were small, suggesting that maltreatment experiences may be just one of many factors influencing criminal behavior. Other factors, such as individual characteristics, family dynamics, peer influences, and community contexts, may also play important roles in the development of female criminal behavior [53]. Therefore, prevention and intervention efforts should adopt a multifaceted approach that addresses not only maltreatment issues but also other relevant risk and protective factors.

The results of this study indicate that juvenile female offenders of different crime types differ significantly in self-esteem and shame. The violent crime group had the highest mean scores on self-esteem and shame, while the property crime group had the lowest scores. This finding is partially consistent with previous research suggesting that violent offenders may have higher self-esteem [54]. The high self-esteem of violent offenders may serve as a defensive mechanism to cope with feelings of shame and guilt or may reflect positive attitudes toward aggressive behavior [55]. However, the violent crime group also reported higher levels of shame, which is inconsistent with some previous studies that have shown a negative association between shame and aggressive behavior [56]. This discrepancy may reflect the multifaceted nature of shame, which can either promote or inhibit aggressive behavior, depending on how individuals cope with shame [57]. For some violent offenders, high shame may lead to aggressive behavior as a way to externalize their shame. Future research should further explore the complex relationship between shame and violent offending and the potential moderating factors that may influence this relationship. The property crime group had the lowest scores on self-esteem and shame, suggesting that this group may have unique difficulties in emotional regulation. Low self-esteem and low shame may reflect negative evaluations of self-worth and a lack of concern for the consequences of criminal behavior. Prevention and intervention efforts should focus on enhancing self-esteem among property offenders while fostering healthy shame and empathy.

This study explored the relationships between childhood abuse, self-esteem, and shame, and the results revealed significant positive correlations among these variables. This finding is partially consistent with previous research, which has shown a positive correlation between childhood abuse and shame [58]. Abusive experiences may lead individuals to form negative self-evaluations and internalize shame [59]. However, the positive correlation between childhood abuse and self-esteem is inconsistent with most prior studies, which have found

associations between childhood abuse and low self-esteem [60]. The positive correlation in the current study may reflect a defensive form of high self-esteem, a fragile and unstable form of self-esteem that appears as narcissism on the surface but hides deeper insecurities and self-doubts [61]. This defensive high self-esteem may serve as a coping mechanism to deal with the emotional pain and shame resulting from abusive experiences. The positive correlation between self-esteem and shame further supports the concept of defensive high self-esteem. Individuals with defensive high self-esteem may be more prone to experiencing shame because their self-esteem is built on an unstable foundation, making it vulnerable to threats and challenges [55]. When faced with difficulties or failures, they may be more likely to interpret these as reflections of their own deficiencies or inadequacies, triggering feelings of shame. These findings highlight the complex impact of childhood abuse on the emotional well-being of juvenile female offenders. While abusive experiences may lead to a superficially high self-esteem, this self-esteem may be fragile and defensive, associated with greater shame. Prevention and intervention efforts should focus on fostering genuine self-esteem, one that is based on self-acceptance and a sense of self-worth, rather than reliance on external validation [62].

The results of the mediation analysis indicate that childhood abuse affects self-esteem through two pathways: The direct effect suggests that experiences of childhood abuse may lead to increased self-esteem. The mediation effect suggests that childhood abuse also indirectly influences self-esteem by increasing feelings of shame. This finding supports the theoretical perspective that shame plays a crucial role in the impact of childhood abuse on self-esteem [59]. Childhood abuse may first evoke intense feelings of shame, which in turn may lead to changes in self-esteem. Shame may prompt individuals to adopt defensive strategies, such as displaying an inflated sense of self-esteem, to cope with painful emotions and self-doubt [55]. The study results provide valuable information for formulating prevention and intervention measures targeting female juvenile offenders. Particularly in family and educational environments, more attention and resources are needed to mitigate these environmental factors' negative impacts on young women and to provide necessary support and treatment for those who have already suffered abuse.

Practical implications

The findings of this study have important practical implications for the prevention and treatment of criminal behavior in juvenile female offenders with a history of childhood maltreatment. The results emphasize the necessity of early identification and intervention for abused children, the importance of incorporating shame-reduction and self-esteem building strategies into treatment programs, and the need for a comprehensive treatment approach. Furthermore, the study highlights the need for further research to develop and evaluate targeted interventions for this population, which may help reduce recidivism rates and improve long-term outcomes.

Limitations and future directions

The study's limitations include reliance on self-report measures, potential recall or reporting bias, and a cross-sectional design that precludes causal inferences. Future research should incorporate diverse data sources, employ longitudinal designs, and investigate additional correlates of criminal behavior to gain a more comprehensive understanding of female offending. The role of defensive high self-esteem in the relationship between childhood maltreatment and maladaptive outcomes, as well as potential moderating factors, warrant further exploration. Despite these limitations, the findings emphasize the importance of addressing childhood maltreatment in prevention and intervention efforts for female offenders. Trauma-informed care approaches may promote rehabilitation and reduce recidivism risk. Further research is needed to develop effective strategies fostering the healthy development of childhood maltreatment survivors.

Conclusions

This study investigated the relationships between childhood maltreatment, shame, and self-esteem among juvenile female offenders and explored the potential influencing factors on their criminal behavior. Notably, the study found that childhood maltreatment was positively associated with both shame and self-esteem, suggesting that abusive experiences may lead to a defensive form of high self-esteem that masks underlying insecurities and self-doubt. Mediation analysis further indicated that childhood maltreatment affects self-esteem through direct and indirect pathways. The direct effect suggests that childhood abuse may lead to increased self-esteem, possibly reflecting a defensive coping mechanism. The indirect effect, mediated by shame, suggests that childhood maltreatment may first evoke intense feelings of shame, which in turn influence self-esteem. Shame may prompt individuals to adopt defensive strategies, such as displaying an inflated sense of self-esteem, to cope with painful emotions and self-doubt.

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No datasets were generated or analysed during the current study.

Declarations

Ethical approval and consent to participate
All human experiments and use of human tissue samples conducted in this research strictly adhered to relevant ethical guidelines and regulations. This study has been approved by the Ethics Review Committee of Nanshan Hospital of Shandong Province (Approval Number: [2023-07-X105]). All research procedures were in compliance with international standards and local laws and regulations. We confirm that for all participants in our study who are prisoners, informed consent was duly obtained from their Legally Authorized Representatives (LARs).

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Coaching the Toxic Leader by Manfred F.R. Kets de Vries

From the Magazine (April 2014)

Summary.

In his work as an executive coach, psychotherapist Kets de Vries sometimes comes across bosses with mental demons. The four kinds he encounters most frequently are pathological narcissists, who are selfish and entitled, have grandiose fantasies, and pursue power at all costs; manic-depressives, who can leave a trail of emotional blazes behind them; passive-aggressives, who shy away from confrontation but are obstructive and underhanded; and the emotionally disconnected—literal-minded people who cannot describe or even recognize their feelings.

Left unchecked, these personalities can warp the interactions, plans, and systems of entire organizations. But with appropriate coaching, toxic bosses can learn to manage their conditions and become effective mentors and leaders. This article describes how to recognize each pathology and, step by step, guide people who suffer from it toward healthier and more-productive interactions.

Senior executives have the power to create an environment that allows people to grow and give their best—or a toxic workplace where everyone is unhappy. How executives end up using that power depends in part on their mental health. Sound, stable bosses generally build companies where the rules make sense to employees, freeing them to focus on performing their jobs well. But if the boss's psychological makeup is warped, business plans, ideas, interactions, and even the systems and structure of the organization itself will reflect his or her pathologies.

As an executive coach, I've sometimes come across leaders with mental demons. I've put a number of these bosses on the couch, in an effort to understand and counsel them. In the following pages I'll describe some of the more common pathologies I've encountered and explain how I've helped people deal with them.

Notably, these pathologies don't include isolated instances of depression. Depression is part of the human condition; we all suffer from it. When it's moderately present, it doesn't require special coaching intervention. And when it's acute and chronic, it tends to be part of the syndromes I'll present here.

Not everyone falls neatly into one or another of the categories I describe; we're often a bit of this and a bit of that. And most bosses are not mentally ill, but a surprising number of senior executives do have a personality disorder of some kind. Even with executives who are relatively healthy emotionally, you nearly always run across some of the characteristics described here, which need to be addressed in similar fashion (though not necessarily accompanied by medication and formal therapy).

What's the Difference Between Coaching and Therapy?

People often ask this question, and they get various answers. Some claim that the distinction lies in time orientation —that coaching focuses on the present and the future while therapy looks more at the past. Others draw a line between the conscious (coaching) and the unconscious (therapy). Still others see psychotherapy as a long-term treatment, and coaching as a short-term intervention.

These all seem rather artificial distinctions to me. It's fair, perhaps, to say that psychotherapists have more-intensive training in personality dynamics, while executive coaches focus more on the general work environment in which executives operate. But it's my conviction that therapists can benefit from knowing more about the organizational world, and coaches without training in psychology would do well to acquire its basics. In my own work, when appropriate, I often move from past to present and from conscious to unconscious material. Both as a therapist and as a coach, I've had some assignments that were short and highly focused and others that lasted for years.

While these disorders can be managed, some toxic leaders will prove impossible to change. (See the sidebar "The Incurable Executive.") Change can often be an uphill battle, in no small part because many companies support (and are even breeding grounds for) dysfunctional behavior. Fortunately, most

executives recognize when they have problems and have the strength of character to want to fix them, as the stories that follow will illustrate.

The Incurable Executive

It's hard to imagine that there are people who function without a conscience (except for the occasional historical tyrant or dictator). Nevertheless, sociopaths and psychopaths do exist, and they blend in very easily. Both types are the product of genetic and environmental factors, though sociopaths are more environmentally influenced while psychopathic disorders tend to be more hereditary and more dangerous. The bad news is that neither type of disorder can be cured.

I've learned from experience that psychopaths' and sociopaths' relationships with coaches usually take one of two forms. Individuals with these dysfunctions will either try to enlist the coach as an ally against the people who "forced" them to undergo treatment or try to impress the coach to gain some kind of advantage. In both cases they will "mirror" what you want them to be and claim that they have seen the error of their ways.

When I met Arnold, a highflier at a large consumer products company, he seemed really on the ball. He was good-looking, gregarious, and, not least, adept at sweet-talking me, but his deferential manner didn't sit well with me. I began by suggesting that he undergo a 360-degree evaluation exercise. He seemed eager to oblige, but when the results came back, feedback from a number of important people with whom he interacted (in particular, his subordinates) was missing. I asked him to do something about this, naming the people he should include.

As expected, the second report came back with sharply negative comments: Arnold never acknowledged his mistakes and always shifted responsibility for them to others. He broke promises and did not respect confidentiality. I let him make his own interpretation of the feedback, asking him how he experienced the information: What surprised him? What was fair and what was unfair? I knew that with people like Arnold you have to avoid arguments and head-to-head confrontations.

Despite my reservations, Arnold managed to convince his bosses that he had made progress, and they sent him to Southeast Asia to spearhead the firm's expansion in that region. A year later I read in the financial press that the company had been involved in a major bribery scandal. Arnold had initiated a kickback operation in which he was one of the major beneficiaries.

The Narcissist

The dysfunction most frequently found at senior levels is pathological narcissism. Narcissism is not something a person either has or hasn't. We all possess narcissistic characteristics to a degree. In fact, we need a modicum of narcissism to function properly—it's part of the immune system, if you will, defending us against the vicissitudes of life. It enables us to feel good about ourselves and to impose ourselves a little. But too much narcissism is dangerous. Driven by grandiose fantasies about themselves, pathological narcissists are selfish and inconsiderate, demand excessive attention, feel entitled, and pursue power and prestige at all costs.

How to Recognize the Condition

A good way to spot a narcissist is to look at how his subordinates respond to him. Let me tell you about Simon. When I first met him, he was regarded as one of the most promising senior executives in his company, although a number of directors had doubts about whether he was the right person to succeed the CEO. Would Simon be able to take the company to its next level? Did he have enough maturity? Given their doubts, I was asked by Agnes, the VP of talent management, to become Simon's executive coach with the aim of preparing him for possible succession.

Questions about Simon had begun to arise, Agnes explained, after he made a series of rash decisions, which raised a red flag about whether he understood what the corporation's culture was all about. Meanwhile his lobbying efforts to be elected "businessman of the year" had inspired resentment in the company. If that weren't enough, he had relocated the regional head office to a new, more upmarket location. It may have been the right decision (given the cramped conditions of the old office), but it had

turned out to be a lot more expensive than planned. Capping that (and here Agnes sounded exasperated), Simon was leasing a small corporate plane—his somewhat lame excuse being that it would save money, given the difficulties of connecting the head office to the other offices in the region.

Another criticism related to his deal making. Agnes told me that Simon had embarked on a dramatic expansion plan and discussed possible acquisitions with investment bankers, despite cautioning from the people who worked for him.

More generally, people in the organization viewed Simon as a "user"—he never reciprocated. One person said that he felt like part of the furniture on Simon's stage to success. Agnes told me that when she met with some of Simon's subordinates over drinks, they went on and on about their dislike of what was happening at the office. Some of the better people had already joined the competition; some had transferred to different units. It made her (and others) wonder whether Simon really was the golden boy.

Like many narcissists, Simon was anything but a wallflower. He was tall, well dressed, and friendly, with a somewhat seductive manner. He seemed easy to talk to; he didn't hold back and opened up quickly about his relatively short tenure at the company—telling me he'd been "poached" from a competitor and adding that the press had made a fuss about how costly a hire he'd been. He told me that he'd really liked his previous job, but given how things stood, the top job would not have been open for some time. That was the main reason that he'd accepted his present position. When I asked about his future, Simon made it apparent that he believed he was a shoo-in as the CEO's replacement. He obviously didn't think much of the other candidates.

Most revealing was the extent to which Simon lived in a binary world where people were either "for" or "against" him. He made quite clear that anyone against him would be a target. He'd already removed some of the more independent thinkers on his team. Executives who hesitated to take his side were easily cast as villains.

Coaching a Narcissist

Tempting though it may be to administer a loud wake-up call, the first rule when dealing with narcissists is to avoid anything that might upset their delicate sense of self. Typically, their grandiosity is a childhood coping mechanism compensating for a sense of inadequacy—of never being able to please a parent (although parental "overstimulation" without a realistic foundation can have a similar effect). Narcissists may seem very confident, but that confidence conceals a deep vulnerability.

The coach's first goal, then, must be to place the narcissist's self-esteem on firm foundations, not destroy it. You must convey respect and acknowledge his or her need to be recognized. Though you shouldn't reinforce grandiose self-perceptions (which would constitute a denial that anything was wrong with the executive's way of dealing with others), neither should you accentuate weaknesses (which could frighten the narcissist). Show empathy initially to gain trust, so you can begin to try minor confrontations of individual dysfunctional behaviors.

The key to success here is exploiting two aspects of a narcissist's relationships with others:

Transference.

Typically, narcissists have a binary tendency to idealize and devaluate. They're prone to transferring their childhood desire to please their parents onto other authority figures, and a coach is very likely to be one of them. Experienced coaches (who stay attuned to the fact that the pendulum can swing in the other direction) will use this propensity to establish a more secure working relationship that allows them to begin confronting the narcissist about his dysfunctions, pointing out how they're limiting him. Simon quickly saw me as an authority figure, and that allowed me to make mild suggestions about what actions might or might not improve his standing in the firm. For example, I was able to suggest that although the corporate jet might well be a practical asset for a busy executive, it may actually look somewhat ridiculous and perhaps perverse in a context of cost-cutting initiatives elsewhere—a comment he took to heart.

Competitiveness.

Narcissists' ambitions can be used to motivate them. With Simon I once went too far in a criticism, making him angry. He tried to persuade Agnes to cancel my engagement, but when we reminded him that he'd been assigned a coach because of his high potential to succeed the CEO, he was willing to continue, and over several sessions I managed to restore equilibrium. The challenge in drawing on ambitions, of course, is to avoid fueling the narcissist's grandiosity. It helps to keep conversations tactical. Tacitly accept the ambition and discuss how likely possible actions are to help or hinder the realization of the executive's goal. This improves the actual behavior and strengthens the coach's credibility.

Building self-confidence takes time, as it did in Simon's case. But gradually I could see him become less needy and more prepared to share the limelight. He slowly began to empathize with colleagues and become an effective mentor. All in all, his behavior was more grounded in reality and better attuned to the values of the company. The key decision makers there noted the changes and liked what they saw. When the time came for the CEO to retire, Simon was selected for the top job.

Unfortunately, narcissists all too commonly regress into their old ways, especially once they've achieved their ambition. For this reason, it's important to follow up with more engagement. To ensure the continuity of Simon's new self after his appointment as CEO, I suggested that he attend a CEO seminar I was running. I felt that these group sessions with leaders from other companies would help stabilize his new, more balanced self-image.

The Manic-Depressive

Manic depression, or bipolar disorder, is another psychological condition that some executives suffer from. Like most mental disorders, it varies in intensity, but even relatively mild forms can derail careers and alienate friends and colleagues.

How to Recognize the Condition

Let me share another experience I had, this one with a founder and CEO called Frank. People told me that dealing with Frank, a person for whom there seemed to be no emotional middle ground, often made them feel like firefighters; they were constantly running behind him putting out emotional blazes. But, despite his volatility, colleagues also noted how attractive and contagious Frank's energy and ebullience could be. What's more, he had a knack for drawing people to him—something that had contributed to the original success of the firm.

Yet Frank was now a major risk. The firm's situation was precarious: A big expansion attempt had failed, creating a serious liquidity problem, while a worrisome number of capable executives were leaving or looking for an exit. If Frank couldn't be reined in, the dissolution of the firm was a real possibility.

When I talked to Frank, it became clear that he had a bipolar disorder. Some years before (on the advice of his wife), he'd consulted a psychiatrist, who had prescribed him lithium. Frank acknowledged that it had helped him for a while but added that the experience had been mixed. Life with the drug was not as rich as life without it: It was more flat and less exciting and dampened his emotions. Whatever he did—looking at the garden, listening to the birds, talking with an associate, making a deal—was experienced much less deeply. He missed the "high highs," and he decided to stop taking the medication.

Frank was also no stranger to substance abuse. He would turn to alcohol when he was feeling manic, because it seemed to prolong and intensify his euphoria. He also confessed that he had experimented with cocaine.

I learned that his marriage, at the age of 23, had helped balance his moods. Recently, however, his wife had embarked on a part-time career, which had changed the dynamic in their home, as they saw less and less of each other. Frank began to spend even more time at the office and on the road. He reluctantly confessed that he'd had a number of affairs. He wasn't sure whether his wife knew, but it was apparent that his behavior had affected their relationship. According to Frank, he and his wife had become like ships passing in the night. He admitted that he longed for their previous intimacy.

Coaching a Manic-Depressive

Serious mood disorders like manic depression are usually treated with a combination of psychotherapy and medication. The problem is, manic-depressives are rarely receptive to receiving treatment (and Frank was no exception). Their reality testing is impaired: Whether manic or depressed, they have poor insight into how they are perceived by and act toward others.

Getting them to admit that they have a problem is a main challenge. Here, the best approach is the opposite of what you would do with narcissists: Make manic-depressives confront the reality of their relationships with others and work with the people they affect to create a new structure in which they can operate safely. In this kind of situation a coach would do well to draw on the help of others (in Frank's case, his spouse and supporting executives).

Partners and family.

I suggested to Frank that it would be useful to meet his spouse—an atypical coaching request. But given her role in helping Frank stabilize his moods, I believed that it was essential to have his wife as an ally. To get his approval, I said it was important for me to know what her wishes and goals were, since he needed to better understand her perspective. After developing a working alliance with both of them, I explored with Frank various scenarios about how he saw himself in the future. What did he really want? Where would he like to be? Who would be a part of his life? Once Frank realized what was happening to his relationship with his family, he had an incentive to do something about his behavior.

Colleagues.

At the same time, I talked to Frank's executive team and a number of nonexecutive directors about what they felt was particularly disruptive about his behavior. Before I did, I got Frank's permission, of course, explaining that I had to get a sense of how he was perceived in the organization. At first I talked to these stakeholders separately, but then I brought Frank into the discussions. In these conversations he began to recognize that he needed to play a different role in the company, one that got him away from day-to-day activities, where his penchant for micromanagement was causing stress. He decided to appoint a chief operations officer to handle those responsibilities. Frank recognized that his greatest contributions came from his contacts with important clients. That was where he should put his energy.

Even though they have trouble admitting it, manic-depressives (unlike narcissists) are at some level aware that they have a problem, which is why you can more easily confront them with the truth and work with them. Over six months I managed to help Frank figure out how to restructure his job, which helped him stabilize his mental state, both at work and at home. At the end he began working regularly again with a psychotherapist, and he has since begun to take medication.

The Passive-Aggressive

This term describes a person who expresses negative feelings indirectly and shies away from confrontation. The behavior originates in families where the honest, direct expression of desires is forbidden; children quickly learn to repress their feelings and are very reluctant to be assertive. They go through life being outwardly accommodating but obstructive in an underhanded way. What's more, their feelings may be so repressed that they don't consciously realize that they're being uncooperative. So when others get upset by their behavior, they take offense, because in their minds whatever caused the irritation was someone else's fault.

How to Recognize the Condition

Though passive-aggressive executives overtly agree to requests, they covertly express their resentment of them by missing deadlines, showing up late for meetings, making excuses, or even undermining goals.

They tend to use procrastination, inefficiency, and forgetfulness to avoid fulfilling obligations. Although they can become dysfunctional when pushed, if they're not feeling pressured, they can produce high-quality work—which explains why some manage to reach senior executive positions. They themselves are usually the principal victims of their behavior. Take Mary, who was referred to me by a senior executive I had been working with for some time. He told me that he thought she had a lot of potential but somehow never delivered on that promise. Listening to his lament, I realized that I might be dealing with a passive-aggressive person, and my first meeting with Mary confirmed my suspicion. I experienced her as cold, passive, and even somewhat depressed.

When I asked about her colleagues and her boss, she described them as unreasonable. Whether she felt that she herself played a role in the poor chemistry was not apparent. Indeed, when I asked her why she was seeing me, she could not give a coherent answer. The only thing she could come up with was that her boss had told her it would be a good idea. She didn't seem to realize (in spite of having gone through a 360-degree feedback exercise) that others were perturbed by her behavior.

Coaching a Passive-Aggressive

Passive-aggressives need to resolve their hostility toward authority figures. To help them do that, the coach has to encourage transference. By getting Mary to see me as an authority figure, I would attract her anger, which would allow me to work on helping her express it in a healthier, direct manner. This work involved:

Consistent confrontation.

Every time that Mary was passive-aggressive with me I'd say something like: "Mary, it seems to me that you are angry at me. Is that what you are experiencing?" I would also point out the inconsistencies in her behavior. Of course, she would resort to denial or evasion—often citing forgetfulness as an excuse when she hadn't done what she was supposed to—but it became increasingly difficult for her to get away with it. I was always careful, however, to accept her defensive reactions for the time being. When dealing with people like Mary, you should never argue or correct denials; just quietly back away, leaving them to reflect on your comments. Passive-aggressives see arguments as an invitation to cast themselves as victims, making you the bad guy, and they are very experienced at it. By sharing my awareness of her covert anger, I gave Mary the message that her style was not the way to deal effectively with interpersonal relationships.

Practicing better behavior.

Passive-aggressives have low self-esteem, and the coach has to help them build it up. This is best done by getting them to practice directness and asking them to explain how they would resolve or improve situations they find themselves in. In the beginning Mary would hem and haw, but over time I persuaded her to stick her neck out. I also assigned her specific tasks, putting them in writing. If she didn't deliver, I expressed my disappointment with her directly, factually, and unemotionally. I would say that I was confused by her behavior: Why did she keep doing what she was doing? Why not find a better way? If she wanted to continue our coaching sessions, such behavior needed to stop. At the same time, I devoted a considerable part of each session to acknowledging her strengths.

Exploring the family.

Mary needed to recognize the causal relationship between her tendency to procrastinate and the resentment she felt toward the person making the request. Discussing her original family dynamics helped Mary understand why she was the person she was; it quickly came out that it had been very difficult for her to stand up to her authoritarian father. The analysis of her childhood led to a general discussion of the way she dealt with authority figures—including me—and her frequent anger toward them, which she gradually came to acknowledge. Some of our discussions also centered on the way Mary dealt with her own family. We explored how her style affected her children—and what the

consequences would be. After all, she wanted them to be happy, and the way she was treating them was no prescription for happiness.

Coaching passive-aggressives is exhausting. They're irritating because they subtly show that they feel a sense of accomplishment when they've managed to frustrate you. It took a lot not to let Mary get to me. But as time passed, she took the first baby steps of trying to interact with people in a different way. She would practice expressing her irritation more directly and then report her successes and failures back to me. And because she generally liked the results, she gained the assurance to continue down the right path. Eventually, I expressed confidence that she could go on without my help. Thereafter, I saw her a few times to check that she had not fallen into her old habits.

The Emotionally Disconnected

The previous cases deal with executives who may be troublesome but can also be quite charismatic—the kind of people who don't leave you emotionally untouched. But with the fourth type of pathology, a lack of feeling rather than an excess of it gives rise to difficulties.

The term psychiatrists use for these people is alexithymia, which comes from the Greek and means "no words for emotions." Alexithymics are literal-minded, display little imagination, and typically are unable to describe or even recognize their feelings. This inability makes it difficult for them to interpret the many and often complex emotional signals they receive from others, which they perceive as dangerous, potentially uncontrollable forces.

That doesn't mean alexithymics cannot be successful, particularly within large, bureaucratic organizations where playing safe, making the right noises, predictability, and relative inconspicuousness are rewarded. But in other kinds of organizations, they provide entirely the wrong role models for others. Since alexithymics don't exude the dynamism, inspiration, or vision that a high-performing organization needs, it's hard for them to motivate others. Having poor communication skills and being hard to read, they don't get the best out of people. And because they have difficulty dealing with the unpredictable, they may get in the way of progress. Their emotional absence puts a negative stamp on an organization's culture, discouraging creativity and innovation.

How to Recognize the Condition

One executive—let's call him Robert—came to me because he felt he was at a dead end in his firm. Until recently, he had been quite successful in his career, but after changing jobs he seemed to hit a wall. When I asked about his new job, he mentioned that he felt uncomfortable with its lack of structure. It wasn't clear to him what he was expected to do; there was a great fluidity in relationships and structures.

Robert had left a technical function in a government job to become the chief information officer of a private company, a position that required considerable interpersonal skills. Robert saw that he had difficulties integrating himself with the executive team. Not knowing what to do, he spoke with a colleague in HR, who suggested that he try to work on his emotional intelligence—the reason he came to me.

At our first meeting, I was struck by the mechanical manner in which Robert answered my open-ended questions—always completely matter-of-fact. From the way he talked about friends and family members, I also inferred that he did not have any intimate relationships. When I asked how he saw his future, his imagined scenario was devoid of any emotional content. His fantasy life and emotional memory seemed impaired.

When I asked how he felt under stress, he mentioned stomach pains, muscle tension, and headaches, but was unable to articulate the corresponding feelings. That's typical of alexithymics: They feel physically unwell rather than recognize emotional reactions. It was clear that Robert didn't understand why his body acted the way it did.

Despite their physical complaints, you should resist any temptation to recommend medical interventions to alexithymics. (Physicians, take note.) In Robert's case, his doctor (obviously at her wit's end) had sought to refer him to a psychiatrist or a psychotherapist, but he had not chosen that option.

Coaching the Emotionally Disconnected

Because alexithymics are not the most engaging clients, there's a risk that their coaches will get bored, which may undermine their effectiveness. And there is no direct medication for this disorder, although antidepressants can help people with it focus on feelings and interpret inner experiences. With Robert, my goal was to gradually get him to recognize and react appropriately to emotions. Our engagement had two phases:

Fixing immediate problems.

What works best for me when dealing with people like Robert is first to explore and find solutions to their immediate interpersonal problems. To build a trusting relationship with Robert, therefore, I needed to help him become more effective in his day-to-day work environment, and in our initial sessions I focused on this. When I asked whether anything had recently happened at work that puzzled him, he mentioned the strange behavior of his new assistant, who had suddenly burst into tears in his office. When I pressed him on what he had felt when that happened, he said, "Not much." It only gave him a headache. When I asked what he'd done to stop his assistant from crying, he said, "Nothing." But he had asked her to return to her office. I asked whether it might have been more helpful to inquire what her problem was—and if there was anything he could do to help her. He responded that he hadn't thought about it, but if such a situation recurred, he would try to follow my advice.

Describing the pain.

Once I'd built up Robert's confidence in the coaching process, I started getting him to describe more-difficult encounters at work, pushing him to say which part of the experiences had caused him pain. When distress had manifested itself physically, we developed a story about these symptoms—why they happened, what they represented, and how they fit within the chain of events described. After many sessions, Robert began to recognize the link between his symptoms and emotionally disturbing events in his life. As we progressed, he displayed an increasing depth of feeling, and it dawned on him that sharing it with others would be beneficial in his work. He became more playful and less mechanical.

Other approaches can also work with alexithymics. I've found that group and family therapy can help coachees learn to recognize, tolerate, and verbalize the emotional spectrum. It gives them a chance to practice reflective self-observation. Behavioral techniques such as biofeedback, relaxation training, autogenic training, guided imagery, and hypnosis may also help. These techniques may give people with the disorder a sense of control over stressful responses, increasing their awareness of the relationship between bodily sensations and the events around them.

Like the Tin Man, who discovered that he had a heart, alexithymic executives can learn to deal with emotions. When they do, the change in how they relate to others goes a long way toward inspiring the best from their people, raising morale, and making their organizations more exciting places to work.Sigmund Freud once told the novelist Stefan Zweig that all his life he had been "struggling with the demon"—the demon of irrationality. Executives who fail to recognize their irrational side are like ships facing an iceberg, forgetting that the greatest danger lies below the surface. Effective executives know how to combine reflection with action by using self-insight as a restraining force when the sirens of power beckon them. It is here that the executive coach can help by pointing out the extent to which unconscious, seemingly irrational processes affect behavior.

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18 SEP 2023

Opslaan Reacties 0 Delen

Mishandelde kinderen zelf vaak ook gewelddadig tegen ouders

Kinderen die te maken hebben met kindermishandeling zijn zelf vaak ook gewelddadig tegen hun ouders, blijkt uit een studie van het Verwey-Jonker Instituut. Twee op de drie mishandelde jongeren zegt zelf geweld te gebruiken tegen hun vader of moeder.

Het Verwey-Jonker Instituut volgt gezinnen die kampen met huiselijk geweld sinds 2009. Uit dat onderzoek bleek al dat dergelijke mishandeling en verwaarlozing schadelijker is voor kinderen dan gedacht en dat het geweld ook na een melding bij Veilig Thuis in ruim de helft van de gevallen nog doorgaat.

Dit keer keek het instituut ook naar oudermishandeling door hun kinderen. Dat gebeurt vooral psychisch, dat wil zeggen dat kinderen hun ouders uitschelden, treiteren, kleineren of bedreigen.

Aangeleerd

De kinderen willen niet hetzelfde gedrag vertonen als hun ouders, maar kunnen niet anders, zegt de wetenschappelijk directeur van Verwey-Jonker Majone Steketee. ‘Ze hebben gewoon nooit een andere manier geleerd om met ruzies en conflicten om te gaan.’

'Ze hebben zich eigenlijk aangeleerd dat je je dan gewelddadig moet gedragen. Deze kinderen weten niet dat je zulke problemen ook kunt oplossen door te praten en te luisteren.'

Dat leidt er volgens haar ook toe dat er een grote kans is dat deze jongeren in hun liefdesrelaties geweld gaan gebruiken of er slachtoffer van worden.

Cirkel doorbreken

Steketee noemt het zorgelijk dat het om zo'n groot deel van de mishandelde kinderen gaat die zelf ook geweld gebruikt. Ze vindt dat de hulpverlening nog veel meer aandacht moet hebben voor de kinderen, juist omdat zij de ouders van de toekomst zijn.

'We weten al heel lang dat geweld van generatie op generatie wordt doorgegeven', zegt Steketee. 'Maar deze cijfers zijn echt veel hoger dan ik had verwacht. Dat vraagt om een andere, gerichtere aanpak om deze kinderen te leren anders met conflicten om te gaan. Willen we de cirkel doorbreken, dan zal je de kinderen van nu echt goede hulp moeten bieden.'

Bron: NOS

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