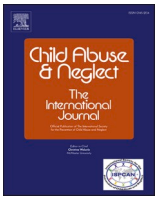
Child Abuse & Neglect 167 (2025) 107536

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg



Identification with the aggressor and the body self: The role of body boundaries and trust in the body☆

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ARTICLE INFO

Keywords:
Trauma
Childhood maltreatment
Identification with the aggressor
Body self
Body boundaries
Trust in the body

ABSTRACT

Background: Studies suggest that childhood maltreatment may have negative effects on survivors' body self – namely, a sense of disrupted body boundaries and reduced trust in the body.
Objective: In this study we examined the role of identification with the aggressor, a survival defensive process, as a mediator in the associations between the severity of childhood maltreatment and a sense of disrupted body boundaries and trust in the body among adults.
Participants: A convenience sample of 240 individuals participated in this study, mean age 40.35 years ($SD = 12.69$). Seventy-five percepts of participants ($n = 180$) defined themselves as women.
Methods: Participants completed self-report questionnaires assessing childhood maltreatment (Childhood Trauma Questionnaire; Bernstein et al., 2003), identification with the aggressor (Identification with the Aggressor Scale; Lahav et al., 2021), sense of body boundaries (Sense of Body Boundaries Survey; Krzewska & Dolińska-Zygmunt, 2013), and trust in the body (Multidimensional Assessment of Interoceptive Awareness; Mehling et al., 2018).
Results: One-hundred-and-seventy-four participants (72.5 %) reported an indication of childhood maltreatment. Severity of childhood maltreatment was positively associated with levels of disrupted body boundaries ($r = 0.40$, $p < .001$) and negatively with levels of trust in their body ($r = -0.33$, $p < .001$). Path analysis indicated that the associations between severity of childhood maltreatment and disrupted body boundaries and trust in the body were mediated by identification with the aggressor, $b = 0.06$, $p = .004$, $b = -0.04$, $p = .006$.
Conclusions: The findings may contribute to future clinical interventions by illuminating the importance of identification with the aggressor, to facilitate and establish a well-defined body self among adult survivors of childhood maltreatment.

1. Introduction

Cumulative evidence suggests that survivors of childhood maltreatment may display various behaviors that reflect complicated relations with their bodies (Tsur, 2022), such as self-injurious behaviors (Lang & Sharma-Patel, 2011), and eating disorder symptoms (Rosenberg et al., 2023). These manifestations of distress may represent negative perceptions and attitudes toward their bodies (Dyer et al., 2013; Tripp & Petrie, 2001). Thus, childhood maltreatment may affect survivors' body experiences and representations (Talmon

☆ This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.
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https://doi.org/10.1016/j.chiabu.2025.107536
Received 16 July 2024; Received in revised form 15 May 2025; Accepted 22 May 2025
Available online 31 May 2025

& Ginzburg, 2017; Tsur, 2020). The aim of this study was to examine the implications of history of childhood maltreatment on the body self, as reflected by survivors' sense of body boundaries and trust in their body. Furthermore, given that childhood maltreatment is a relational trauma, which often occurs in the context of close relations with the perpetrator (Davies & Frawley, 1994; Herman, 1992), we propose a model according to which these detriments to the body self would be associated to identification with the aggressor.

Disrupted body boundaries following childhood maltreatment.

A central dimension constituting the body self that has been suggested to be disrupted following abuse is the sense of body boundaries (Talmon & Ginzburg, 2017). Body boundaries establish the physical barrier between the self and its surroundings (Sakson-Obada, 2014), and reflect the differentiation of the self as a physical and emotional experience (Shontz, 1989). These boundaries allow one to mentally and cognitively process information from both the inner and outer environment (Sakson-Obada, 2010). Demarcating the self, body boundaries serve as a barrier from the surroundings, providing a sense of security and protection (Krzewska & Dolińska-Zygmunt, 2013).

Sense of body boundaries is a subjective experience. Individuals with well-defined body boundaries may be attuned to their bodily experience, being able to perceive, interpret and regulate different physical and emotional states (Sakson-Obada, 2014). In contrast, individuals with disrupted, or undefined sense of their body boundaries may feel alienated from their bodies (Talmon & Ginzburg, 2018), susceptible and vulnerable to outer effects (Krzewska & Dolińska-Zygmunt, 2013).

Disrupted body boundaries among childhood maltreatment survivors may reflect the feeling of one's self as being perpetually invaded by the other (Talmon & Ginzburg, 2017, 2018). As acts of physical and sexual abuse are directed toward the body, they harm the child's body integrity by invading the body, possibly objectifying it by ignoring the child's needs. This intrusiveness may exist during emotional abuse as well, as such abuse often entails verbal references to the child's body. As the child's sense of self forms in an environment which negates their autonomy and needs, the fear and expectation of being invaded by others may persist long after the abuse has ended (Finkelhor, 1987; Herman, 1992).

The sequelae of abuse on body boundaries as described may be relevant not only to abuse but to childhood neglect as well. Physical and emotional neglect refer to the failure to meet children's physical and emotional needs – for example, the failure to provide proper nutrition, hygiene, nurturance, and affection (Stoltenborgh et al., 2013). As the development of a well-defined body self is dependent on the identification of the child's physical and emotional needs by their caretakers (Kochan-Wójcik, 2011), the negation of these basic needs during childhood neglect may impact the sense of body boundaries, resulting in a diffused, undefined sense of the body.

Indeed, studies among non-clinical populations have demonstrated that a sense of disrupted body boundaries is related to childhood maltreatment. Talmon and Ginzburg (2017, 2018), in their studies conducted among university students, found that a disrupted sense of body boundaries was associated with different forms of childhood maltreatment, both abuse and neglect. Previous support had been obtained from studies demonstrating that abuse survivors need more space from others in order to feel safe, compared to people who did not experience abuse (Sakson-Obada, 2014; Vranic, 2003). Furthermore, early interpersonal trauma, when the perpetrator is also the child's caregiver, has been associated with a disrupted body identity and negative attitudes toward the body (Sakson-Obada, 2014).

1.1. Loss of trust in the body following childhood maltreatment

Trust in one's body is another aspect of the somatic experience that may be damaged following maltreatment. If the sense of body boundaries represents an internalized *interpersonal* experience (namely, the extent to which one is protected from the other), trust in the body represents an *intrapersonal* experience (the experience of oneself inside their body), or the extent to which they trust their body and feel protected by it. As the body holds the emotions and physical states of being attacked (Rothschild, 2000), child abuse may pose a threat to this sense of safety in one's body and disrupt one's overall orientation toward it (Tsur, 2020). Following the discard to the child's physical and emotional privacy, abusive acts may lead to a loss sense of control over the body (Ataria & Somer, 2013), and may result in perceiving the body and the world it exists in as hostile (Ataria, 2016). As a reaction, survivors may lose the sense of basic trust in their body. This notion is supported in clinical writing, as childhood abuse survivors often describe a feeling of betrayal by their bodies (Gur, 2019; Herman, 1992).

A loss of trust in the body may occur pursuant to neglect as well. Winnicott (1954) described the different ways infants may lose touch with their body and its needs in reaction to impingements from the primary environment. Attachment theory stresses physical and emotional nourishment as pivotal in creating a secure attachment (Bowlby, 2008), and a secure attachment may lead to a sense of trust in the body, in which the experience of the body is integrated into the self (Lutz, 2014; Mehling et al., 2009). Therefore, when neglected, this sense of bodily trust may be denied, as children are deprived of their basic needs.

This notion has received some indirect empirical support. Qualitative analyses of the body experience of sexual abuse survivors have pointed to survivors' sense of mistrust in their bodies (Bennett & Starnino, 2022; Rhodes & Hutchinson, 1994). Tsur (2020) conceptualized a posttraumatic orientation toward bodily signals and found it to be associated with different forms of childhood maltreatment. This orientation denotes a fearful and catastrophic orientation toward the body (Tsur et al., 2018), hence pointing to a loss of trust in one's body. Talmon and Ginzburg (2018) found childhood maltreatment to be associated with body shame, suggesting that not only is the body not a trustworthy safe space, it may be experienced as a shameful object. Moreover, fearful/disorganized attachment has been negatively associated with trust in bodily sensations (Lutz, 2014).

1.2. Identification with the aggressor among survivors of childhood maltreatment

Identification with the aggressor is a defensive mental process that may occur in the wake of ongoing trauma and has been

associated in a number of studies with childhood maltreatment (Lahav et al., 2021; Rosenberg et al., 2023; Sultana Eliav & Lahav, 2023). This process was first described by Ferenczi (1933), as he recognized that children undergoing abuse may subject themselves to the will of their attacker and internalize their attacker's experience, as a way to survive the abuse. They may undergo the replacement of their own agency with that of the perpetrator's, develop a hypersensitivity to their attacker, learn what the attacker feels and expects from them, adopt the attacker's views concerning the abuse, and even internalize the attacker's aggression (Frankel, 2002).

Identification with the aggressor is essentially a defensive reaction, whose various manifestations denote its different defensive functions. Given that abused children cannot escape from or prevent the abuse (Lahav et al., 2022), they may undergo dissociation, with detached self-states potentially internalizing the perpetrator's experience (Frankel, 2002). Replacing their agency with that of their perpetrator allows the children to understand what to feel and do and how to attune themselves perfectly to the perpetrator (Amir, 2016). They may develop hypersensitivity to the perpetrator, which helps them to anticipate the abuse and minimize its hazards (Ferenczi, 1933; Frankel, 2002; Katz & Barnetz, 2013).

In this way, maltreated children may adopt their perpetrator's experience in regard to the maltreatment, denying or justifying, while doubting their own sense of reality (Lahav et al., 2019). As they mold their experience of themselves upon the perpetrator's experience of them, and identify with the perpetrator's aggression (Lahav et al., 2022), they may maintain a sense of order and meaning in the world, a world in which they are maltreated because they are bad while their caretakers remain good (Fairbairn, 1943; Lahav et al., 2021). These perceptions may prevent the terror evoked by arbitrary suffering in a world the child can't predict or understand (Amir, 2016). In addition, this fragmentation of the self may allow abused children to maintain their essential connection to their caretakers (Gurevich, 2008, 2014), as feelings and memories that may threaten this connection are dissociated (Howell, 2014), creating a relational pattern of identifying with the perpetrator's aggression (Davies & Frawley, 1994).

Identification with the aggressor may occur following not only active acts of abuse, but acts of neglect as well. Ferenczi (1932) stressed that excessive lack of attunement and environmental adaptation may cause the child to erase their needs and incorporate those of others. As neglect constitutes not only a deep lack of attunement but a renunciation of the child's basic physical and emotional needs, neglected children may learn that their needs are unimportant, negligible, or even shameful. Thus, neglect may pose a threat to the child's tender psyche, as it may lead the child to fearfully identify with the psyche of their aggressor (Gurevich, 2016).

This defensive process may persist into adulthood and become an essential part of the adult survivor's self (Lahav et al., 2021). Its intensity has been found to be related to the severity of the abuse and the role of the perpetrator in the victim's life: Severe abuse, multiple episodes of abuse, and being abused by a parental figure have been found to be related to higher levels of identification with the aggressor among adult survivors (Lahav et al., 2021). Furthermore, it has been shown to be related to various body-related expressions of distress among survivors, such as eating disorders (Rosenberg et al., 2023) and self-injurious behaviors (Lahav et al., 2022).

1.3. Identification with the aggressor and the body self: the current study

Given that the somatic realm often mirrors individuals' experiences concerning themselves as well as their relationships with others, and may serve as a platform for traumatic material (Adamowicz et al., 2022; Piontek et al., 2021; Van der Kolk, 1994), one could suggest that identification with the aggressor would be related to loss of trust in the body and the disrupted sense of body boundaries in survivors. Furthermore, it may serve as a mediator for the relations between the severity of childhood maltreatment and these somatic outcomes. Also, as mentioned, identification with the aggressor reflects survivors' mental fusion with their perpetrators at the expense of their own sense of self. This loss of differentiation between themselves and their attackers, may bring them to be disconnected from their inner experiences.

It may be that these mental experiences are translated into the somatic realm, affecting survivors' trust in their own body as well as their sense of body boundaries. In this way identification with the aggressor may be linked not only with elevated levels of loss of trust in the body and the disrupted sense of body boundaries in survivors, but may also mediate the relations between severity of childhood maltreatment and these somatic outcomes: Elevated levels of childhood maltreatment severity may be associated with the defensive reaction of identification with the aggressor, which in turn may be related to loss of trust in the body and a disrupted sense of body boundaries.

Previous empirical and theoretical writings imply the current suppositions. Being abused by a close family member, which has previously been linked to the intensity of identification with the aggressor (Lahav et al., 2021), has been shown to be related to higher levels of discomfort in situations of close proximity to others (Sakson-Obada, 2014). Given that such discomfort has been shown to be related to disrupted body boundaries (Talmon & Ginzburg, 2018), this finding may offer indirect support for the association between identification with the aggressor and disrupted body boundaries. Additionally, theory insinuates that identification with the aggressor may manifest itself through a loss of trust in the body. When the child learns how to attune themselves to the perpetrator, their body and its signals become irrelevant in their own right, and the child may therefore lose the ability to rely on them.

Although the body self has been documented both clinically and empirically to be harmed by maltreatment (Gur, 2019; Talmon & Ginzburg, 2018; Tsur, 2020), to the best of our knowledge, no empirical evidence currently exists referring to the association between identification with the aggressor, disrupted sense of body boundaries and a loss of trust in the body. As the child's relationship with the perpetrator has been noted to have a great impact on the forming of the self and one's relations to others (Herman, 1992), we aimed to explore the association between identification with the aggressor and the body self, in order to deepen the understanding of the dynamics between these fundamental experiences of child maltreatment.

Thus, in the current study, the following hypotheses were suggested: a) Individuals with a history of childhood maltreatment would report higher levels of disrupted body boundaries and lower levels of trust in the body, as compared to individuals without a history of

childhood maltreatment; b) Severity of childhood maltreatment would be positively associated with levels of identification with the aggressor; c) Identification with the aggressor would be positively associated with levels of disrupted body boundaries; d) Identification with the aggressor would be negatively associated with levels of trust in the body; and e) Identification with the aggressor would mediate the association between the severity of childhood maltreatment and levels of disrupted body boundaries and trust in the body.

2. Methods

2.1. Participants & procedure

A convenience sample of 240 participants took part in the survey. Participants were recruited through social media, through a post that was virally distributed in a snowball technique. The inclusion criteria were being 18 years of age or older and being able to read and write in Hebrew. The average age of the participants was 40.35 years ($SD = 12.69$, range = 18–76). Most of the study participants (71.7 %, $n = 172$) reported that they were currently in an intimate relationship. Of the total sample, 75.0 % ($n = 180$) defined themselves as women, 24.2 % ($n = 58$) as men, and 2 (0.08 %) as other. Regarding sexual orientation, 86.4 % ($n = 204$) defined themselves as heterosexual, 6.4 % ($n = 15$) as gay, 5.9 % ($n = 14$) as bisexual or pansexual, and 1.3 % ($n = 3$) as other. Most of the study participants (71.7 %, $n = 172$) reported that they were currently in an intimate relationship. Finally, 59.7 % of the participants ($n = 141$) identified as parents.

Data were collected between July and September 2022, after the study protocol was approved by the authors' university's institutional review board (IRB) and informed consent from the participants was obtained. Participants used Qualtrics research software to fill in the questionnaires, and completion took about 30 min. Participation was voluntary, and participants were not compensated for their participation.

2.2. Measures

Childhood maltreatment was assessed by the Childhood Trauma Questionnaire (CTQ; Bernstein et al., 2003), a 28-item self-report measure reflecting childhood maltreatment: emotional abuse (e.g., "People in my family called me things like stupid, lazy, or ugly."), physical abuse (e.g., "People in my family hit me so hard that it left me with bruises or marks."), sexual abuse (e.g., "Someone tried to touch me in a sexual way, or tried to make me touch them."), emotional neglect (e.g., "There was someone in my family who helped me feel that I was important or special.", reversed item), and physical neglect (e.g., "I didn't have enough to eat."). Respondents were asked to rate on a 5-point scale, ranging from 1 (*never true*) to 5 (*very often true*), to what extent they experienced the behaviors described. Sum scores were used, with higher scores representing greater levels of childhood maltreatment.

The validity of the CTQ scores was supported by positive correlations between CTQ scores as reported by adolescents admitted to inpatient psychiatric clinics, and their therapists' ratings (Bernstein et al., 2003). The Hebrew version of the CTQ has been widely used; Cronbach's alphas for the current sample were 0.83 for sexual abuse, 0.78 for physical abuse, 0.85 for emotional abuse, 0.90 for emotional neglect, 0.41 for physical neglect, and 0.89 for the total score. Due to the low level of reliability of the physical neglect subscale, which is a well-known problem of this scale (See for example, Badenes-Ribera et al., 2024), this subscale was excluded from the results.

Identification with the aggressor was assessed by using the Identification with the Aggressor Scale (IAS; Lahav et al., 2021), a 23 item self-report questionnaire, addressing its four main aspects: adopting the perpetrator's experience concerning the abuse, identifying with the perpetrator's aggression, replacing one's agency with that of the perpetrator, and becoming hypersensitive to the perpetrator (e.g., "Sometimes the needs and desires of people are similar to those of their perpetrator", "Some people 'read the thoughts' of their perpetrator"). Respondents were asked to rate on an 11-point scale, ranging from 0 (*never*) to 10 (*all the time*), the frequency with which they experienced each manifestation of identification with the aggressor when they were in the presence of the perpetrator or when they talked to or thought about the perpetrator. Mean scores were used, with higher scores representing greater levels of each subscale. The IAS has been shown to have good psychometric characteristics, including high criterion validity, as well as high internal reliability (Lahav et al., 2021). Cronbach's alpha for the current sample was 0.97.

Disrupted body boundaries was assessed by the Sense of Body Boundaries Survey (BBS; Krzewska & Dolińska-Zygmunt, 2013), a 17-item self-report scale, assessing the individual's physical separateness from their surroundings, and the sense of body vulnerability to permeability (e.g., "I feel that my body is susceptible to outer influences," "My feeling of physical separation from the environment is rather vague"). Respondents were asked to indicate on a five-point Likert-type scale the extent to which the statement described their body experience, with scores ranging from 1 (*definitely don't agree*) to 5 (*strongly agree*). Mean scores were used, with higher scores reflecting higher levels of disrupted body boundaries. The validity of scores on the BBS has been supported by its positive correlation with the Body Self Questionnaire (Sakson-Obada, 2014). Cronbach's alpha for the current sample was 0.92.

Trust in the body was assessed via the Trusting subscale of the Multidimensional Assessment of Interoceptive Awareness (MAIA-2), developed by Mehling et al. (2018). This subscale includes three self-report items assessing bodily trust (e.g., "I am at home in my body"," I trust my body sensations."). Respondents were asked to rate on a five-point scale ranging from 0 (*never*) to 5 (*all the time*) the extent to which they felt at home in their bodies, felt that their body was a safe space, and trusted their body sensations. Mean scores were used, with higher scores reflecting higher levels of trust in the body. Cronbach's alpha for the current sample was 0.81.

2.3. Data analysis

Overall, 1.2 % to 23.8 % of data were missing across variables. Little's Missing Completely at Random (MCAR) test (Little, 1988) was not statistically significant $X^2(77) = 88.80$, $p = .17$, suggesting that the missing data patterns were consistent with the MCAR assumption. Missing data were imputed with maximum likelihood estimation based on all variables in the model, a procedure referred to as expectation maximization.

First, Spearman correlations examined the association between severity of child maltreatment, disrupted body boundaries and trust in body. As identification with the aggressor applies only to survivors of interpersonal trauma, the rest of the analyses were conducted among those who reported some level of childhood maltreatment. For this purpose, we used the following criteria: CTQ total score > 36, or, sexual abuse subscale score: > 5, physical abuse subscale >7, emotional abuse subscale >8, or emotional neglect subscale >9 (Bernstein & Fink, 1998), 174 participants met this criterion. To examine the research model, we conducted path analysis. This analysis enables users to examine the direct and indirect effects of the variables simultaneously, and to evaluate how well the hypothesized model's structure fits the data. This analysis was chosen over structural equation modeling due to the sample size. Since preliminary examination indicated that women reported higher levels of disrupted body boundaries and lower levels of trust in body, than men, $p = .003$, $p = .022$, respectively, these effects were controlled for.

Variance inflation factor (*VIF*) and tolerance indices were used to evaluate multicollinearity, as *VIF* lower than 2.5 and tolerance >0.4 indicated that multicollinearity is unlikely (Thompson et al., 2017). Preliminary analyses indicated that $1.21 < VIF < 1.43$; $0.70 < tolerance < 0.83$. Further analysis indicated, however, that the assumption of variables' normal distribution is violated. To deal with this violation, the following steps were taken: First, logarithmic transformation of the data was performed. Second, 5000 bootstrap samples were used, and biased-corrected confidence intervals were taken into account to test whether the hypothesized effects were significant (Nevitt & Hancock, 2001; Preacher & Hayes, 2008).

Several complementary fit indices were used to examine the overall quality and fit of the hypothesized model to the data: Comparative Fit Index (*CFI*), Normed Fit Index (*NFI*), and Root Mean Square Error of Approximation (*RMSEA*). For *CFI* and *NFI*, values >0.90 indicate a good fit between the model and the data (Arbuckle, 2013; Yadama & Pandey, 1995). A chi-square analysis enables an examination of the significance of the difference between the model and the data: a non-significant $\chi 2/df$ value ranging between one and three indicates an adequate model fit (Arbuckle, 2013). Lastly, a *RMSEA* value of 0.08 or less and a nonsignificant test of close fit (PCLOSE) also indicate a fair fit (Hu & Bentler, 1999). Yet, Kenny et al. (2015) demonstrated that models with a combination of small *df* and small sample sizes may produce larger *RMSEA* values, therefore recommended relying on other parameters, including *PCLOSE*. IBM Statistics Package for the Social Sciences (SPSS) version 28 and AMOS 28 software package were used to analyze the data.

3. Results

Of the total sample, 174 (72.5 %) reported some indication of childhood maltreatment. Ninety-six (40.0 %) reported some level of sexual abuse, 15 (6.2 %) reported some level of physical abuse, 92 (38.8 %) reported some level of emotional abuse, 46 (19.1 %) reported some level of physical neglect, and 140 (58.3 %) reported some level of emotional neglect. Severity of each type of abuse, according to the cutoff scores suggested by Bernstein and Fink (1998) is presented in Table 1. Further examination indicated that 27.3 % of the participants ($n = 66$) did not report any type of maltreatment. 72 (30.0 %) reported one type of maltreatment, 44 (18.3 %) reported two types, 49 (20.4 %) three types, and 9 (3.8 %) reported four types of maltreatment.

Spearman correlations indicated that severity of childhood maltreatment is positively associated with levels of disrupted body boundaries, $r = 0.40$, $p < .001$, and negatively associated with levels of trust in the body, $r = -0.33$, $p < .001$. In addition, levels of disrupted body boundaries and trust in body were negatively associated with each other, $r = -0.46$, $p < .001$.

3.1. Research model

Path analysis was conducted to test the hypothesized relations between all of the study variables, among the participants who reported some level of childhood maltreatment ($n = 174$). The fit indices of the model indicated a good fit between the model and the data, $\chi^2/df = 2.72$, $CFI = 0.97$, $NFI = 0.95$, $RMSEA = 0.10$, $PCLOSE = 0.15$. The model explained 23.3 % of the variance of body boundaries and 15.2 % of the variance of trust in the body. The results of the path analysis are depicted in Fig. 1, with a presentation of the standardized estimates of the direct effects. Unstandardized coefficients, standard errors, and 95 % confidence interval of direct and indirect effects are presented in Table 2.

As can be seen, the model yielded the following direct effects: Severity of childhood maltreatment was significantly associated with

Table 1
Distribution of severity of childhood maltreatment types.

	None/minimal		Low to moderate		Moderate to severe		Severe to extreme	
	n	%	*n*	%	*n*	%	*n*	%
Sexual abuse	144	60.0	59	24.6	28	11.7	9	3.8
Physical abuse	225	93.8	10	4.2	2	0.8	3	1.3
Emotional abuse	148	61.7	60	25.0	15	6.3	17	7.1
Emotional neglect	100	41.7	94	39.2	24	10.0	22	9.2

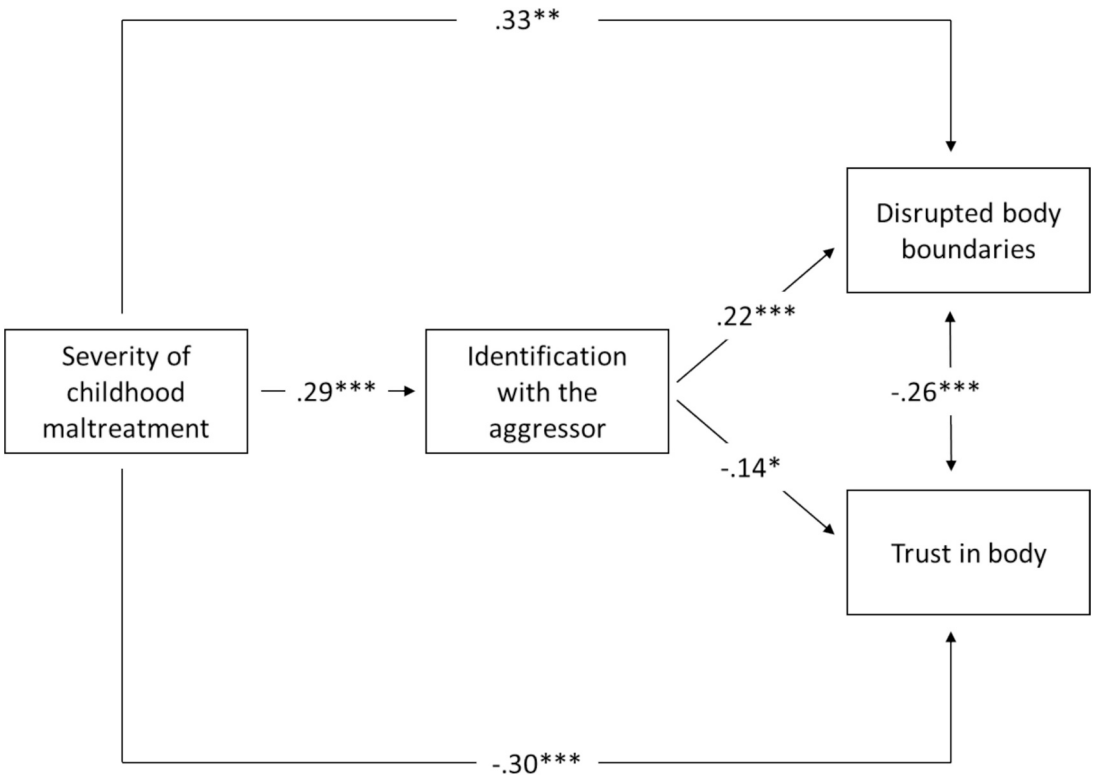

Fig. 1. The research model.
* $p < .05$; ** $p < .01$; *** $p < .001$.

Table 2
Unstandardized coefficients, standard errors, and 95 % confidence interval of direct and indirect effects.

	B	*SE*	*95 % LBCI*	*95 % UBCI*
Direct effects				
Childhood maltreatment ➔ Identification with the aggressor	2.17	0.55	0.43	3.58
Childhood maltreatment ➔ Disrupted body boundaries	0.52	0.11	0.26	0.79
Childhood maltreatment ➔ Trust in body	−0.38	−0.09	−0.59	−0.20
Identification with the aggressor ➔ Disrupted body boundaries	0.05	0.01	0.01	0.08
Identification with the aggressor ➔ Trust in body	−0.03	0.01	−0.04	−0.006
Indirect effects				
Childhood maltreatment ➔ Identification with the aggressor ➔ Disrupted body boundaries	0.10	0.04	0.04	0.21
Childhood maltreatment ➔ Identification with the aggressor ➔ Trust in body	−0.05	0.03	−0.12	−0.01

identification with the aggressor, $p < .001$: The higher the level of childhood maltreatment, the higher the level of identification with the aggressor. Identification with the aggressor was significantly associated with disrupted body boundaries, $p < .001$, and trust in the body, $p = .047$: The higher the level of identification with the aggressor, the higher the level of disrupted body boundaries and the lower the level of trust in the body. The associations between severity of childhood maltreatment and disrupted body boundaries and trust in the body were also significant, $p < .001$ for both: the higher the severity of childhood maltreatment, the higher the level of disrupted body boundaries, and the lower the level of trust in body. Disrupted body boundaries and trust in the body were negatively associated with each other, $p < .001$. Finally, the association between gender and disrupted body boundaries was significant, $b = -0.17$, $p = .01$, as women reported higher levels of disrupted body boundaries than men. There were not significant gender differences in trust in body, $p = .07$.

In addition, the analysis yielded two significant indirect effects: The association between severity of childhood maltreatment and disrupted body boundaries was mediated by identification with the aggressor, $b = 0.06$, $p = .004$, 95 % *CI* 0.02, 0.13). In addition, the association between severity of childhood maltreatment and trust in the body was mediated by identification with the aggressor, $b = -0.04$, $p = .006$, 95 % *CI* (−0.09, −0.01).

4. Discussion

The ramifications of ongoing trauma on the body self have been recognized to be of great meaning, the body being a central vessel through which the trauma is expressed (Van der Kolk, 1994). The relationship with the perpetrator, and the effect that this relationship has on the development of the self, has also been noted to be one the central consequences of interpersonal trauma (Herman, 1992). The model presented in this study allowed for an examination of the way that these two core experiences of childhood maltreatment are associated with one another, illuminating the possible role of identification with the aggressor on survivors' sense of body boundaries and trust in their bodies.

Our findings regarding frequencies of the different forms of child maltreatment are partially aligned with previous studies conducted in Israel. In a national study conducted among adolescents, 52.9 % reported at least one lifetime experience of victimization, 31.1 % emotional abuse, 18.7 % sexual abuse, 18 % physical abuse, 17 % emotional neglect, and 17 % physical neglect (Lev-Wiesel et al., 2018). However, maltreatment rates as reported by adults are higher, recently ranking up to 73.4 % reporting an indication of childhood sexual abuse, and 80.6 % an indication of childhood emotional abuse (Lahav et al., 2025). This gap may be understood through delayed disclosure of abuse, as many children disclose their abuse only later on in life (McElvaney, 2015; Wallis & Woodworth, 2020), or reflect different thresholds for identifying of these experiences.

Identification with the aggressor was related both to a disrupted sense of body boundaries and a loss of trust in the body. The nature of traumatic memories, which are often not coded or assimilated, but rather expressed through the body (Van der Kolk, 1994; Van der Kolk & Fisler, 1995), may explain this association. As identification with the aggressor is essentially a dissociative-based mechanism, it is possible that a disrupted body self may provide a way to express the detached mental experience. Amir (2023) described different forms and qualities of somatoform dissociation following trauma. She expressed the idea that the displacement of traumatic memories through the body may be a metaphoric manifestation of identification with the aggressor, but may also be a way to create contiguity with the feelings and sensations that occurred in the primary traumatic environment. The disrupted body self may be a way to both express the detached traumatic material and at the same time recreate the primary experiences of intrusiveness and betrayal, through the body.

Identification with the aggressor mediated the association between the severity of childhood maltreatment and a disrupted sense of body boundaries. This finding supports the existing literature stating that the development of the body self is dependent on the identification of the physical and emotional needs of children by their caretakers (Kochan-Wójcik, 2011). The psychoanalytic framework refers to the significance of the skin, as the physical barrier of the body, and the importance of its holding and care for the development of the psychological skin. Anzieu (1989) referred to the skin ego, describing that just as the skin encompasses the body, so too does it encompass the mind. With attuned regulation from the child's caretaker, the psychological skin can serve as a filter between the outer reality and the inner reality. Similarly, Bick (1968) described the psychological skin that holds the most primary parts of the self, stating that this internal function comes into being through tender physical care, as the caretaker provides a dermal sheath gathering together body and mind.

Identification with the aggressor represents an intrusion of the outer reality into the inner reality. Although identification with the aggressor protects the child from comprehending the reality of being abused, it robs the child of the ability to develop a coherent and differentiated self, which is expressed through the body as well. Our findings suggest that the experience of intrusion into the mind and the body in an abusive environment coexist, manifested in a diffused and fragmented mental and physical experience, as these dimensions of the self develop in attunement with the other. Even if the abuse or neglect did not occur during infancy but later on in childhood, it may be that such abuse/neglect – if severe enough to lead to identification with the aggressor – would alter the experience of the self not only in the mental sense but in the physical sense as well.

In addition, identification with the aggressor mediated the association between childhood maltreatment and loss of trust in the body. This finding may be understood through the concept of body agency. Body agency refers to the ability to understand, act, and affect what is happening in the body. It is the experience that a person's physical space is in their control, and that they – not an outer source – generate what happens to them (Ataria, 2015). As replacing one's agency with that of the perpetrator's is a core aspect of identifying with the aggressor, it may be that this loss refers to body agency as well. Our finding suggests that the loss of agency may be an extensive experience: If survivors experience themselves as absent in the presence of their perpetrator, this absence may affect the way they experience their bodies as well.

In addition, we found that disrupted body boundaries and trust in the body were negatively associated with each other. Our findings are congruent with findings from previous studies on the various detriments of disrupted body boundaries on the body self. Talmon and Ginzburg (2017, 2018) found disrupted body boundaries to be linked to body shame and to impact one's overall well-being. Furthermore, the authors suggested that disrupted body boundaries may impact body awareness. Body awareness is another dimension of the body self. Impaired body awareness may on the one hand lead to indifference toward the body or detachment from it (Streeck-Fischer & Van der Kolk, 2000), and on the other to hypersensitivity to touch (Sakson-Obada, 2014) and hypervigilance toward physical sensations (Schmidt et al., 1997). These various reported detriments may support our findings, indicating that when the body is experienced as permeable and diffused, people may lose the ability to trust it.

The findings of this study should be considered in light of its limitations. First, the data for this study were collected online, among a convenience sample. Despite the growth in the use of online data collection and accumulation of evidence supporting its reliability, validity, and contribution to participants' greater perceived anonymity (Gosling et al., 2004; Ward et al., 2014), a possible bias resulting from online participant recruitment should be taken into account. Thus, generalizing from the findings should be done with caution. Second, the data concerning childhood maltreatment were based on retrospective reports; as such, they may have been subject to selective recall or current interpretations of past events. Due to the low reliability of the physical neglect subscale, the distribution of

this type of maltreatment could not be calculated. Social desirability may also have affected participants' responses. Finally, the cross-sectional study design should be taken into account before drawing conclusions regarding causal relations between the study variables; in other words, these associations could also be understood in the opposite direction, outwards in. As the primary human experience is that of the body (Winnicott, 1954), it may be that a disrupted experience of the body and its boundaries are that which constitute a diffused sense of self, with identification with the aggressor adding to this fragile situation. Moreover, identification with the aggressor may be a solution for the loss of trust in the body, solving the conflict that may arise following the experience of betrayal by the body (Lev-Wiesel, 2015).

Bearing these limitations in mind, this study represents a step forward in understanding the associations between the mind and the body among survivors of childhood maltreatment, namely the associations between identification with the aggressor, body boundaries, and trust in the body. Our findings imply that the pervasive effects of identification with the aggressor may go beyond the psyche alone and affect survivors' experience of their body as well. Therefore, our findings suggest the importance of an integrative therapeutic approach, one which may combine body-based interventions (e.g., Payne et al., 2015; Price, 2005), alongside long-term psychodynamic therapy, which allows survivors to relive, reenact, and process the destructive effects of identification with the aggressor on the self. These clinical implications are aligned with recent approaches, stressing the need for therapeutic flexibility when treating survivors of chronic interpersonal trauma (Horesh & Lahav, 2024). Furthermore, our findings suggest the need for clinical interventions that would weaken survivors' connection to their perpetrator and facilitate and establish a well-defined body self. Therapists should aim to verbalize and interpret bodily experiences in relation to identification with the aggressor, while being aware of the relational matrix reenactment that may occur in the therapeutic relationship and paying attention to body transference and counter-transference (Yarom, 2014).

CRediT authorship contribution statement

Tamar Rosenberg: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Yael Lahav:** Writing – review & editing, Writing – original draft, Methodology, Conceptualization. **Karni Ginzburg:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization.

Data availability

Data will be made available on request.

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