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Predicting Childhood Trauma Based on the Unconscious with the Mediating Role of Alexithymia in Adults with Social Anxiety Attending Counseling Centers in Tehran

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A B S T R A C T

Objective: The present study aimed to predict childhood trauma based on the unconscious with the mediating role of Alexithymia in adults with social anxiety attending counseling centers in Tehran.

Methods and Materials: The research method was fundamental in aim and descriptive-correlational in design. The study population included all adults with social anxiety attending counseling centers in Tehran. Samples were selected from Tehran through a non-probabilistic and purposeful method. Considering the number of observed variables and allocating a coefficient of 15 for each observed variable, 240 individuals were chosen as the sample size. The data collection tools were the Childhood Trauma Questionnaire by Bernstein et al. (1988), the Alexithymia Scale by Bagby et al. (1994), and the Unconscious Awareness Questionnaire by Bell (2000). Data analysis was conducted using Pearson correlation coefficient analysis and structural equation modeling. SPSS-24 and AMOS-26 software were used for data analysis.

Findings: The results showed that the indirect relationship of the unconscious to childhood trauma through Alexithymia is significant at $\beta=0.24$ and $p\leq0.05$. It can also be said that since the zero is not included in the upper and lower limit range, Alexithymia plays a mediating role in the relationship between the unconscious and childhood trauma.

Conclusion: Considering the theoretical validation of the research findings, health and treatment specialists are advised to develop educational and therapeutic programs for individuals with symptoms of social anxiety at the clinical level.

Keywords: *Childhood Trauma, Unconscious, Alexithymia, Social Anxiety*

1. Introduction

Social anxiety is characterized by persistent and specific worry and fear of one or more social situations (such as conversation or meeting with strangers, eating or drinking, or speaking in the presence of others) where the individual feels their actions and behaviors are being evaluated, leading to avoidance of social situations and interpersonal relationships. Social anxiety disorder is the fourth most common psychiatric disorder, with a lifetime prevalence reported to be near 12% (Hur et al., 2020; Van Niekerk et al., 2017). Individuals with social anxiety tend to avoid initiating contact with others, avoiding any situation that might expose them to others' judgment, characterized by a feeling of fear and unusual persistence. Social anxiety is identified by physiological features (blushing, sweating, dry mouth, and trembling in anxiety-provoking social situations), psychological traits (shame, shyness, fear of making mistakes, fear of negative evaluation, and fear of criticism), and behavioral characteristics (withdrawal, avoiding eye contact, fear of assertiveness, and fear of speaking in public or being addressed) (Kirk et al., 2019). This fear, anxiety, or avoidance causes significant distress or impairment in social, occupational, or other important areas of functioning. Findings indicate that individuals with social anxiety face numerous issues such as lower social status, submissive behaviors, perceived lack of intimacy in relationships with peers and romantic relationships (Koyuncu et al., 2019), lower sexual satisfaction, reduced social support and mental health (Goetter et al., 2020), and decreased quality of life (Versella et al., 2016). Alongside a reduction in various life indices, daily functioning is severely diminished not only in social domains but also in occupational areas (Zhang et al., 2022).

Despite the extensive body of research in this area, the roots of social anxiety are not well understood. Epidemiological and clinical studies show a reciprocal relationship between physiological and biological processes in social anxiety (Crișan et al., 2016). Variables such as mood, parenting style, peer relationships, and negative life events indicate the development and evolution of social anxiety (Leichsenring & Leweke, 2017). Lamp's (2009) findings suggest that cognitive factors maintain social anxiety disorder and that elements such as genetics, personality, and mood play a role in susceptibility to social anxiety. According to Jung, the roots of many critical issues lie in the hidden or unconscious mind of humans. He believes that the three main sources of mind and psyche include the self, the personal unconscious, and the collective unconscious (Aloisi, 2023). The self represents the conscious mind aware of human thoughts and feelings. The personal unconscious contains all the information that the individual might have forgotten or suppressed memories and feelings, what Jung refers to as psychological complexes (Benzi et al., 2023). Jung distinguished between the ego-self and individual differentiation, referring to the conscious mind as persona, and believed that the persona often distances from the real self. Indeed, the persona is the character that the individual prefers to show. The unconscious mind plays a significant role in controlling all life aspects (Sejersen, 2023), acting as an active repository of feelings, memories, dreams, emotions, and thoughts outside the conscious mind. This part of the mind is rigid and inflexible. An individual might recall various childhood memories, each time experiencing a fresh wave of emotions, while the unconscious mind does not offer new dimensions to feelings and events (Detmar, 2023). In the deepest and most hidden mental layers, the unconscious resides, housing the most important, sensitive, and profound thoughts and feelings. Every suppressed feeling, undesirable traits overlooked, and painful memories preferred to be forgotten are stored in the unconscious (Newell & Shanks, 2023). Individuals have limited access to this area, only transferring parts of it to their conscious mind under specific conditions. Dreams are one manifestation of the unconscious mind (Priya & Jain, 2021).

According to Freud's theory, a secondary event in the lives of individuals with social anxiety can activate their primary traumas and reawaken an unresolved conflict or issue. Freud's concept of deferred action refers to how a secondary event reactivates a primary trauma that has been suppressed from memory. The primary trauma becomes accessible again and can be reevaluated and integrated into the mind after a protective delay (Goodman et al., 2021). According to this theory, childhood traumas can be activated in some way through subsequent life events. Various types of childhood traumas, including social, psychological, and emotional traumas during childhood, indicate a deficiency in the attachment relationship between the caregiver and the child through a lack of emotional bonding, emotional neglect, or the overt acts of verbal and emotional abuse causing psychological disorders in the child and hindering the normal development of essential capacities like self-efficacy, autonomy, and the increase of mentalization and emotion regulation abilities (Spinazzola et al., 2018). Diverse forms of traumatic experiences and maltreatments

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during childhood are associated with various psychological vulnerabilities, including social anxiety, depression, suicidal thoughts, and personality issues in later years (Liu et al., 2023). Few studies have indirectly addressed emotional and psychological traumas during childhood in individuals with social anxiety. Various studies have shown that childhood traumas lead to insecure attachment styles, affecting individuals' future relationships, extending this pattern of relationship into later life stages, and increasing the likelihood of social anxiety in adulthood (Dekel et al., 2018; Warach et al., 2018; Yumbul et al., 2010). It is noteworthy that childhood trauma can have a destructive impact on a child's development, particularly in psychological and interpersonal functioning, affecting individuals' mental health in adulthood. Systematic literature reviews indicate that childhood trauma predicts anxiety and depression (Ahmadi, 2017; Hatcher et al., 2018; Li et al., 2016), post-traumatic stress symptoms, aggression, substance use, risky sexual behaviors, schizotypal personality disorder, avoidant personality disorder, antisocial behaviors, and schizoid personality disorders (Hosseinzade Khanmiri et al., 2017; Pournaghash-Tehrani & Amini-Tehrani, 2018) in adulthood; these psychological outcomes may become chronic over time, leading to low levels of social functioning (Ebrahimi et al., 2014; Ebrahimi et al., 2013).

However, not all individuals who experience childhood trauma report psychological issues; few studies have explored variables that might mediate or moderate the relationship between childhood trauma and psychological problems. The present research focuses on Alexithymia, examining its role as a mediator in the relationship between childhood trauma and the unconscious. Alexithymia is another crucial mechanism in the formation of psychological outcomes due to social anxiety. It is believed that Alexithymia is a risk factor for many psychiatric disorders. Alexithymia is a construct comprising difficulties in identifying feelings, describing them, and an externally-oriented thinking style. This deficiency hinders emotional regulation, complicating successful adaptation (Fietz et al., 2018). Individuals with Alexithymia, due to their inability to recognize and understand the emotions of others and their difficulty in expressing and describing their own feelings, are unable to achieve the intimacy and closeness required for an appropriate level of interpersonal relationships, always facing challenges in expressing their emotions, desires, and inner needs. The lack of expression of these inner desires and feelings prevents intimacy and closeness, resolving wants and issues, and creates an emotional distance and gap, thereby resulting in social anxiety and, in a way, leading to the formation of various psychological issues in individuals (Darjazini & Moradkhani, 2017).

Based on the aforementioned points, it can be understood that the unconscious, through the mediation of emotional inarticulateness, can generate childhood trauma in individuals. Given this basis and considering social anxiety and the importance of examining the dimensions and factors involved in this issue, along with the scarcity of studies in this area, the present research aims to predict childhood trauma based on the unconscious with the mediating role of Alexithymia in adults with social anxiety attending counseling centers in Tehran. The findings from the current research could increase awareness about the variables of the unconscious and emotional inarticulateness and their roles in childhood trauma, offering significant insights about the mechanisms of these variables' influence, theoretically contributing to the expansion and modification of approaches related to the research variables, and practically assisting researchers, psychiatrists, and psychotherapists interested and specialized in mental health centers in acquiring information about the mentioned variables, enabling them to develop appropriate prevention programs and pursue special therapeutic plans for individuals with social anxiety. Therefore, given the research conducted in the field of social anxiety, various ambiguities still surround the mentioned variable, presenting it as a source of the problem. Considering the importance of the unconscious in relation to childhood trauma, the present study seeks to predict childhood trauma based on the unconscious with the mediating role of Alexithymia. It appears that in addition to the direct relationships of childhood trauma, another variable such as Alexithymia may act as a mediating variable between childhood trauma and the unconscious, affecting them. Thus, the present research aims to answer whether the unconscious can predict childhood trauma considering the mediating role of Alexithymia in adults with social anxiety attending counseling centers in Tehran.

2. Methods and Materials

2.1. Study Design and Participants

The present study is fundamental in its aim and descriptive-cross-sectional in its methodology, correlational in type. The research population included all adults with social anxiety who attended counseling centers in Tehran. The samples were selected from Tehran through a non-probabilistic and purposeful method. The research was

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conducted from the beginning of December 2023 to the end of April 2024. There are varying opinions regarding the optimal sample size for studies related to structural equation modeling. For instance, Kline (2010) and Lohelin (2004), as cited by Ghasemi (2011), believe that a sample size of less than 100 is inadequate and sizes above 200 are preferable. McCullum (2001), as cited by Ghasemi (2011), mentions a range between 300 to 400. Hair et al. (2008) also refer to a range between 200 to 400. For compatibility with the structural equation modeling pattern, the sample size should be more than 200 based on a coefficient for the number of observed variables (Stevens, 1994, as cited by Hooman, 2014). In this study, considering the number of observed variables and allocating a coefficient of 15 for each observed variable, 240 individuals were chosen as the sample size. For sample selection, District 2 of Tehran was randomly chosen, and through convenience sampling, 6 counseling centers in District 2 of Tehran in 2023 (Companion Counseling Center, Better Life, Emotion Thought, Kowsar, Delsa, and Mind Shadow Counseling Center) were selected. Subsequently, 240 individuals with social anxiety attending these centers were chosen for the study through simple random sampling. Entry criteria for the study included being within the age range of 25 to 40 years and scoring one standard deviation above the evaluated sample on the Social Anxiety Questionnaire. Exclusion criteria included the use of psychiatric drugs (based on self-report in the demographic questionnaire) and participation in individual or group psychotherapeutic-educational courses (as per the participants' statements). Data collection tools were as follows:

2.2. Measures

2.2.1. Childhood Trauma

Developed by Bernstein et al. in 1988, this questionnaire consists of 25 items applicable for age groups of 12 years and older, measuring five areas of traumatic experiences including sexual abuse, physical abuse, physical neglect, emotional abuse, and emotional neglect. It employs a 5-point Likert scale (never=1 to always=5) with score ranges for each subscale from 5 to 25 and for the entire questionnaire from 25 to 125. Its reliability has been reported through test-retest and Cronbach's alpha in the range of 0.70 to 0.94. Its concurrent validity with therapist gradings of childhood trauma has been reported in the range of 0.59 to 0.78 (Bernstein et al., 2003). In a study on the Iranian population, its construct validity was confirmed, and Cronbach's alpha for the short form was estimated between 0.81 to 0.89 (Ebrahimi et al., 2014).

2.2.2. Alexithymia

Designed by Bagby et al. in 1994, this test consists of 20 questions covering three subscales: difficulty identifying feelings (7 questions), difficulty describing feelings (5 questions), and externalizing thinking focus (8 questions). It uses a 5-point Likert scale ranging from strongly disagree to strongly agree, with a total score calculated from the sum of the three subscales' scores, ranging from 20 to 100 (Bagby et al., 1994). In the Persian version, Cronbach's alpha coefficients for overall Alexithymia were 0.85, and for the subscales difficulty in identifying feelings 0.82, difficulty in describing feelings 0.75, and for externally oriented thinking 0.72, indicating good internal consistency. The concurrent validity of the Alexithymia Scale was also verified through correlations between its subscales and emotional intelligence scales, psychological well-being, and psychological helplessness. The overall validity of the scale in the Iranian sample was confirmed using the split-half and test-retest methods (after one month), with results of 0.74 and 0.72, respectively (Besharat, 2013).

2.2.3. Unconscious

Developed by Bell et al., this questionnaire measures three factors: reality distortion (RD), perceptual uncertainty (UP), and delusions and hallucinations (HD). Bell et al. reported retest reliability coefficients for the questionnaire's subscales over four and thirteen weeks, respectively, ranging from 0.63 to 0.89 and 0.63 to 0.64. The test's validity was confirmed through high correlations with the Brief Psychiatric Rating Scale (BPRS), the Positive and Negative Syndrome Scale (PANSS), the Revised 90-Item Symptom Checklist (SCL-90-R), the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and the Millon Clinical Multiaxial Inventory-II (MCMI-II) (Bell, 2017). Additionally, a preliminary study on the validity and reliability of its Persian version by Hadi Nejad et al. (2014) on 141 (88 female and 53 male) students from the University of Tehran using convenience sampling and evaluated with the Revised 90-Item Symptom Checklist (SCL-90-R) found significant correlations between all BORRTI subscales and all SCL-90-R dimensions ($p \leq 0.001$). The test-retest reliability of BORRTI over 21 weeks ranged from 0.78 for delusions and hallucinations to 0.65 for perceptual uncertainty. Cronbach's alpha for the subscales ranged from

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0.66 for social incompetence to 0.82 for alienation, indicating that the Persian version of BORRTI has satisfactory validity and reliability for this assessment (Hadi Nejad et al., 2014).

2.3. Data analysis

Data analysis was conducted using Pearson correlation coefficient analysis and structural equation modeling methods. SPSS-24 and AMOS-26 software were utilized for data analysis.

3. Findings and Results

The statistical sample in this research comprised 240 individuals with social anxiety attending counseling centers in Tehran, with a mean age of 34.65 (SD = 1.65). The means and standard deviations of the research variables are presented in Table 1.

Table 1

Descriptive Statistics of Variables

Variables	Mean	Standard Deviation
Unconscious	32.18	6.16
Uncertainty	12.86	2.49
Delusions and Hallucinations	13.12	2.56
Reality Distortion	13.23	2.63
Childhood Trauma	88.68	16.14
Sexual Abuse	19.15	3.13
Physical Abuse	19.24	3.18
Physical Neglect	20.08	3.20
Emotional Abuse	18.65	3.12
Emotional Neglect	18.70	3.15
Alexithymia	75.26	12.18
Difficulty Identifying Feelings	26.59	4.85
Difficulty Describing Feelings	19.34	3.10
Externally-Oriented Thinking	28.85	5.17

Table 1 contents indicate that the mean (and standard deviation) for the unconscious variable is 32.18 (SD = 6.16), for childhood trauma is 88.68 (SD = 16.14), and for Alexithymia is 75.26 (SD = 12.18). Table 2 presents the correlation coefficients of the research variables.

Table 2

Correlation Coefficients Between Research Variables

Variables	1	2	3
1. Unconscious	1		
2. Childhood Trauma	.47**	1	
3. Alexithymia	.43**	.51**	1

**p<0.01

The assumption of data normality, which must be examined before utilizing structural equation modeling, was tested using the Kolmogorov-Smirnov test. According to the results, all research variables were normally distributed (p > 0.05). In addition to the normality assumption, before testing the model, the hypotheses of linearity of variables and independence of errors were examined. The results showed that the tolerance index for all predictor variables was 0.85, the Variance Inflation Factor (VIF) was 1.27, and the Durbin-Watson statistic, used to check the independence of errors, was 1.97. When the tolerance index is greater than 0.10, the VIF is less than 10, and the Durbin-Watson value is less than 4, it can be said that there is no violation of regression assumptions. Therefore, based on the obtained indices, it can be concluded that the conditions for conducting the test have been met. Consequently, structural equation modeling was used to test the proposed research model.

The results showed that the fit indices of the structural equation analysis indicate a good overall model fit. Fit

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indices such as the ratio of chi-square to degrees of freedom ($\chi 2/df$), Bentler-Bonett Non-Normed Fit Index (NFI), Non-Normed Fit Index (NNFI), Root Mean Square Error of Approximation (RMSEA), and other criteria (Tucker-Lewis Index (TLI), Goodness of Fit Index (GFI), Adjusted Goodness of Fit Index (AGFI), Comparative Fit Index (CFI), Incremental Fit Index (IFI)) were used. The fit characteristics of the proposed model are presented in Table 3.

Table 3

Fit Indices for the Proposed Research Model

Fit Indices	Value
Chi-Square Test (χ^2)	49.58
Significance Level (p)	.001
Degrees of Freedom (df)	29
Chi-Square to Degrees of Freedom Ratio (χ^2/df)	2.63
Goodness of Fit Index (GFI)	.99
Adjusted Goodness of Fit Index (AGFI)	.98
Normed Fit Index (NFI)	.96
Comparative Fit Index (CFI)	.97
Incremental Fit Index (IFI)	.98
Tucker-Lewis Index (TLI)	.99
Root Mean Square Error of Approximation (RMSEA)	.05

If $\chi 2/df$ is less than 3, RMSEA is less than 0.06, and the values of GFI, AGFI, NFI, IFI, and CFI are between 0.90 to 1, it can be said that the model has an acceptable fit. In Table 3, it is observed that all mentioned indices have achieved suitable values for model fit.

Table 4 presents the direct, indirect, total effects, and significance levels between the main research variables.

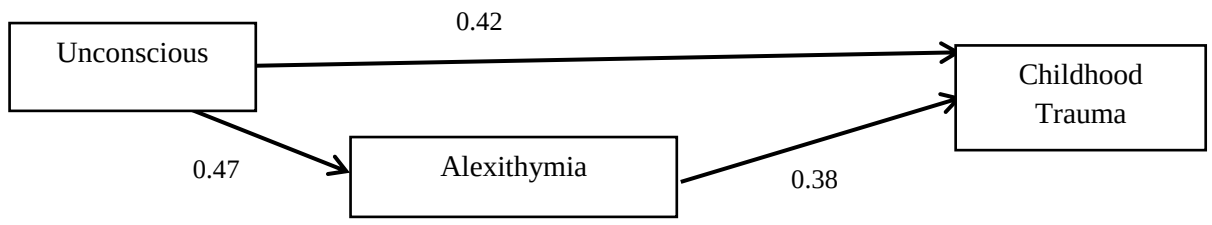
Table 4

Estimated Standardized Direct, Indirect, and Total Effects in the Model

Path	Direct Effect	Indirect Effect	Total Effect
Unconscious → Childhood Trauma	.42**	.24**	.66**
Unconscious → Alexithymia	.47**	-	.47**
Alexithymia → Childhood Trauma	.38**	-	.38**

Figure 1

Simple Model of the Study with Standard Coefficients



As seen in Table 4, there is a direct relationship between the unconscious and childhood trauma ($\beta = 0.42$, $t = 6$), a total relationship ($\beta = 0.66$, $t = 8.25$), and an indirect relationship ($\beta = 0.24$, $t = 3.14$). There is a direct relationship between the unconscious and Alexithymia ($\beta = 0.47$, $t = 6.73$) and a total relationship ($\beta = 0.47$, $t = 6.73$), and between Alexithymia and childhood trauma, there is a direct relationship ($\beta = 0.38$, $t = 4.33$) and a total relationship ($\beta = 0.38$, $t = 4.33$).

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Table 5

Parameters of Direct Relationships in the Proposed Model

Path	Standard Estimate	Unstandardized Estimate	Standard Error	Critical Ratio	Significance Level (p)
Unconscious → Childhood Trauma	.42	1.32	.22	6	.018
Unconscious → Alexithymia	.47	1.37	.20	6.73	.012
Alexithymia → Childhood Trauma	.38	1.22	.28	4.33	.016

Table 5 reports the regression coefficients (direct relationships) of the measurement models and latent variables in the model. According to the standardized path coefficients and the corresponding critical values presented in Table 5, it is observed that all direct paths are significant. Among the direct significant standard relationships in the proposed research model, in order, are the relationship of the unconscious with childhood trauma ($\beta = 0.42$, $p \leq 0.05$), the relationship of the unconscious with Alexithymia ($\beta = 0.47$, $p \leq 0.05$), and the relationship of Alexithymia with childhood trauma ($\beta = 0.38$, $p \leq 0.05$).

Table 6

Bootstrap Results for the Indirect Relationship in the Mediation Model

Indirect Path	Standard Estimate	Upper Limit	Lower Limit	Significance Level (p)
Unconscious to Childhood Trauma through Alexithymia	.24	.33	.19	$p \leq .05$

According to the results presented in Table 6, it is shown that the indirect relationship of the unconscious to childhood trauma through Alexithymia ($\beta = 0.24$) is significant at the level of significance ($p \leq 0.05$). It can also be said that since the zero does not fall within the upper and lower limit range, Alexithymia plays a mediating role in the relationship between the unconscious and childhood trauma.

4. Discussion and Conclusion

The present study aimed to predict childhood trauma based on the unconscious with the mediating role of Alexithymia in adults with social anxiety attending counseling centers in Tehran. The findings of the research showed that childhood trauma can be predicted based on the unconscious with the mediating role of Alexithymia in adults with social anxiety attending counseling centers in Tehran. The indirect relationship of the unconscious to childhood trauma through Alexithymia was significant. It can also be said that, given that the zero does not fall within the upper and lower limit range, Alexithymia plays a mediating role in the relationship between the unconscious and childhood trauma. This finding is consistent with the previous results (Berenz et al., 2018; Gamache Martin et al., 2016; Hopfinger et al., 2016; Huh et al., 2017). In explaining this finding, it can be said that the conscious mind is logically situated at the highest part of the mind and acts as an analyzer. Many of the arguments we make and the justifications we provide come from consciousness, and humans are the only beings that possess consciousness (Berenz et al., 2018). This ability allows us to think about and analyze our own thoughts and feelings, giving us the power to be observers of the processes occurring within us and voluntarily initiate changes in any field, accessing the mechanisms of the unconscious with the awareness present in consciousness, thereby reprogramming our mind and brain, which can be effective in individuals with social anxiety disorder.

Another aspect of consciousness is that information and changes at the conscious level are forgotten and do not have the capability to endure, which is why when we change our behaviors, the new behavior does not last because it was created at the conscious level and is soon forgotten, and consciousness can only manage a limited number of our behaviors and processes a small amount of incoming information, while the central and main processor is the unconscious. The unconscious plays a significant role in forming human thoughts and behavior. All habits and emotions that are formed in our unconscious affect our behaviors and choices in life. For example, people who are afraid of heights may use this unconscious existing in their minds to justify this fear. Some of the significant impacts the unconscious has on our lives include decision-making, where the majority of our daily decisions are based on the unconscious mind. Human reactions are formed through unconscious processes in the mind. For example, sometimes our unconscious feelings about a person, a situation, or an

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event influence our decision-making. Ethics and behavior: Some of our behaviors are unconsciously formed in response to previous experiences, unwanted experiences, and imitations of others' behaviors (Huh et al., 2017). For example, if an individual had a negative feeling about a topic in the past, they are likely to view that topic negatively in the future without being aware of that experience. Interpersonal relationships: We may unconsciously seek relationships with people who are similar to us or look for relationships that satisfy our intellectual and sensory needs. Also, our unconscious may seek to experience behaviors that we have not learned from in the past and do not seem to help us. Creativity: The unconscious is a place for storing information and experiences of each person throughout their personal life, including ideas, images, and thoughts derived from all these elements but because we do not have conscious access to this information, we cannot always use them directly. These thoughts and images may play a crucial role in creating innovative and creative ideas in an individual.

In explaining other findings of the research, it can be stated that harm during childhood affects the emotional-social development of adolescence and adulthood, including the development of negative cognitions about oneself and others, which can facilitate the formation of conditional relationships between the trauma-related stimulus and emotional disturbance and undeveloped emotional regulation (Hopfinger et al., 2016). It appears that childhood traumas prevent the development of emotional regulation abilities in a healthy manner. Childhood traumas, especially repeated interpersonal traumas between the caregiver and the child, interfere with acquiring appropriate emotional regulation skills. The quality of emotional exchanges between the child and the caregiver is an essential factor in the capacity for emotional regulation in adulthood, and individuals with traumatic childhood experiences typically have weaknesses in receiving and organizing emotional information because, in stressful situations and tense conditions, they always focus on emotions related to threats. Continuous stresses in childhood sensitize the central nervous systems involved in stress response and emotional regulation. At the same time, the individual's inability to comprehensively attend to all stimuli and their biased attention to threatening stimuli can be associated with stress and anxiety, inadvertently exposing the person to a wave of negative emotions (Huh et al., 2017). On the other hand, from the perspective of strategies used in managing disturbing emotions, it must be said that although in normal individuals, the strategies used in regulating and managing emotion are of a healthy and appropriate type, such as confronting the distressing event and identifying and expressing one's emotions related to that event, which ultimately can lead to other benefits such as compromise and maintaining or rebuilding the relationship with others, thereby reducing the stress of the provoking event, individuals with traumatic childhood experiences typically use ineffective emotion management strategies such as suppression or ignoring disturbing emotions in anxiety-provoking situations, resulting in escaping from their feelings and not recognizing and expressing them, as well as distancing in relationships with others, which in turn means nothing but experiencing high levels of depression, anxiety, and stress. Difficulty in expressing emotions and emotional suppression can, through creating a disorder in the normal functioning of the cognitive processing system of emotional information and also regulating and managing emotions, and consequently producing a weakness in the process of materializing feelings and emotions at the level of personal behaviors and interpersonal interactions lead to increased stress, anxiety, depression, and psychological distress. In this context, findings from various studies indicate that the inability to identify and describe emotions and an individual's weakness in managing emotions, especially negative emotions, can lead to increased levels of social anxiety (Khademi et al., 2019). In fact, it can be argued that the incorrect relationship between the recall and evaluation of the emotional stimulus is related to the identification and expression of emotion. In other words, the relationship between secondary evaluation and readiness for action can be related to an inability in emotional expressiveness, and the execution defect, which is actually the main sign of Alexithymia, leads to superficial affect, defective emotional manifestations, dysfunction in emotional expression, language, and disproportionate facial expressions, which in the long term can cause the individual to suffer psychological burnout and lay the groundwork for the occurrence of psychological injuries, psychological distress, and anxiety, stress, and depression. Children who have been harmed in childhood usually have to endure a lot of emotional and physical pain, preventing them from developing a sense of security and making them avoid their inner experiences and interpersonal relationships. Furthermore, structural and functional development at the neural level also leads to the development of executive processes required for emotional regulation, including inhibitory control during adulthood. The interaction between

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neural cognitive processes and social pressures resulting from mistreatment may lead to exacerbating the individual's inability to perceive and process emotions, which itself generates social anxiety (Gamache Martin et al., 2016). Also, in another explanation, it must be stated that avoidance of emotional reality and inability in proper emotional organization often lead to functional impairment, including in the areas of problem-solving, evaluation of issues, decision-making, planning, or seeking emotional and social support, which can also contribute to further anxiety production (Marchi et al., 2019). In fact, it can be argued that for individuals with childhood trauma with experiences of emotional neglect and mistreatment, interpersonal relationships and trust in others and seeking social support in times of need are considered difficult, distressing, and risky (Gamache Martin et al., 2016). Moreover, they may have trouble in problem-solving or reassessing the problem because these coping methods emphasize recognizing threats and errors that individuals with childhood mistreatment experiences prefer to deny or ignore. In explaining these findings, it can be said that individuals who have experienced mistreatment in childhood have experienced more negative affect. Childhood trauma leads to negative affective, cognitive, and behavioral effects, and such individuals experience less compassion towards themselves. In fact, the experience of childhood trauma is a risk factor for personality disorders and a wide range of disruptive behaviors (Quide et al., 2021). Such individuals form incorrect beliefs about positive emotions. Beliefs such as fear of happiness lead to reduced life satisfaction and psychological capital. Consequently, individuals with low psychological capital experience less physical health and satisfaction.

5. Limitations & Suggestions

Alongside the importance of applying the results of the present study, to generalize these results, the limitations of the research must be considered. Limitations such as measuring constructs solely through self-report questionnaires, which could lead to overestimation or underestimation of symptoms. Therefore, researchers are suggested to use complementary methods such as interviews or projective tests in future research to eliminate potential respondent bias. Based on the results, it is recommended to thoroughly investigate and analyze initial trauma signs and to provide complete education, care, and treatment so that these individuals do not bear a high psychological and physical cost in adulthood. Considering the theoretical validation of the research findings, health and treatment specialists are advised to develop educational and therapeutic programs for individuals with symptoms of social anxiety at the clinical level.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed in this article.

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