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MATERNAL CONTROL, SHAME AND ALEXITHYMIA

A Thesis
Presented To
Eastern Washington University
Cheney, Washington

In Partial Fulfillment of the Requirements
For the Degree
Master of Science in Experimental/General Psychology

By
Alyson Pogue
Spring 2018

Abstract

There is research to suggest that a girl's negative relationship with her mother can affect her psychological adjustment as an adult. One example of this negative relationship is a mother who excessively controls her daughter. This type of negative relationship is associated with many psychological difficulties, including alexithymia (i.e. the inability to identify and express what one is feeling) and shame (i.e. pervasive feelings of worthlessness and inadequacy; Kooiman et al., 2004; Kapur & Rai, 2013). A controlling mother can make her child feel like she lacks autonomy (i.e. she lacks a sense that she is capable of accomplishing important tasks on her own), and that which she does independently is always unacceptable. Excessive maternal control can lead to feelings of learned helplessness in girls, because they are not given the opportunity to learn how to trust their own instincts (Kapur & Rai, 2013; Uji, Kitamura, & Nagata, 2009). This sense of being incompetent when facing life challenges can lead to a global sense of shame. In turn, shame can lead to alexithymia (Zimmermann, Rossier, Meyer de Stadelhofen, & Gaillard, 2005). The results of a bootstrapped mediational analysis were consistent with the hypothesis that maternal control would be associated with higher levels of alexithymia via the indirect influence of shame.

THESIS OF ALYSON POGUE APPROVED BY

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Controlling Mothers, Shame, and Alexithymia

It is common to hear adolescent girls and women talk about how their mothers were too strict and controlling. This controlling behavior, by mothers, which includes trying to make her daughter feel dependent on her, invading her daughter's privacy, and not allowing her daughter to make her own decisions, can have an adverse psychological impact. For example, a controlling mother/daughter relationship has been associated with the daughter's over-reliance on others, being self-critical, feeling inferior, and exhibiting behaviors of emotional withdrawal (Symonds, 1939; Amitay, Mongrain, & Fazaa, 2008; Hare, Szewedo, Schad, & Allen, 2015).

On a basic level, a child's emotional and social development is largely dependent on their relationship with their primary caregivers, particularly the mother. John Bowlby is often cited for his research in parental bonding and the effects that separation, deprivation, and bereavement have on child development. In his early work, Bowlby asserted that when a young child is separated from her mother (or the person acting as the primary caregiver), the child is more likely to experience psychological difficulties (i.e. anxiety, depression, anti-social behaviors) as an older child or adult (Bowlby, 1952).

A primary goal of secure attachment is increasing a child's ability to self-regulate emotions and behaviors in an appropriate and healthy manner. In effect, a caregiver who is consistently responsive and soothing helps the infant build a foundation of emotional security (Posner & Rothbart, 2000). Emotional self-regulation helps control reactions to stress, maintain focused attention, and promotes the accurate interpretation of the mental states of oneself and others (Fonagy and Target, 2001). In one study of maltreated children, Shields, Ryan, and Cicchetti (2001) found that maltreated children who perceived their primary caregivers negatively also exhibited more emotion dysregulation, aggression, and peer rejection than children with

positive representations of primary caregivers. Similarly, Toth and colleagues (2002) found that maltreated children with a negative representation of their mother exhibited more internalizing (i.e. withdrawal, anxiety, and depression) and externalizing behaviors (i.e. aggressiveness and attention problems) than children with a positive representation of their mother.

Controlling Mothers

Controlling parenting can be defined as parenting that is intrusive of the child's privacy, discourages autonomy and personal growth, and uses guilt to control behavior (Parker, Tupling, & Brown, 1979). Controlling parents stifle self-confidence in their children and discourage the independent development of new skills (i.e. by a lack of scaffolding). There are three important dimensions of controlling parenting: affectionless control, affectionate constraint, and overprotection. In affectionless control, the parent does not display warmth toward their child and utilizes control as a primary means of discipline. Prior research has found that maternal affectionless control is a risk factor for the later development of anxiety and depression (Parker, 1983; Kerver, Van Son, & Groot, 1992; McGinn, Cukon, & Sanderson, 2005; Young, Lennie, & Minnis, 2011). Additionally, research has found a link between affectionless control and negative coping strategies (i.e. self-blame and rumination; Kraaij et al., 2002).

Affectionate constraint refers to a parent that is overprotective in a loving manner, trying to protect the child from harm. This can be seen in mothers who are considered to be "helicopter parents". Similar to affectionless control, the parent is over-involved and does not trust the child with autonomy. However, the parent is emotionally warm toward their child and provides support for the child's goals and ambitions. This type of control can be thought of as behaviorally controlling, rather than psychologically controlling, as in the case for affectionless control. The warmth and emotional support, even in the face of control, has had mixed results in

research. Padilla-Walker and colleague (2012) found a negative association between helicopter parenting, life satisfaction and positive parent-child relationships. Additionally, research has indicated a negative association between helicopter parenting and satisfaction in day-to-day family interaction as well as a child's lack of confidence in their own abilities (Schiffrin, et al. 2014).

Research regarding control on its own, without consideration of the dimension of care, tends to be more inconsistent, and not as widely researched. However, there is some indication that maternal control is associated with depressive symptoms, anxiety, and negative thinking in their child (Hall, Peden, Rayens, & Beebe, 2004; Ispa et al., 2004; Thirlwall & Creswell, 2010). In one such study, de Wilde and Colleague (2008) conducted an experiment that asked mothers to help their child prepare for a speech in either an over-controlling or minimally controlling manner. There was an indication that the children whose mothers were over-controlling displayed more anxiety than those whose mothers were minimally controlling during preparation of the speech.

Maternal Control and Shame

Shame can be defined as a pervasive and global feeling of worthlessness and inadequacy. Due to confusion in use and definition, it is important to understand the distinction between shame and guilt. Guilt is feeling bad for something you have done. This feeling of guilt develops as a motivator to alter behaviors that one has learned are morally or ethically wrong. Because of this opportunity for alteration in behavior, guilt can promote prosocial behavior and lead to a person becoming more socially adept. Shame, on the other hand, develops as an internal sense that the global self is powerless, unacceptable and flawed (Tangney & Dearing, 2002). This emotional distress leads to symptoms (i.e. depression, withdrawal, and anxiety, aggression) that

ultimately hold the person back from living their life in a productive and healthy manner (Stuewig & McCloskey, 2005). Thus, shame is more likely to lead to an inability to form positive relationships with others because the child lacks understanding of social cues and an ability to cope with negative interactions in a healthy manner.

An object relational/attachment perspective on the development of shame suggests that insecure attachments with primary caregivers affect a child's social and emotional development, thereby increasing the child's proneness to shame (Mills, 2005). Research has indicated that a parent's unresponsiveness can lead to disengagement and emotional distress. In an experiment by Tronick and colleagues (1978), a parent is instructed to interact with their infant (i.e. at 4 months old) for a period of time, then turn away. When they turn back toward the child, they are instructed to remain straight-faced, and to not interact with the child in any way. The typical response of the child is to first attempt to engage the parent by smiling, making noises, and moving their hands and head. When the parent does not respond to their attempts, the child begins to divert eye contact and begins to cry.

While there is no evidence that the still-face experiment elicits shame in infants, it does support the affect relational theory that, in infancy, a child expects a positive response from her caregivers, and a disruption in the expected response causes distress. In the case that a caregiver is consistently angry toward the child, belittles her, and controls her behavior with guilt, humiliation, or coercion, the child receives messages that she is consistently doing something wrong (Kaufman, 1985, 1989). As the child grows older, she internalizes these messages and determines that she must be defective. This internal perception of defectiveness affects the whole self, leading to feelings of shame in multiple aspects of the child's life (i.e. in emotions, school, relationships with peers, activities).

Research has indicated that higher parental control is associated with higher levels of shame. That is, the more controlling a parent is, the more shame a child will experience. Mills (2003) conducted a longitudinal study in girls and detected a positive association between an authoritarian parenting style, by both parents, at 3 years of age, and a shame response (i.e. reaction to failure and criticism), by the child, at 5 years of age. Mills (2003) suggested that the lack of positive feedback by the parents toward their daughter and a preference for coercive and negative means of discipline were a distinguishing factor between the girls who had shame responses and those who did not. Similarly, Wang and colleagues (2007) confirmed their hypothesis that children with psychologically controlling parents would have increased emotional ill-being (i.e. often feeling ashamed, depressed, angry, or worried). These results suggest that parental psychological control has detrimental effects to a child's emotional development and regulation.

Shame and Gender

Shame research suggests that girls experience shame more frequently than boys (Tangney & Dearing, 2002; Woien, Ernst, Patock-Peckham, & Nagoshi, 2002; Walter & Burnaford, 2006; Akbag & Imamoglu, 2010). Cultural child rearing practices are thought to play a role in the differences between girl's and boy's shame; that is, adult caregivers more often criticize girls in relation to behavioral expectations, whereas boys are excused as "boys being boys." In relation to emotional criticism, girls are often taught that they must be polite, quiet, and to resist emotional outbursts. Boys, on the other hand, are often not criticized for angry outbursts, and are often encouraged to be loud and aggressive. Ferguson and colleagues (2000) assert that these differences in emotional and behavioral acceptance lead to more shame in girls because there are more identities that girls find undesirable. While these undesirable identities also exist for boys

(i.e. performing poorly in sports, earning money, crying, expressing intimacy), they are not as global, instead persisting mostly in the realm of traditional traits of masculinity and power over their environment. Additionally, boys will more often use anger to deflect focus from the self to others (Ferguson, Eyre, & Ashbaker, 2000).

Shame and Alexithymia

Alexithymia, which literally means “a lack of words for feelings” was originally proposed by Sifneos in 1972 and can be defined as obstruction of the ability to identify what one is feeling and to express it. Originally investigated in psychosomatic patients at a psychiatric facility, Sifneos and his colleagues observed patients who had difficulty describing their emotions, and were noted to have suppression, repression and denial of affect (Sifneos, 1996). Additionally, people with alexithymia are unable to identify bodily sensations related to emotional arousal, often rationalizing the sensations to their external environment (i.e. if they are crying, they might state that their eyes are watering, without recognition that they are feeling sad).

Research has indicated that alexithymia is associated with shame (Suslow, 1998; Zinnermann, Rossier, Meyer de Stadelhofen, & Gaillard, 2005). The experience of shame can affect the way a person perceives themselves. That is, they perceive their feelings as something that is wrong with them, versus the recognition that all people have negative emotions and that it is normal. This experience of shame may lead to emotional withdrawal as a way to avoid the constant pain of these feelings (Franzoni et al., 2013). While this maladaptive coping strategy serves to protect them initially, the long-term effects of alexithymia result in a lack of social functioning. It's been suggested that the emotional withdraw experienced in response to shame essentially stunts one's development of an internal representation and emotional self-regulation,

leading to an inability to interpret and communicate their emotional states (Fonagy & Target, 2002). When emotions cannot be understood and expressed, effective and healthy coping skills that are needed to regulate negative emotions and social situations will be under-developed, leading to difficulty in problem-solving, negotiating social situations, and relying on social support (Skinner & Zimmer-Gembeck, 2007; Powell, Coll, Trotter, Thobro, & Haas, 2011).

Maternal Control and Alexithymia

There is evidence to suggest that alexithymia can develop as a response to various negative childhood experiences (i.e. childhood abuse, neglect, insecure attachment, maladaptive parenting styles), and is a trait found in those with Post-Traumatic Stress Disorder, eating disorders, anxiety, depression, dissociation, and maladaptive anger, among many others (Sifneos, 1996; Aust, Hartwig, Heuser, & Bajbouj, 2013; Grynberg, Luminet, Corneille, Grezes, & Berthoz, 2010). Alexithymia has also been linked to insecure attachment patterns (i.e, avoidant and anxious), parental control, and a negative family environment. A failure to model positive expression of emotion and provide a supportive environment can lead to a child's inability to understand and regulate her emotions (King & Malindkrot, 2000; Fukushimi & Paris, 2001; Kooiman et al., 2004; Spitzer, Siebel-Jurges, Barnow, & Grabe, 2005; Kench & Irwin, 2000; Thorberg, Young, & Sullivan, 2011; Taylor, Bagby, Kushner, & Atkinson, 2014). This could be because there is no secure base (i.e. a mother who allows her child to express herself and helps her communicate about emotional experiences) that the girl can learn to associate physiological symptoms to distinct emotions (Fonagy and Target, 2002).

The Present Study

The present study aims to add to prior research regarding the development of alexithymia and its antecedents. On the basis of previous theoretical and empirical research, it was hypothesized that maternal control would be associated with alexithymia via the indirect influence of shame. It was also hypothesized that there would be positive correlations between maternal control and shame, shame and alexithymia, and maternal control and alexithymia.

Method

Participants

Participants included 131 undergraduate females between the ages of 18-24 years, who were recruited from undergraduate courses at a university in Eastern Washington. Two cases were deleted due to incomplete measures. Other demographic information included ethnicity (86 Caucasian/White, 23 Hispanic/Latino, 5 African American/ Black, 10 Asian/Pacific Islander, 2 Native American/American Indian, 5 Other/Prefer not to say) and who participant was primarily raised by (82 by both parents, 41 by mother, 6 by father, 2 by another caregiver).

Procedure

Participants completed self-report scales that measured their perception of the bond to their primary caregivers during the first 16 years of their lives, their perception of their experiences of shame, and traits of alexithymia. The questionnaires were distributed in a paper and pencil format to undergraduate students enrolled in psychology courses. Students received extra credit, by their professors, for their participation. The series of questionnaires took approximately 20-25 minutes to complete. All participants were informed of the study, the

potential risks, and their voluntariness to participate via an enrollment script that was read to them within 24 hours of the data collection, and right before the measures were distributed. All participants were anonymous. All procedures were reviewed and approved by the university's Institutional Review Board.

Design

The present study was analyzed using bootstrapped multiple mediational analysis. The independent variable was cold parenting and the dependent variable was alexithymia. Shame was assessed as the mediator.

Measures

Parental Bonding Instrument (PBI): The PBI (Parker, Tupling & Brown, 1979) is a 25-item self-report scale rated on a 4-point Likert scale ranging from 1 (very unlike) to 4 (very like). The PBI measures retrospective childhood attachment to primary caregivers. It includes subscales for “care” and “overprotection” or “control”, and is separated for maternal and paternal figures. The present study utilized the items for “overprotection” in assessing the variable of maternal control. Examples of these items included “tried to control everything I did”, “tended to baby me”, and “was overprotective of me”. The PBI “overprotection” subscale has a Cronbach's alpha of .63 for maternal indicating acceptable internal consistency.

Experience of Shame Scale (ESS): The ESS (Andrews, Qian & Valentine, 2002) is a 25-item self-report scale rated on a 4-point Likert scale ranging from 1 (not at all) to 4 (very much). ESS measures shame with 3 subscales: characterological shame (shame of personal habits, manner with others, sort of person you are, and personal ability), behavioral shame (shame about doing something wrong, saying something stupid, and failure in competitive

situations), bodily shame (feeling ashamed of your body or any part of it). Each subscale measures an experiential component (“Have you felt ashamed of any of your personal habits?”), a cognitive component (“Have you worried about what other people think of the sort of person you are?”), and a behavioral component (“Have you tried to cover up or conceal things you felt ashamed of having done?”). The total scale has a Cronbach’s alpha of .92, indicating good internal consistency.

Toronto Alexithymia Scale- 20-item (TAS-20): The TAS-20 (Bagby, Parker & Taylor, 1994) is a 20-item self-report scale rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). TAS-20 measures alexithymia with 3 subscales, including; Difficulty Describing Feelings, that consists of 5 items (“I find it hard to describe how I feel about people”), Difficulty Identifying Feelings, that consists of 7 items (“I am often confused about what emotion I am feeling”), and Externally Oriented Thinking, that consists of 8 items (“I don’t like looking for hidden meanings in movies or plays”). The total scale has a Cronbach’s alpha of .81, indicating good internal consistency.

Results

Correlations

It was predicted that there would be positive correlations between maternal control (PBMCON) and shame (SHAME), shame and alexithymia (TASTOT), and maternal control and alexithymia. As predicted, maternal control was positively correlated with shame ($r = 0.33, p < .01$), shame was positively correlated with alexithymia ($r = .43, p < .01$), and maternal control was positively associated with alexithymia ($r = .26, p < .01$). See Table 1 for correlation matrix.

Bootstrapped Multiple Mediation Analysis

Bootstrapped multiple mediational analyses were completed to assess the hypothesis that maternal control would be statistically associated with alexithymia via the indirect influence of shame. PROCESS was used to conduct these analyses, which allows for testing of mediational models with bootstrapped confidence intervals (CI). A mediation consists of 5 pathways; Path A represents the relationship between the independent variable and the mediating variable, Path B represents the relationship between the mediator and the dependent variable, Path C' (direct effect) represents the relationship between the independent variable and the dependent variable, and Path ab (indirect effect) represents the indirect relationship among the independent variable and the dependent variable, via the mediator. Finally, Path C represents the total effect, that is the combination of the indirect effect and direct effect. To be considered statistically significant, the confidence interval (95%) of an indirect relationship must not contain 0.

Figure 1 demonstrates the bootstrapped multiple mediational analysis used to test for association among maternal control and alexithymia via the indirect influence of shame. Consistent with the hypothesis, the analysis showed a significant indirect effect of maternal control, $B = .17$, $BootSE = .06$, $95\% BootCI = [.0698, .3251]$ on the association of alexithymia via the influence of shame.

Discussion

The results of the present study indicated that maternal control was associated with alexithymia via the indirect influence of shame. It has been established that children whose mothers have an authoritative parenting style (i.e. set limits and boundaries, but are also supportive of autonomy, are warm toward their child, and utilize modeling and scaffolding in their teaching) have fewer psychological issues as adults, have higher self-esteem, and have more secure interpersonal relationships (Milevsky, Schlechter, Netter, Keehn, 2006). Consistent

with these prior findings, the correlational results of this study indicated that maternal control may adversely impact the long-term emotional development and self-regulation of girls.

Presumably, a lack of support and guidance for personal autonomy leads to shame, and, in turn, the pain of shame leads girls to emotionally withdraw from herself and others (i.e., become alexithymic).

These results have many implications for families and clinicians. The potential consequences that maternal control has on shame, and ultimately, alexithymia, make it important to help mothers understand the importance of autonomy granting and positive regard toward their daughter. Parents can help promote autonomy by assessing their child's zone of proximal development, originally proposed by Vygotsky (1978). In this approach, parents are sensitive to their child's cues and provide support in activities that are just out of reach of the child's ability to accomplish independently. By the use of scaffolding (Wood, Bruner, & Ross, 1976), the parent first supports the child's task completion, then as the child increases her ability to complete a task herself, the parent provides less support until the child reaches the stage of autonomous functioning. While the parent is providing support for the child, in turn, the child builds skills and confidence, thereby decreasing the potential for the development of shame.

Piaget's stages of cognitive development is another important consideration in relation to providing the necessary support for a child's healthy development. Piaget theorized that children gain cognitive skills through assimilation. During exploration of their environment, a child will assimilate prior experiences to new ones, leading to further development in their thinking and problem-solving skills. Maternal control can lead to a decrease in a child's ability to perform tasks and solve problems independently (Fei-Yin Ng, Kenney-Benson, & Pomerantz, 2004). Allowing a child to safely explore her environment and encouraging her to solve problems on

her own can lead to a sense of accomplishment, build self-esteem, and teach her emotional self-regulation.

According to Erik Erikson, a child's development is at least partially dependent on how they interact with their primary caregiver. Erikson (1964) theorized that children are born insecure. That is, their lack of experience makes children unsure of their surroundings and how they are to react to various daily tasks and challenges. It is the job of primary caregivers to provide security and build trust so that the child can feel more confident in pursuing activities and developing skills. When this base of trust and consistency in experience is not provided, the child develops anxieties, depression, and anger. Additionally, Erikson's developmental stage relating to autonomy has linked the lack of self-control to later development of shame and doubt. This stage involves developing the independence that increases survival skills (i.e. walking, climbing, problem solving). Micro-managing the child's attempts to achieve independence makes her feel that she is inadequate, (Erikson, 1964). This shame and doubt can cause the child to become self-reliant on others and lack the self-esteem to further explore her environment and attempt to learn new skills, thereby stunting her ability to develop successfully in other stages.

Identifying experience of shame as a partial mechanism for a stunted emotional development could have implications for treatment. Interventions, such as Compassion-Focused Therapy (CFT) could be used to help reduce shame and to increase one's ability to understand and express a wide range of emotions. CFT is based upon the principle that compassion towards oneself forms the cornerstone of healthy emotional development. Self-compassion is the ability to understand that all people have strengths and weaknesses, and weaknesses do not have to be experienced as shameful (Kolts, 2012). In general, people accept weaknesses in others, but are critical of their own perceived shortcomings, resulting in a defensive retreat from difficult

emotions. Self-compassion can be cultivated by early relationships with our parents, but when parents are overly critical and controlling, the child is not receiving the assurance that their weaknesses are acceptable and that it is appropriate to build skills through the process of trial and error. Instead, controlling parents micromanage their children, thereby undermining their drive towards self-acceptance, self-confidence, and autonomy.

The results of this study suggest that parents should adopt an authoritative parenting style, defined by emotional warmth, an acceptance of children's natural drive towards autonomy, while setting the firm limits and boundaries that all children require for their own safety (Baumrind, 2013). Presumably, authoritative parenting should reduce the tendency towards self-perfectionism that leads to shame and emotional withdrawal. On the other hand, this study indicates that high maternal control of daughters leads to shame and alexithymia that persists into emerging adulthood.

Limitations and Future Research

This study has some limitations that deserve mention. First, this study only used participants who were female and between the ages of 18 and 24 years old. Therefore, the results may not be applicable to males or to females outside of this age range. For the purpose of this study, it was decided that limiting the age range would help maintain consistency in life stages. Older participants with more life experience may develop different perceptions of their upbringing as they mature. Additionally, their levels of shame and alexithymic traits may change over time with life experience, maturity, and relationships.

Second, the self-report methodology utilized in this study may limit interpretation of the results. Future studies may be able to better analyze the aspects of maternal control in relation to

shame and alexithymia by conducting interviews with more direct questions about what maternal attitudes and behaviors the participant perceives as having attributed to the development of shame and alexithymic traits. It would also be beneficial for future research to study the variables longitudinally.

Third, the ethnic diversity of participants in this study was limited. With over 65% of participants considering themselves Caucasian, the results may be more accurate for this race than for others, when controlling for cultural differences between races. It could be that what one culture considers to be controlling, is considered normal in another culture, and therefore not maladaptive. Future research could examine the differences between cultures, in regard to the study variables.

Table 1

Descriptive Statistics for Main Study Variables

Variable	Mean	SD
Maternal Control	26.67	6.98
Shame	61.57	17.25
Alexithymia	55.86	10.00

Percentage of Sample (%)

Ethnicity

Caucasian/White	65.2
Hispanic/Latino	18.2
African American/Black	3.8
Asian/Pacific Islander	7.6
Native American/American Indian	1.5
Other/Prefer not to say	3.8

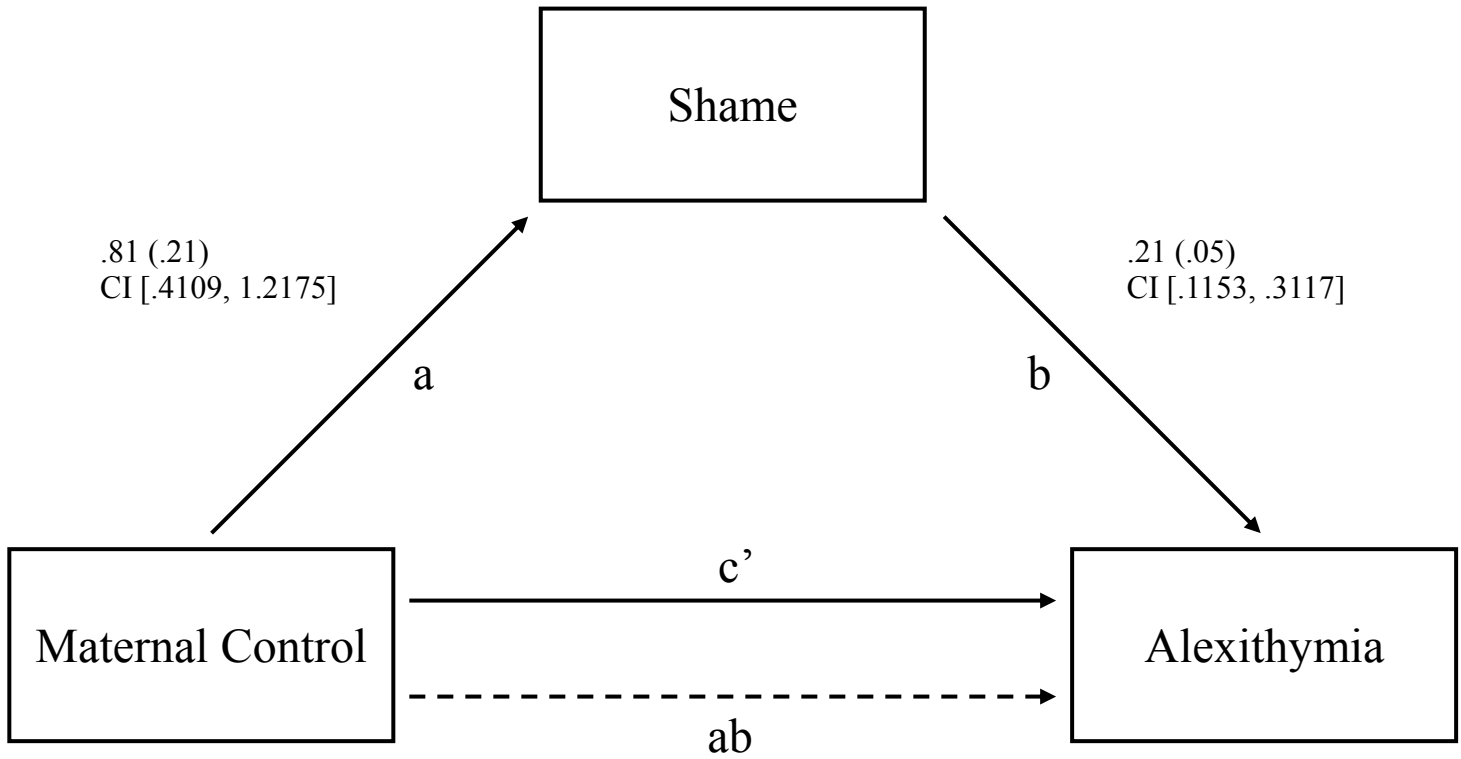
Raise By

Both Parents	62.9
Mother	31.1
Father	4.5
Another Caregiver	1.5

Table 2

Variables	1	2	3
1. Maternal control	---	.33*	.26*
2. Shame		---	.41*
3. Alexithymia			---

Figure 1



Total effect (c) = .37 (.12); CI = [.1299, .6163]
 Direct effect (c') = .20 (.12); CI [-.0412, .4417]
 Indirect effect (ab) = .17 (.06); CI [.0698, .3251]

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