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THE RELATIONSHIP BETWEEN PSYCHOSOMATIZATION LEVEL OF WOMEN AND THEIR RELATIONSHIP SATISFACTION, EMOTIONAL PROCESSING AND LIFE QUALITY

Ahmet Eren GÜNSAN
114649008

Yrd. Doç. Dr. Alev Çavdar SİDERİS

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The Relationship between Psychosomatization Level of Women and Their Relationship Satisfaction, Emotional Processing and Life Quality

Kadınların Psikosomatizasyon Gösterme Eğilimi ile İlişki Tatminleri, Duygusal İşleme Kapasiteleri ve Yaşam Kaliteleri Arasındaki İlişki

Ahmet Eren Günsan
114649008

Yrd. Doç. Dr. Alev Çavdar Sideris :
Yrd. Doç. Dr. Yudum Akyıl Söylemez :
Yrd. Doç. Dr. Gizem Erdem :

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1) psikosomatizasyon
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1) psychosomatization
2) romantic relationship satisfaction
3) emotional processing
4) quality of life

ABSTRACT

The aim of the study was to investigate the relationship between psychosomatization level of women and their relationship satisfaction, emotional processing and life quality. The sample of the study consisted of women between the ages of 20 and 40, who have a romantic partnership. Participants were evaluated with a Demographic Form, Somatization Scale (SS), Relation Assessment Scale (RAS), Emotional Intelligence Scale (EIS), World Health Organization Quality of Life Scale (WHOQOL-BREF-TR). The results revealed that physical life quality, relationship status, romantic relationship satisfaction and appraisal of emotion were found as factors that are associated with psychosomatization. In other words, women who have low physical life quality, low romantic relationship satisfaction, low appraisal of emotions ability and who are not married are more likely to experience psychosomatic symptoms. Among these variables, physical aspect of life quality was found as the strongest predictive factor for psychosomatic symptoms, and it was followed by relationship status, relationship satisfaction and appraisal of emotion. On the other hand, psychological, social and environmental aspects of the life quality were not found as significant predictors of psychosomatization.

Key Words:

1. Psychosomatization
2. Romantic relationship satisfaction
3. Emotional processing
4. Quality of life

ÖZET

Bu araştırmanın amacı kadınların psikosomatizasyon düzeyleri ile romantik ilişki tatminleri, duygu işleme kapasiteleri ve yaşam kaliteleri arasındaki ilişkiyi incelemektir. Araştırmanın örneklemi, 20 ile 40 yaşları arasında ve romantik ilişki içinde olan kadınlardan oluşmaktadır. Katılımcılar, Demografik Bilgi Formu, Somatizasyon Ölçeği, İlişki Doyum Ölçeği, Duygusal Zeka Ölçeği ve Dünya Sağlık Örgütü Yaşam Kalitesi Ölçeği aracılığı ile değerlendirilmişlerdir. Analiz sonuçlarına göre fiziksel yaşam kalitesi, ilişki statüsü, ilişki tatmini ve duyguların değerlendirilmesi psikosomatizasyonu önemli derecede açıklayan faktörlerdir ve psikosomatizasyon ile negatif yönde ilişkililerdir. Diğer bir deyişle, fiziksel yaşam kalitesi, romantik ilişki tatmini, duyguları değerlendirme kapasitesi düşük olan ve evli olmayan kadınların psikosomatik semptom gösterme eğilimi daha yüksektir. Bu faktörlerden psikosomatizasyonu en güçlü şekilde açıklayan fiziksel yaşam kalitesidir ve onu sırasıyla ilişki statüsü, ilişki tatmini ve duyguların değerlendirilmesi takip etmektedir. Buna karşın, fiziksel yaşam kalitesinin psikolojik, sosyal ve çevresel alt boyutlarının psikosomatizasyonu açıklayan bir etkisi bulunamamıştır.

Anahtar Kelimeler:

1. Psikosomatizasyon
2. Romantik ilişki tatmini
3. Duygu işleme
4. Yaşam Kalitesi

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1. PSYCHOSOMATIZATION

1.1. Definition of Psychosomatization

Somatization or psychosomatization is commonly defined as the expression of distress and psychological disturbance in bodily forms. Escobar et al., (1987) broadly defines somatization as physical symptoms that are medically unexplained. Further, it is a common notion that these medically unexplained physical symptoms are caused by pent-up psychological states. In other words, emotional states that could not have been expressed in any other form might reveal themselves physically (Breuer & Freud, 1893). Similarly, mental tensions may have various impacts on central and autonomic nervous system. These impacts cause functional changes in circulation, respiration, endocrine glands and organs of the body (Hartley, 2004). From another perspective, somatization might be understood as the physical indicator of psychological and social issues (Kleinmann, 1982). In this sense, it can be accepted as a "call for aid." Ford (1983) also stated that physical symptom is a tool which is used unconsciously to be able to reach psychological and individual aims. With varying emphases on cause or consequences, all definitions refer to the existence or exacerbation of disturbing bodily experiences due to an underlying psychological issue.

1.2. Historical Antecedents

The term, psychosomatization consists of two words psyche and soma, which refer to mind and body, respectively. Heinroth, a German physician, is the first one who used the term psychosomatic in 1818 (cited in Sofuoğlu, 1984). From a historical perspective, the concept of integrated body-mind duality goes

back to Ancient Greeks and it was prevalent in both healing practices and philosophy (Hartley, 2004). The concept of body-mind duality in Ancient Greek was quite different than current contemporary view and it was thought that there was a split between body and mind. Plato stated that body and mind are fighting each other in a constant struggle (as cited in Shaw, 1995; Hutchins, 1952). According to Descartes, mind and body are separate substances in the same unit (Duncan, 2000). Body-mind related disorders date back to the Egyptian Era, and it was believed that those disorders were caused by the movement of the uterus in human body. In other words, when "wandering uterus" relocates from one organ to another organ, several physical symptoms were thought to arise. Furthermore, the word hysteria was grammatically derived from uterus in Ancient Greek times. In middle ages, hysteria was also considered to be a representation of involvement with demons, witchcraft and sorcerers (Videbeck, 2010).

As it can be seen above, there are several approaches that explain somatization from different perspectives. These varied approaches enable somatization to be distinctly discussed. Yet, all these approaches put emphasis on body-mind duality as a holistic view.

1.3. Psychoanalytic Perspective

1.3.1 Freud's View of Somatization.

Although Freud's view about physical symptoms is accepted as the building block of psychosomatic approach, the term psychosomatic was not mentioned explicitly in his works (Denzler, 2002). Instead of that, he discussed bodily symptoms by way of two separate concepts, "actual neuroses" and "psychoneuroses". Actual neuroses, differently from psychoneurosis, was described as physical experiences that is the outcome of physical sensations without any access to the mind; in other words, the ones that have a purely somatic origin. In other words, actual

neuroses have no psychical meaning since they were not formed as a result of repression (Zeph, 2014). On the other hand, hysterical conversion of psychoneuroses is characterized as physical experiences which have symbolic meaning, and which are internal conflict based (Gubb, 2013). In his works with Breuer, Freud studied Hysteria as a bodily manifestation of unaccepted desires, fantasies and impulses (Breuer & Freud, 1893). Specifically, when wishes were in conflict with each other, countered by a fear or incongruent with the expectations of the real world -that are thought to be intrapsychically represented as the moral demands of the superego,- they were repressed. Consequently, some of the libidinal energy stays bound to the repressed material. Then, the withdrawn energy turns into somatic sensations, which are defined as conversion (Taylor, 2003). In Freud's and Breuer's studies; headaches, muscular pain, neuralgia, gastric pain, tics, vomiting, clonic spasms, petit mal seizures, epileptoid convulsions were mentioned under the title of hysterical symptoms (Breuer & Freud, 1893). Along these lines, psychoneuroses were accepted as a principle model of hysteria (Akhtar & O'Neil, 2013).

Although Freudian thought does not explicitly mention somatization, its suggestion of a connection between the physical symptoms without a known physical cause and the underlying intrapsychic causes that are not readily accessible to consciousness serves as the basis for the current model of somatization.

1.3.2. Post Freudian Approach to Psychosomatization

The concept of psychoneuroses, actual neuroses and organic illnesses, following Freud, continued to be discussed from the viewpoint of various theorists and/or schools within psychoanalysis. Sándor Ferenczi is the pioneer among the psychoanalysts who worked on the concept of psychosomatization. In his paper titled "Organ Neuroses and Their Treatment", Freud's concept of actual neuroses was expanded by Ferenczi, and he proposed the term "organ neuroses," which

refers to real disturbances that arise in the normal functioning bodily organs. Thus, organ neuroses was distinguished from hysteria by definition. Freud's idea that the redirection of erotic object cathexes towards the affected organ creates a mechanism in individual with a somatic illness is the cornerstone of Ferenczi's works on neurotic illnesses (Smadja, 2011). Moreover, by the notion called pathoneurosis, he sought to shed light on neurotic, psychotic and narcissistic forms, which arise after somatic illnesses and he stated that "masochism" could be a significance factor in the developing of these illnesses (Aisenstein & Smadja, 2010).

Afterwards, Felix Deutsch expanded Ferenczi's organ neuroses concept and worked on organ specificity. According to Felix, Deutsch's statement, specific organs might be affected from early developmental problems and as a result of the interaction between these specific organs and intra-psychic conflict, a "psychosomatic unit" can arise (Bronstein, 2011; Deutsch, 1939). "Psychosomatic unit" refers to the idea that there is not a split between body and mind; therefore, the fluctuation in any part of the organism is reflected upon the whole body (Deutsch, 1952). The bodily behaviour integrated into psychomatic patterns which "are formed as the result of experiences during the individual's psychological and biological development" (Deutsch, 1952, p.615).

Franz Alexander, student and collaborator of Ferenczi, was the first person who systematically studied psychosomatization (Gubb, 2013). He developed a new concept called "psychosomatic medicine," and founded Chicago School of Psychosomatic Medicine (Aisenstein & Smadja, 2010). According to his approach, psychosomatic illness should be discussed from a dualistic point of view that combines psychoanalysis and physiopathology. Psychosomatic medicine was built on two main ideas; (1) organic neurosis that is rooted in actual neurosis -which is also known as the Freudian notion-, and (2) repressed emotions at the psychic level. This approach suggests that emotions that were repressed can be transmitted through autonomic nervous system to bodily organs. This transmis-

sion initially leads to functional disturbances, which may further develop into organic illnesses. Alexander (1950) listed seven categories of psychosomatic illness (the Chicago Seven): peptic ulcer, ulcerative colitis, bronchial asthma, neurodermatitis, rheumatoid arthritis, essential hypertension, and thyrotoxicosis. One of the most significant contributions of Alexander's systematic work was his attempt to link each emotion with a corresponding physiopathological syndrome (Smadja, 2011). For instance, a cause-effect relation had been assumed between unexpressed, unconscious rage and headaches, other cardiovascular disorders; gastrointestinal disorders and fears that come up with threat to dependency needs (Alexander, 1950)

1.3.3. Paris School of Somatization

After the Second World War, a group of psychoanalysts from Paris Psychoanalytic Society such as Pierre Marty, Michel Fain, Michel de M'Uzan and Christian David took an interest in somatic complaints. The approach of these psychoanalysts, who identified themselves as Paris School of Psychosomatics, was also grounded on Freudian drive theory (Gubb, 2013).

The main difference between the previous approaches to psychosomatic symptoms and the view of Paris Psychosomatic School is about their starting point. Paris School began to identify somatization process in terms of one's mental life, unlike the medical approaches that has the body as their outset. They had a special interest in concepts of mentalization, operational thinking and essential depression (Aisenstein & Smadja, 2010).

Mentalization can be defined as "psychic working-through," and it contains one's representational world and fantasy activity (Aisenstein & Smadja, 2010). Operational thinking, in other words mechanical thinking, is factual and it is not linked to symbolization and fantasy. Patients with this mental functioning do not have ability to do psychic work of elaborating or working through. Besides

that, they cannot mentalize because they lack the connections between their psychic apparatus and their body.

The third concept, essential depression, might be described as “little or no emotional life, and lack of desire” that occurs in the sequel of libidinal loss (Gubb, 2013). Patients with essential depression, in other words white depression or depression without an object, feel tired; they want nothing. Moreover, these patients deny that they mourn or that they feel depressive by reason of someone or something. Contrary, they report that they “feel just empty” (Aisenstein, 2006).

Concepts mentioned above, operational thinking and essential depression, can be explained as pathways that enable uncovering of the conflicts that somatizing patients have. In this way, through the uncovering process, these conflicts that were previously somatized can be mentalized (Gubb, 2013).

1.3.4. Contemporary Psychoanalytic Perspective

In addition to several approaches that ground on drives and defenses, psychosomatization was also discussed by more developmental and relational psychoanalytic schools of thought. The common point in contemporary psychoanalytic perspectives is that they ascribe the early relational exchanges a pivotal role in the development of a child’s affect regulation capacity, which is a direct corollary of the abilities to symbolize physical and affective states.

Peter Fonagy and his theory on mentalization is one of the most prominent approaches in contemporary psychoanalysis. Fonagy (1991) highlighted the importance of the disturbances of child’s early relationships in terms of his/her inner capacity and he stated that these disturbances may impede child’s “capacity to understand interpersonal behavior in terms of mental states” (Fonagy et al., 2002, p. 191). He conceptualizes the development of a cohesive self and the affect regulatory functions as mutually interacting; and both are formed through early interactions with the caregiver. Such a perspective prioritizes the relational world over

the solely intrapsychic, and paves the way for a further understanding of psychosomatization as a consequence of relationships and as a factor that might influence the relationships in turn. As Fonagy et al., (2002) suggests, when in the early relational exchanges, the caregiver(s) are expected to symbolize the inner tensions of the child in a way that would signify that the child is a separate mental agent and that the affects can be regulated. Otherwise, it would not be possible for the child to connect physical sensations to internal states, and interpersonal behavior to mental state of the other.

Peter Fonagy's perspective closely parallels and expands Stern's earlier contributions about the importance of affective attunement in the early relationship with the caregiver (Stern, 1985). He specifically emphasized that affective attunement is an experiential concept, rather than a cognitive one, that signifies psychic security and intimacy. He also suggests a developmental line for the formation of self, that's almost solely based on the "shared experiences" in the early relational context.

Similarly, Krystal (1988) more directly pointed out the importance of caregiver's empathy and attuned responsiveness that enable development of child's bodily states becoming verbally articulated. In this sense, limitation of interpreting/regulating emotions, and presence of early relational challenges which cause to diminish affectivity may drive one's somatic distress.

There are several implications of these contemporary psychoanalytic perspectives on the current understanding of psychosomatization. Although there are no systematic studies that directly focus on somatization from a relational psychoanalytic perspective, it can be inferred that the conceptualization of psychosomatization cannot be reduced to solely intrapsychic processes. Placing the core of the selfhood as well as the capacity to regulate affect in the early relational context might have two repercussions: (1) any failure in the early exchanges will result in psychosomatization, (2) psychosomatization will be closely related to the intimate relationships in adulthood, in terms of unfolding and/or escalating within these

context, and also in terms of shaping the experience of the affectively loaded incidents within the intimate relationships.

1.4. The View of Family Systems Theory

In addition to psychoanalytic approach to somatization, it is also essential to mention systemic view that discusses psychosomatization through family systems model. Family systems theory asserts that experiences of a member of the family affect the whole family system (Becvar & Becvar, 1996). Based on the systems theory, Minuchin et al, (1975) developed a concept called "psychosomatic families" and asserted that there are four typical family system characteristics of these families: enmeshment, overprotectiveness, rigidity and avoidance of conflict. Enmeshment basically refers to lack of differentiation in family system. Namely, the family members intrude on each others' thoughts and emotions. Overprotectiveness, the second concept, indicates high concern of family members for each others' welfare and being hypersensitive to sign of distress. Rigidity can be explained as maintaining the status quo and resistance to change and growth in family. Lastly, avoidance of conflict mainly refers to lack of the capacity for conflict resolution and tolerating any conflict in family.

Minuchin is the pioneer who demonstrated the relationship between family interactions and physiological processes. Minuchin and colleagues (1975) indicated that exacerbation of the illness -in child- stems from stress that arises with parental conflict in the family (as cited in McKenry & Price, 2005). The psychosomatic family system model highlights that certain types of families are related to development of psychosomatic syndromes -in children- which enables maintaining the family homeostatis (Minuchin et al., 1978). Among these syndromes; child diabetes, asthma, anorexia nervoza are the psychosomatic disorders which Minuchin treated through the "psychosomatic families" model (Minuchin, 1978).

1.5. Somatization in Diagnostic Systems

1.5.1. DSM - V

Somatization is listed as a disorder in the oldest psychiatric and medical categorization systems (North, 2002). Although the exact names of the disorders changed in time, medically unexplained or psychologically instigated presence of physical symptoms were always included. Recently, in DSM - IV the title that is used to denote such conditions was “Somatoform Disorders,” and this category included Somatization Disorder, Hypochondriasis, Pain Disorder, and Undifferentiated Somatoform Disorder.

In the latest version, DSM-V, the title was changed to “Somatic Symptom and Related Disorders,” and the disorders that are listed under this title are revised as Somatic Symptom Disorder, Illness Anxiety Disorder, Conversion Disorder, Psychological Factors Affecting Other Medical Conditions, Factitious Disorder, and Other Specified and Unspecified Somatic Symptom and Related Disorders. According to DSM V, to be diagnosed as a disorder, somatic symptoms must be significantly distressing or disruptive to daily life. Plus, somatic symptoms must be accompanied by “excessive” thoughts, feeling or behaviors (American Psychiatric Association, 2013). Absence of medical explanation for the somatic symptoms was mentioned as a diagnostic criterion for only the Conversion Disorder and one of the Other Specified disorders of the category, Pseudocyesis, whereas it is not a key diagnostic feature for the other disorders that are listed as Somatic Symptom and Related Disorders. Thus, the diagnostic emphasis in DSM-V is not on the explanation of the symptoms, but on the incongruence of the affective, cognitive and behavioral components of the experience with the existing condition.

This diagnostic emphasis of DSM V put the disorder with quite distinct clinical presentations together under the Somatic Symptom and Related Disorders

category. Somatic Symptom Disorder (SSD) is characterized by the presence of one or more somatic symptoms that are distressing or that result in significant disruption of individual's daily life. Other criteria includes a high level of health concern and a persistent symptomatic presentation that typically last at least for 6 months. Illness Anxiety Disorder is considered as the diagnosis for conditions in which the person has a preoccupation with having or acquiring a serious, undiagnosed medical illness despite the lack or insufficiency of the somatic symptoms, which also should persist for at least 6 months. The definitive diagnostic criteria for these disorders, as described above, do not require the physical symptoms to be unexplained; in fact, in some cases there is a medical condition that explains it.

On the other hand, Conversion Disorder (also called as Functional Neurological Symptom Disorder) diagnosis requires the individuals to have one or more symptoms of altered voluntary motor or sensory function. The most important criterion is that these symptoms must not be explained by another medical or mental disorder. Besides, clinical findings must provide evidence incompatibility between the symptom and medical conditions. Conversion Disorder closely echoes the initial formulations and the psychoanalytic understanding of psychosomatization as discussed above.

Other Specified Somatic Symptom and Related Disorder category includes somatic disorders, which do not meet the full criteria of the main categories above. The category includes Brief Somatic Symptom Disorder, Brief Illness Anxiety Disorder, Illness Anxiety Disorder (without excessive health-related behaviors), Pseudocyesis which refers to a false belief of being pregnant. Patient with Pseudocyesis not only think that they are pregnant, but also experience physical symptoms of pregnancy. In this case of Other Specified Somatic Disorders only, there is an indication of a mental/psychological cause for the physical symptoms.

To sum up, the definition that psychosomatization is a disorder that is caused by unconscious or unexpressed conflicts is not valid for the all disorders listed under Somatic Symptom and Related Disorders in DSM V. The categoriza-

tion logic of the DSM series for somatoform disorders is whether the symptom is body-related or not.

1.6. Etiology of Psychosomatic Symptoms

From a diagnostic point of view, although there is a consensus about the idea that emotional states of the individuals have an impact on their health status, the etiology of somatization is not totally clear (Sayar, 2002). There are several factors considered to be effective on somatic symptoms and related disorders. The first factor is *genetic and biological vulnerability*, such as increased sensitivity of pain. Another factor is *early traumatic experiences*; violence, deprivation, abuse can be listed as examples. *Learning* is another effective factor, since it comprises attention obtained from illness and lack of reinforcement of non-somatic expressions of distress. Additionally, *cultural and social norms* that might devalue or stigmatize psychological suffering are also mentioned as one of the factors that are effective on somatic symptoms and related disorders (American Psychiatric Association, 2013). Overall, somatization contemplates a combination of biological, developmental and social factors that almost explicitly suggest a tendency to somatically express or exacerbate experience.

1.7. Epidemiology of Psychosomatic Symptoms

The first study aimed at obtaining the prevalence rate of Somatization Disorder was conducted in New Haven, United States with an urban community, and 0.4 was reported as the prevalence rate (Weissman et al., 1978). According to the results of another study conducted by Swartz et al., (1990) and included patients who apply to general practitioners, an estimated 0.13 percent of the general population, in other words one person in a 1,000, has somatization disorder. Furthermore, Hamilton et al., (1996) conducted a study in United Kingdom with the pa-

tients who apply to gastroenterology, neurology, cardiology clinics with several medically unexplained complaints. The results showed that %53 percent of patients applied to gastroenterology, %42 percent of patients applied to neurology and %32 percent of patients applied to cardiology by reason of medically unexplained complaints. According to findings of another study conducted in Canada, 15-30% the percentage of patients who applied to primary health care centers had medically unexplained symptoms (Kirmayer et al., 2004).

Furthermore, Barsky and Klerman (1983) stated that individuals who have low socio-economic and educational level have a higher tendency to present with psychosomatic symptoms. Escobar et al., (1987), also highlighted that gender and age are related to psychosomatization. According to the findings of their fieldwork, being a female and being 40-yrs-old or older are associated with an increased somatization tendency.

In Turkey, there is a limited number of studies about psychosomatization. According to the findings of a study conducted with patients who apply to primary health care centers in Ankara, the mean score of somatic symptoms was 3.46 measured by Sağduyu (1995), and females have tendency to show somatic symptoms two times more than males. Among the symptoms that were reported by the patients, headaches (%24) was the most reported (Sağduyu, 1995). Besides, the prevalence rates of psychosomatization of the patients referred to the hospital with psycohsomatic complaints in Turkey were found to be between %43 and %68 (Ayhan et al., 1988).

The theoretical literature and research findings on somatization suggest that it is a widely experienced condition, especially by women. Further, in addition to the affective regulation and expression component, the relational correlates of psychsomatization might be a promising area for further exploration. In this study, experiences in romantic relationships is selected as a vantage point for this further exploration, since it reflects the most intimate adult relationship (Maister & Tsakiris, 2016). The emotion processing capacity will also be considered, as

one of the most common explanations of psychosomatization.

2. ROMANTIC RELATIONSHIP SATISFACTION

It is defined as an interpersonal evaluation of the positivity of feelings for one's partner and attraction to the relationship (Rusbult & Buunk, 1993). Relationship satisfaction would be also considered basically as feelings, thoughts and behaviors within the relationship (Hendricks, 1988). Sprecher and Hendrick (2004) discussed relationship satisfaction within the context of emotional self-disclosure, which refers to the process of expressing one's own feelings about, attitudes towards, and experiences with the partners.

Since it is an all-encompassing concept, marriage and other types of romantic partnerships can be efficiently evaluated in terms of relationship satisfaction. By evaluating relationship satisfaction, both the negative and positive aspects of the relationship would be taken into account. Besides, several studies indicate that relationship satisfaction is a significant correlate of several important factors, which supports it as a potent measure in terms of the assessment of a relationship. Rusbult and Buunk (1993) stated that couples that reported higher levels of commitment and intimacy also reported high relationship satisfaction. Other components, namely love, trust and cohesion, were also positively correlated with relationship satisfaction (Kurdek, 2005). On the other hand, verbal and physical aggression were negatively correlated with relationship satisfaction (Lavner & Bradbury, 2010). Higher psychological stress also predicted lower relationship satisfaction (Kurdek, 2005). Furthermore, including lower rates of relationship dissolution and greater relationship stability are related with high level of relationship satisfaction (Malouff et al., 2014). Lastly, better mental health, physical health, and well-being are also associated with high levels of relationship satisfaction (Hendrick et al., 1988; Prigerson et al., 1999).

2.1. Somatization and Romantic Relationship Satisfaction

The association between somatization tendency and experiences in close relationships, as indicated both by theory and observations, has not been widely studied yet. Although limited in number, several studies directly addressed an association between relationship satisfaction and psychosomatization. Gottman and Levenson (1986, 1988) stated that in marriages, when partners were not satisfied with the relationship, the tense atmosphere of conflict resulted in high physiological arousal. This physiological activity had a negative impact on the autonomic nervous and endocrine systems, which in turn weakened the immune system (Jemmott & Locke, 1984). If the physiological arousal due to the marital conflict had not been processed in healthy ways, the general well-being of each person was affected and psychosomatic problems were exacerbated. Additionally, it was reported that lower marital satisfaction was related with poor immune system (Kielcott-Glaser et al., 1987). According to Moore and Chaney (1985), pain plays a critical role on maintaining homeostatis of the problematic marriages. This point of view was also supported by Feinauer and Steele (1992), they defined these romantic relationships as "caretaker marriages". This view is not very far from Minuchin's idea of "Psychosomatic Families" that are characterized by children who give psychosomatic reaction to conflictual pattern -in order to maintain homeostasis- in the family (Minuchin et al., 1978).

These correlational studies do not provide the readers with a sound expectation about the cause-effect in terms of somatization and relationship continuation and satisfaction. Still, they offer invaluable examples of possible associations between somatization and relationship satisfaction.

3. EMOTIONAL PROCESSING

Emotional intelligence, in the most general sense, refers to "the ability to

carry out accurate reasoning about emotions and the ability to use emotions and emotional knowledge to enhance thought" (Mayer et al., 2008, p. 111). Similarly, it is defined as "the capacity for recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships" (Goleman, 1998a, p.137).

The term "emotional intelligence" was first used by Salovey and Mayer (1990) however, this term gained popularity in the public arena through Goleman's book (1996) called as "Emotional intelligence: Why it can matter more than IQ". Salovey and Mayer (1990) stated that emotional intelligence comprises of three different categories of adaptive abilities which are appraisal and expression of emotion, regulation of emotion, and utilization of emotions in solving problems.

The first one, *appraisal and expression of emotion,* basically refers to identification and expression of emotions. Appraisal and expression of emotions includes two aspects: (1) in the self and (2) in the others. Appraisal and expression in the self, further consists of two facets: verbal and nonverbal, whereas appraisal and expression in the others have two different subcomponents: non-verbal perception and empathy. Zhou and George (2003) explain the differences of these aspects through individuals' abilities and they stated that some of the individuals have an ability to express their feelings and emotions, whereas some of them have not and they are not even aware of their emotions and feelings.

The second component, *regulation of emotion*, refers to regulation of emotions in the self and in others. It refers to something more than just understanding emotions. Regulation of emotions refer to managing one's own emotions and emotions of others. The capacity of managing emotion varies from individual to individual, and managed emotions might provide the individuals with useful insight. Unmanaged emotions, on the other hand, blocks effective information processing. In other words, the individual who has the capacity to regulate his/her own emotions can manage and control emotional reactions, and communicate

them in a controlled manner. Moreover, delaying instant emotional reactions and managing them is related to regulation of emotion (Zhou, George, 2003).

The third component, *utilization of emotion*, refers to flexible planning, creative thinking, redirected attention and motivation (Schutte et al., 1998). Considering the relation between emotion and cognition, it is expected that ability to utilize emotion bridges over the effective cognitive processing of information. In this sense, individuals can enhance their effective cognitive functioning with their ability to use emotions in addition to the ability of appraisal and expression of emotions. Thus, an individual with a low level of emotional intelligence is expected to have difficulty in coordinating his/her own feelings, since s/he cannot utilize emotions effectively. In contrast, an individual with a high level of emotional intelligence is expected to have the ability to adjust according to the changing situations via utilization of emotion (Zhou, George, 2003).

3.1. Emotional Processing and Psychosomatization

Since the introduction of the concept of somatization, the idea that difficulties in emotion processing would result in a higher tendency to express affect using bodily symptoms has been widely discussed in theory. In terms of empirical work, studies in reference to the relation between psychosomatization and alexithymia are prevalent in literature, whereas direct studies of the broader notion of emotional intelligence and psychosomatics are rare. According to Lipowski's (1987) definition of somatization, one of the main feature is absence of emotional experience. Alexithymia is defined as literally "no words for feelings" (Sifneos, 1973), and it contains subdimensions; difficulty identifying feelings, difficulty describing feelings to others, constricted imaginal capacity and externally oriented thinking (Nemiah et al., 1976). Besides, when personality disorders and impulse control disorders are thought, inability to manage emotions and lack of awareness of emotion can be accepted as key symptoms (Matthews et al., 2002). Schutte et

al., (1998) stated the relation between lower emotional intelligence and less impulse control.

The idea that higher emotional intelligence enables individuals to be more sentimental puts a different standpoint. In other words, individuals with higher emotional intelligence give a strong reaction to mood related stimuli as against reactions of individuals with lower emotional intelligence (Petrides & Furnham, 2003). Taking into account the prevalence of comorbidity of mood disorders and medical disorders, especially ones have psychosomatic character, it is possible to predict a relationship between emotional intelligence and psychosomatization.

As implied above, a relation between romantic relationship satisfaction and psychosomatization can be expected, and further emotion processing is a factor that is directly associated to both. Yet, “quality of life” is a comprehensive concept that is affected individual’s varied dynamics. In this sense, when the psychosomatization is being studied, the “overall quality of life” should also be taken into consideration, as the quality of life is expected to both affect and be affected psychosomatization.

4. QUALITY OF LIFE

Thorndike (1939), the pioneer of the researchers who worked on the concept of life quality, defined life quality as the impact of social environment on person. According to Ferrans (1990), life quality can be defined as "a person's sense of well-being that stems from satisfaction or dissatisfaction with the areas of life that are important to him/her” (p.15). Moreover, quality of life was also defined as “the satisfaction of an individual’s values, goals and needs through the actualization of their abilities or lifestyle” (Emerson, 1985, p.282).

Although the concept called life quality seems to be a generic term, it contains various dimensions. Borthwick-Duffy (1992) explained quality of life through three different axes, which are the quality of one’s life conditions, one’s

satisfaction with life conditions and a combination of both life conditions and satisfaction.

As an alternative view, several dimensions were listed under the life quality main concept: physical well-being, material well-being, social well-being and cognitive well-being (Blunden, 1988). The first dimension, *physical well-being*, refers to the ability to use one's body as effectively as possible (Janicki, 1997) and it subsumes health, fitness and nutrition (Blunden, 1988). *Material well-being* contains several factors such as housing, income, possessions, food, neighborhood, security, transport. *Social well-being* includes interpersonal relationships such as family, friends, and acquaintance. *Cognitive well-being* basically indicates one's own perception of life satisfaction, and it comprises socioeconomic factors, level of social interactions and aspects of living situations (Larson, 1978).

4.1. Quality of Life and Psychosomatization

Most of the researchers asserted that life satisfaction should be a major component of the concept of mental health (Sells, 1969). There is a relation between longer stressful experiences and greater risk on one's health (Cohen et al., 2007). According to Kiritz and Moos (1974), social environment can affect individuals' health and physiological process. They discussed this view through three dimensions; relational dimension which refers to the degree of biological, psychological, social support; the dimension of personal development and the dimension of a certain functional system of the social environment. Furthermore, the studies about relationship between the social support and physiological processes showed that social support, one of the components of the quality of life, has a significant impact on the cardiovascular, endocrine, and immune systems (Uchino et al., 1996). Additionally, Gotay et al., (1992) stated that a good mental and physical health are the components of a better quality of life. Besides that, social relations, financial situation, health status, family should be taken into account when evalu-

ating one's quality of life (Jarema, 1996).

When, Freud's and Breuer's (1983) idea that distress that could not be expressed can arise as a psychosomatic symptom and the possible relation between higher stressful life events causing distress and lower quality of life are considered, a relation between quality of life and psychosomatization is indicated. Besides, Kleinmann's (1982) definition of psychosomatization as a "physical indicator of psychological and social issues" and the multidimensional structure of quality of life including physical well-being, material well-being, social well-being, cognitive well-being (Blunden, 1988) indicates a direct association between two concepts.

5. THE PRESENT STUDY

The main aim of the study was to investigate the relationship between psychosomatic tendency and romantic relationship satisfaction for the population who comprises of women between the ages of 20 and 40. As the literature suggest, psychosomatization is more prevalent in women; therefore, women were determined as sample group in this study. Besides, to avoid the level of both psychosomatization and romantic relationship satisfaction being influenced by aging-related factors through the observation of romantic partnership, 20 and 40 was designated as the age range of the sample group.

Further, the roles of the overall life quality and emotional processing were also included, since they are commonly associated with both romantic relationship satisfaction and psychosomatization. Emotional processing is the factor that affects both psychosomatization and romantic relationship satisfaction. In detail, one of the reasons that cause psychosomatization is the failure in emotional regulation. Especially a failure in appraisal and expression of emotions, as suggested by literature, is thought to be an important predictor of somatization. Besides, capacity for emotional regulation have an impact on the quality of their romantic

relationship satisfaction. On the other hand, quality of life which contains one's physical well-being, material well-being, social well-being and cognitive well-being is also related both psychosomatization and romantic relationship satisfaction. These specific common grounds guided the selection these as aspects of study. Besides these, in order to provide a wider picture in terms of somatization that is experienced by women in Turkey, demographic factors such as age, place of birth, education level, romantic relationship status, the frequency of communication with the partner, socio-economic status, and medical condition were also explored.

Considering the literature and the aims of this study, following hypotheses are formulated:

1. There will be a negative correlation between relationship satisfaction and somatization.

2. There will be a negative correlation between all aspects of life quality (physical, psychological, social and environmental) and somatization.

3. There will be a negative correlation between all dimensions of emotional intelligence (mood regulation, utilization of emotions, appraisal of emotions) and somatization.

4. Relationship satisfaction will be an important predictor of somatization level.

5. Among the dimensions of emotional intelligence, appraisal of emotions will be the strongest predictor of somatization level.

METHOD

1. SAMPLE

Sample of this study was restricted to women between the ages of 20 and 40, who have a romantic partnership. This specific age range was chosen to eliminate the effects of other health related symptoms that may be seen in older women. Participants were recruited online from the cities in Turkey by snowball sampling and participation was on a voluntary basis. Following the exclusion of participants that did not meet the initial selection criteria, the final sample consisted of 318 women.

The mean age of the participants is 27.45 (SD = 4.85). The sample was highly educated; only 11.5% of the participants defined their education level as high school or below, whereas 42% were university graduates and 47% had post-graduate degrees. In terms of socio-economic status, 2.9% of the participants defined their socio-economic status as low, 7.3% of the participants defined as low-middle, 47.9% of the participants defined as middle, 37.7% of the participants defined middle-high and 4.2% of the participants defined their socio-economic status as high. Regarding their current romantic relationship, 2.9% of the participants defined their relationship status as flirting, 55% of the participants defined as romantic partnership, 1.9% of the participants defines as betrothed, 4.5% of the participants defined as engaged, whereas 33.2% of the participants defined themselves as married and 2.6% of the participants reported to be in open romantic relationship.

2. INSTRUMENTS

Demographic Form. The demographic form, which was created by the researcher, included questions about gender, age, place of birth, education level,

romantic relationship status, the frequency of communication with the partner, socio-economic status, medical diagnosis, and physical complaints (See Appendix B).

Romantic relationship status of the participants was evaluated through several questions that investigate the duration, living situation, and frequency of communication via different means.

Regarding the medical history and physical complaints, participants were expected to report presence and type of any acute and/or chronic physical illness.

Relationship Assessment Scale (RAS). To measure participants' romantic relationship satisfaction, Relationship Assessment Scale (RAS), developed by Hendrick (1988), was used. The scale has 7 items that were rated on a Likert type scale. Each item of the scale comprises a 7-point scale ranging from 1 (low satisfaction) to 7 (high satisfaction). Two items, 4 and 7, were inversely scored when computing the final score of the scale and total sum score was computed (See Appendix C). For the original version of the RAS, Cronbach's Alpha score was found as 0.91 by Hendrick (1988). Turkish adaptation of the RAS was done by Curun (2001). The reliability score of the Turkish adaptation was found as 0.86 (Curun, 2001).

Somatization Scale (SS). It is originally a subscale of Minnesota Multiple Personality Scale (MMPI) developed by Hathaway and McKinley (1943). It consists of 33 questions and participants are expected to answer questions either yes or no (Dülgerler, 2000). Following the calculation guidelines, a single score is obtained by summing the scores of 33 items (See Appendix D). Turkish adaptation of the Somatization Scale was done by Dülgerler (2000). According to this study, test-retest reliability score was reported as 0.96 and Kuder-Richardson-20 coefficient was reported as 0.83. The validity of the Turkish version was checked by its correlation with SCL-90, and found as 0.80 (Dülgerler, 2000).

Emotion Intelligence Scale (EIS). The first version of the Emotional Intelligence Scale (EIS), which measures one's emotional intelligence, was developed

by Schutte, Malouff, Hall, Haggerty, Cooper, Golden and Dornheim. (Schutte et al., 1998). Basically, emotional intelligence model developed by Salovey and Mayer (1990) is the keystone of the EIS. The first version of the EIS was composed of 33 items and one dimension. After the revision of the scale by Austin, Saklofese, Huang and McKenney, number of items was increased to 41, and three and four-dimensional versions were suggested. Items are rated on a 5-point scale; where 1 represents "strongly disagree" and 5 represents "strongly agree" (Schutte et al., 1998). Cronbach's alpha score was reported as 0.85 for the original version of the scale whereas the scores of the subdimensions (Optimism/Mood Regulation, Utilizations of Emotions and Appraisal of Emotions) were reported 0.78, 0.68 and 0.76 by Austin et al., (2004), respectively.

The study of Turkish adaptation of the scale conducted by Tatar et al., (2011) comprises 41 items and three subscales which measures Optimism/Mood Regulation, Utilizations of Emotions and Appraisal of Emotions (See Appendix E). According to the result of the study adapted Emotional Intelligence Scale (EIS) into turkish, the Cronbach's Alpha internal consistency coefficient for the entire scale was reported as 0.82 by Tatar et al., (2011). Specifically, 0.75, 0.39 and 0.76 were reported as Cronbach's Alpha internal consistency score for Optimism/Mood Regulation, Utilizations of Emotions and Appraisal of Emotions, respectively. For the validity study, Five Factor Personality Inventory was used in addition to Emotional Intelligence Scale through 100 participants. The results indicated that there was a significant correlation, ranging from -0.29 to 0.34, between Emotional Intelligence Scale and personality traits.

World Health Organization Quality-of-Life Scale (WHOQOL-BREF). The original version of the World Health Organization Quality of Life Scale consists of 100 questions, 6 subscales and 25 facets. It is a 5-point scale and each facet contains 4 questions. The short version of the WHOQOL called WHOQOL-BREF contains 4 subscales and 26 questions. Four subscales are physical (7 items), psychological (6 items), environmental (8 items) and social (3 items) dimension of

life quality.

Cronbach's Alpha score of the WHOQOL-BREF was reported as 0.66 to 0.84. Validity of the short version was supported by its correlation with the original scale that was found to vary between 0.89 to 0.95.

The Turkish adaptation of the World Health Organization Quality of Life Scale called (WHOQOL-BREF-TR) was conducted by Fidaner et al., (1999). One item that directly asks the participants to rate their overall life quality was added to 26 questions (See Appendix F). Test re-test reliability coefficients of the Turkish version of the scale ranged from 0.51 and 0.81 whereas The Cronbach Alpha score was reported as 0.85 (Fidaner et al., 1999).

3. PROCEDURE

The target population of the study was women between the ages of 20 and 40, who were involved in a romantic relationship at the time of the study. The data were collected through an online survey tool and the criteria for participation was stated in the description of the study. Participation was voluntary. Upon obtaining the informed consent, the demographic form, Emotional Intelligence Scale (EIS), World Health Organization Quality of Life Scale (WHOQOL-BREF), Somatization Scale (SS) and Relationship Assessment Scale (RAS) were presented in this order to all participants. Completing all of the questions took approximately fifteen minutes.

RESULTS

1. DESCRIPTIVE STATISTICS

In this study, individual's level of psychosomatic tendency was the dependent variable, whereas aspects of emotional intelligence, quality of life and romantic relationship satisfaction were independent variables. Besides, following the initial inspection of the data, romantic relationship status was also included as a possible predictor of somatization.

Initial inspection of data revealed that 43 (%13.7) participants had a chronic medical condition and 37 (%11.8) participants had an acute medical condition. 15 of these participants reported both. Since the presence of such a chronic and/or acute condition might elevate the reported number of physical symptoms that would not qualify as psychosomatization and might have strong associations with other variables that might modify the associations hypothesized in this study, the responses of the participants who reported to have such a condition were excluded. Further analyses were conducted on the remaining 250 participants, who did not report any chronic or acute disorder.

Table 1 shows the mean, standard deviations, minimum and maximum values for psychosomatic symptoms, romantic relationship satisfaction, quality of life and emotional intelligence. The mean score for the participants who show psychosomatic symptoms was found as 9.12 (SD=5.65) whereas the possible maximum score is 32. Thus, the level of somatization of this sample is notably low. Moreover, the mean score for the participants' romantic relationship satisfaction was found as 39.12 (SD=7.71) and the possible maximum score is 49. It can be said that romantic relationship satisfaction is markedly high. The mean values of the subdimensions of the emotional intelligence (Optimism/Mood Regulation, Utilizations of Emotions and Appraisal of Emotions) were found 46.07

(*SD*=4.75), 22.56 (*SD*=2.48) and 40.91 (*SD*=4.*88*), respectively. The possible maximum scores were found as 57 for Optimism/Mood Regulation, 29 for Utilizations of Emotions and 50 for Appraisal of Emotions. It is possible to say that mean scores of the subdimension of emotional intelligence quite high. Furthermore, the mean values of the subdimensions of the Quality of Life (physical, psychological, social and environmental life quality) were found as 15.37 (*SD*=2.51), 14.18 (*SD*=2.33), 14.60 (*SD*=2.94) and 14.22 (*SD*=2.24). The possible maximum scores were found as 20 for physical, psychological, social and 19.5 for environmental life quality. Based on the possible maximum scores and each mean score, quality of life can be reported as moderate.

Table 1

Descriptive for SS, EIS, RAS, WHOQOL-BREF (N = 250)

	Min	Max	Mean	SD
Somatization	0	32	9.12	5.65
Romantic Relationship Satisfaction	14	49	39.12	7.71
Emotional Intelligence				
Optimism/mood Regulation	30	57	46.07	4.75
Utilization of Emotions	15	29	22.56	2.48
Appraisal of Emotions	26	50	40.91	4.88
Quality of Life				
Physical Life Quality	7.4	20	15.37	2.51
Psychological Life Quality	6.7	20	14.18	2.33
Social Life Quality	4	20	14.60	2.94
Environmental Life Quality	8	19.5	14.22	2.24

Note. N=250

Overall, the young, well-educated, typically middle or middle-high SES

women participants of this study demonstrated a low level of somatization, a moderate quality of life and high emotional intelligence and relationship satisfaction. The data was explored to see if there was any unforeseen demographic characteristic that would significantly influence the level of somatization. Education, income, living situation and aspects of the relationship, other than the status of the relationship, were not significantly associated with somatization.

Participants of different relationship statuses demonstrated varying levels of somatization (See Table 2). Due to unbalanced number of participants at each category and since it is beyond the scope of this study, further significance testing was not conducted. Still, depending on this observation, a dichotomous version of relationship status is included as a possible predictor in the analyses below.

Table 2

Descriptive for Relationship Statuses

	N	Mean	SD	Min	Max
Flirting	8	12.63	3.54	8	18
Romantic Partnership	140	9.94	5.77	1	32
Engaged	16	9.33	4.84	2	15
Married	82	7.15	5.14	0	21
Open Relationship	4	10.50	7.33	3	20

Note. N=250

Table 3

Pearson Correlation Coefficients

	Somatization
Romantic Relationship Satisfaction	-.376**
Emotional Intelligence	
Optimism/Mood Regulation	-.323**
Appraisal of Emotions	-.287**
Utilization of Emotions	-0.100
Quality of Life	
Psychological Life Quality	-.498**
Physical Life Quality	-.561**
Social Life Quality	-.380**
Environmental Life Quality	-.371**

Note. ** p<.01, *p<.05.

2. FACTORS THAT PREDICT PSYCHOSOMATIZATION

This study hypothesized low levels of relationship satisfaction to be associated with high levels of somatization. Further, a negative correlation was expected between somatization and emotional intelligence (especially expression of emotions) as well as life quality (especially psychological and social).

In order to examine the association of each variable with the level of somatization, Pearson correlation coefficients were calculated (See Table 3). As expected, it was observed that level of somatization is significantly negatively correlated with relationship satisfaction, all aspects of life quality and dimensions of emotional intelligence, except for Utilization of Emotions. Physical Life Quality (r = -.561) and Psychological Life Quality (-.498) had the strongest correlations with Somatization. The conditional associations of life quality, emotional intelli-

gence and relationship satisfaction to somatization as well as their predictive potential were further investigated. To be able to determine whether these variables would predict the level of psychosomatic symptoms or not, and to allow for further comparisons of their relative impact, a stepwise regression analysis was conducted. Since Life Quality and Emotional Intelligence could be strongly related to each other, correlations among all independent variables were checked to determine multicollinearity. The correlations ranged between .008 and .563. Since possible interaction effects were additionally analyzed, mean-centered scores of these variables were used for Regression analyses.

Other than the hypothesized variables, socio-economic status was included in this analysis since the literature indicated it as a possible predictor. Further, initial inspection of the data suggested that the type of the relationship might have been associated with somatization. In order to see whether this initial observation is maintained while controlling for other related variables, relationship status was also included in the following analyses. In order to balance the number of participants and to be able to include the variable in the regression analysis, categories of relationship status were reduced to two: flirt / relationship and married. Further, since the sample had a wide age range of 20-40 that might introduce effects of aging, age was also included in the analyses. Thus, in the regression analysis, romantic relationship satisfaction, the subscales of quality of life (physical, psychological, environmental, social), the subscales of emotional intelligence (optimism/ mood regulation, utilizations of emotions, appraisal of emotions), age and the two-category relationship status were independent variables whereas somatization level was the dependent variable.

The models generated by the stepwise regression are summarized in Table 4. In the final step, Physical Life Quality, Relationship Status, Relationship Satisfaction, Appraisal of Emotions entered the equation (F (4, 243) = 40.063, $p < .000$), explaining approximately 40% of the variance in Somatization. Psychological, social and environmental life quality variables as well as utilization of emo-

tions and optimism / mood regulation were excluded from the model. Although they were significantly negatively correlated with somatization except utilization of emotions, these variables were not found to be significant predictors of somatization in this sample. On the other hand, Appraisal of Emotions, being the only emotion processing related variable that could enter the model further supports the hypothesis of this study that ascribes a prominence to appraisal over the other aspects of emotional intelligence.

The regression coefficients and significance of each predictor is reported in Table 5 whereas excluded variables reported in Table 6.

Table 5

The Regression Coefficients

	B	Std. Error	Beta	t	Sig.
(Constant)	9.820	.346		28.393	.000
Physical Life Quality	-1.051	.121	-.466	-8.662	.000
Marriage	-2.134	.614	-.177	-3.478	.001
Relationship Satisfaction	-.123	.040	-.167	-3.116	.002
Appraisal of Emotions	-.132	.060	-.114	-2.190	.029

Note. N=250

Table 6

Excluded Variables

Model		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics / Tolerance
1	Relationship Satisfaction	-.216[b]	-3.978	.000	-.246	.899
	Optimism/mood Regulation	-.118[b]	-2.072	.039	-.131	.846
	Utilization of Emotions	-.099[b]	-1.871	.063	-.119	1.000
	Appraisal of Emotions	-.146[b]	-2.702	.007	-.170	.933
	Psychological Life Quality	-.217[b]	-3.065	.002	-.192	.539
	Environmental Life Quality	-.100[b]	-1.613	.108	-.102	.720
	Social Life Quality	-.093[b]	-1.463	.145	-.093	.683
	Age	-.176[b]	-3.389	.001	-.212	1.000
	Marriage	-.217[b]	-4.237	.000	-.261	.997
2	Romantic Relationship Satisfac-	-.178[c]	-3.300	.001	-.207	.865
	Optimism/mood Regulation	-.107[c]	-1.929	.055	-.123	.844
	Utilization of Emotions	-.098[c]	-1.932	.055	-.123	1.000
	Appraisal of Emotions	-.128[c]	-2.436	.016	-.154	.927

	Psychological Life Quality	-.178[c]	-2.561	.011	-.162	.527
	Environmental Life Quality	-.078[c]	-1.287	.199	-.082	.714
	Social Life Quality	-.099[c]	-1.605	.110	-.102	.683
	Age	-.080[c]	-1.304	.193	-.083	.693
3	Optimism/mood Regulation	-.076[d]	-1.374	.171	-.088	.815
	Utilization of Emotions	-.093[d]	-1.855	.065	-.118	.999
	Appraisal of Emotions	-.114[d]	-2.190	.029	-.139	.919
	Psychological Life Quality	-.103[d]	-1.366	.173	-.087	.441
	Environmental Life Quality	-.043[d]	-.704	.482	-.045	.689
	Social Life Quality	-.007[d]	-.106	.915	-.007	.534
	Age	-.113[d]	-1.863	.064	-.119	.677
4	Optimism/mood Regulation	-.026[e]	-.422	.673	-.027	.643
	Utilization of Emotions	-.081[e]	-1.624	.106	-.104	.986
	Psychological Life Quality	-.075[e]	-.989	.324	-.063	.426
	Environmental Life Quality	-.009[e]	-.152	.879	-.010	.643
	Social Life Quality	.041[e]	.570	.569	.037	.487
	Age	-.104[e]	-1.724	.086	-.110	.674

Note. N=250

An increase in each of the predictor variables cause a decrease in somatization. In other words, individuals who have lower physical life quality, who have lower romantic relationship satisfaction, who have lower appraisal of emotions ability and who are not married are more likely to experience psychosomatic symptoms. Among these variables, physical aspect of life quality was found as the strongest predictive factor for psychosomatic symptoms. It is followed by relationship status and relationship satisfaction. As also seen in Table 4, Physical Life Quality alone explains 31% of the variance in somatization for this sample.

Last, in addition to its direct association with somatization, any possible interaction of appraisal of emotions with relationship satisfaction and life quality was also explored by adding the interaction terms to the above regression analyses. None of the interactions were significant.

To sum up, the hypotheses that expect a negative association between somatization and relationship satisfaction, life quality and emotion processing are all supported by correlations. In addition, in terms of the relative prominence and predictive power, physical quality is quite strongly associated with somatization and it is followed by two relational variables; satisfaction and status. This finding also supports the hypotheses that relationship satisfaction is an important correlate and predictor of somatization. However, regarding life quality, although all aspects are negatively correlated with somatization as expected, psychological, social and environmental aspects were not significant predictors of somatization (See Table 6). In terms of emotional intelligence, only appraisal of emotions was found to be predictor and utilization of emotions had no association with somatization. This finding partially supports the hypothesis that emotion processing would be negatively correlated with somatization. As expected, appraisal of emotions is the most related aspect of the emotional intelligence. However, mood regulation, although significantly correlated, did not appear to be a significant predic-

tor. Last, utilization of emotions did not demonstrate any significant association.

DISCUSSION

The aim of the study was to investigate the association between romantic relationship satisfaction and psychosomatic tendency. Besides, the relationship between emotional intelligence and psychosomatic tendency; the relationship between quality of life and psychosomatic tendency was also evaluated. Emotional processing ability was operationalized as emotional and had three different factors; optimism/mood regulation, utilizations of emotions and appraisal of emotions. Quality of life, on the other hand, was evaluated across four dimensions; physical, psychological, environmental, and social. In addition to these independent variables, the study was also included romantic relationship status.

The sample of this study represented young adult, well-educated women living in Turkey. Although the overall level of somatization was low in this sample, due to the exclusion of the participants with any physical conditions that might have contributed to an increase in somatic symptoms, the remaining variance is thought to represent the difference in non-medical factors that affect somatization. This study expected somatization to be negatively correlated with relationship satisfaction, emotional intelligence and life quality. Further, in the light of the literature, appraisal of emotions was hypothesized to be a more prominent predictor of somatization. In order to test these hypotheses, first the correlation among variables were inspected, and then a stepwise regression analysis was conducted.

The negative correlations observed between relationship satisfaction and somatization; all aspects of quality of life (physical, psychological, social, environmental) and somatization; and two emotional processing subscales (appraisal of emotions, optimism / mood regulation) and somatization supported the hypotheses of this study. Utilization of emotions, on the other hand, was not found to be a significant correlate of somatization.

According to the results of the stepwise regression analysis, physical life

quality, relationship status, romantic relationship satisfaction and appraisal of emotion were found as predictive factor for psychosomatic symptoms. Among these variables, physical aspect of life quality was found as the strongest predictive factor for psychosomatic symptoms and it is followed by relationship status and relationship satisfaction. Lastly, appraisal of emotion has a predictive power on psychosomatization. On the other hand, psychological, social and environmental aspects were not found as significant predictors of psychosomatization. Based on the findings, utilization of emotions had no significant association with somatization. Besides that, optimism/mood regulation, although found as significantly correlated with somatization, did not appear to be a significant predictor.

As suggested by the results of this study, women who are satisfied with their romantic partnership have a tendency to show less psychosomatic symptoms. As Gottman and Levenson (1986, 1988) indicated, when partners are not satisfied with their romantic relationship, high physiological arousal can result from the tense atmosphere of conflict between the partners. Further, the autonomic nervous, endocrine and immune system can be negatively affected by the physiological arousal (Jemmott & Locke, 1984). Similarly, Hartley (2004) stated that mental tensions have various impacts -changes in circulation, respiration, endocrine glands and organs of the body- on central and autonomic nervous system. In this regard, the findings of the study support these ideas in literature.

The results of the stepwise regression analysis also show that physical life quality -a subdimension of the quality of life- is significantly correlated with individual's psychosomatization level. In other words, individuals who have better physical life quality show less psychosomatic symptoms. Being not hypothesized in this study, this association seems to be expected by common sense. Psychosomatization and physical life quality are two concepts triggering and feeding each other. On the contrary, psychological life quality -another subdimension of quality of life- was not found as predictor factor of psychosomatization even it was found as correlated with psychosomatization. This result may have occured

because the covarience was captured by other variables. Additionally, all definitions indicate the existence or exacerbation of disturbing bodily experiences because of an underlying psychological issue in the literature. Yet, there may be a difference between the existence of psychological matters and externalizing of these psychological factors through self-report. In that sense, Kirmayer and Robbins (1991) mentioned three different type of somatization and one of them called "somatized clinical presentation" that refers to a tendency to deny or ignore psychological symptoms. Furthermore, patients with Somatoform Disorder who had a low level of emotional awareness reported (through self-report) that they have low level of psychological disturbances (Subic-Wrana et al, 2010). Shedler et al. (1993) also mentioned the concept called "illusion of mental health" refers to a characteristic of patients who use defensive denial mechanism and present themselves as mentally healthy on self-reports. According to the findings of a study conducted by Carlier et al, (2014), patients with somatoform disorder reported less psychopathology on a self-report (as cited in Wineke et al, 2015). Thus, rather than directly (explicitly) asking to patients who have psychosomatic symptoms to evaluate their psychological states, implicitly measurement of those states is crucial to obtain coherent results. Therefore, the lack of association between psychosomatization level and psychological aspect of life quality in this study may be due to the explicit style of the questions in that scale. On the other hand, if a projective scale that enables to measure participants' psychological states imlicitly had been used, the association between psychosomatization level and psychological aspect of life quality might be found.

Based on the findings of this study, appraisal of emotions that refers to identification and expression of emotions was found significantly related with individuals' psychosomatization level, as hypothesized. Women who have a better capacity for appraisal and expression of emotions demonstrated less psychosomatic symptoms in this study. Zhou and George (2003) stated that some of the individuals have a capacity to express their emotions whereas some of them are not

even aware of their emotions. In relation to that, Lipowski's (1987) defined somatization as the absence of emotional experience. In other respects, as Breuer and Freud (1893) stated that emotional states that were not expressed in any other form might reveal themselves physically. According to the concept of "psychosomatic medicine" developed by Franz Alexander, emotions that were repressed can be transmitted through autonomic nervous system to bodily organs and may cause the psychosomatic symptoms (as cited in Aisenstein and Smadja, 2010). Those explanation of psychosomatization emphasized the importance of the ability of both defining and expressing the emotions, namely appraisal of emotions. Lack of the ability for defining and expressing emotions, otherwise, can cause arising psychosomatic symptoms. The findings of the present study support that idea. In the context of the general framework of the study, the capacity of appraisal of emotions in the romantic partnership is siginificantly related with individual's somatization level. Thus, the women who are able to define and express their emotions to their partner show less psychosomatic symptoms.

Furthermore, there are several ideas that put emphasis on the possible relationship between romantic relationship satisfaction and emotion processing -specifically appraisal of emotions-. Sprecher and Hendrick (2004) highlighted the importance of the positive impact of emotional self-disclosure on romantic relationship satisfaction. They explained the emotional self-disclosure as the process of expressing one's own feelings about, attitudes towards, and experiences with the partners. According to Keltner and Haidt (2001), emotions have an important role considering social interactions and relationships. Through emotional intelligence, individuals understand and manage complex feelings whose themselves and others (Abisamra, 2000).

In the sense of interpersonal relations context, "higher emotional intelligence may lead to better management of disagreements, which in turn might predict less conflict and higher relationship satisfaction" (Brackett et al., 2005, p. 198). Besides that, couples who are emotionally intelligent have a capacity to un-

derstand, honor and respect each other better (Gottman and Silver, 1999). Moreover, emotions between the partners are interconnected to each other (Butler, 2011). Co-regulation concept, which explains this emotional connectivity, refers to interpersonal regulation affecting psychological and physicological well-being of the partners. Specifically, reciprocity of the emotional regulation is vital for secure attachment in romantic partnerships (Sbarra & Hazan, 2008).

In the light of the ideas mentioned above, appraisal of emotions can be defined as a common factor that have an impact on both romantic relationship satisfaction and psychosomatization.

Optimism/mood regulation, another subdimension of the Emotional Intelligence, was also found correlated with psychosomatization. Yet, it was not found predictor factor while other variables controlled in stepwise regression analysis. Basically, optimism/mood regulation could be expected to be a predictor factor however, the characteristic of the sample who have low somatization level, high relationship satisfaction and life quality could have been effective.

One question remains regarding the emotional intelligence that is why the other subdimension of emotional intelligence -utilization of emotion- was not found to be related with somatization. Utilization of emotion basically refers to flexible planning, creative thinking. (Schutte et al., 1998). In other words, the ability to adjust according to the changing situations via utilization of emotion (Zhou & George, 2003). In that sense, the ability of utilization of emotion can be considered more advanced ability than mood regulation and appraisal of emotion. Specifically, emotions should be defined and regulated at first to be able to be used. Thus, utilization of emotion may not have been found as significantly associated with somatization.

Romantic relationship status was not hypothesized at first however, it was integrated to the regression analysis because it was thought to be a predictor. According to the results of the stepwise regression analysis, romantic relationship status was found significantly related with individual's experience of psychoso-

matic symptoms. Specifically, women who are married have a tendency to show less psychosomatic symptoms. There is not much study investigating the relationship between marriage and somatization. Kiecolt-Glaser and Newton (2001) stated that marital dissatisfaction is associated with mental and physical health. Escobar et al., (1987) stated that individuals who are not married have a higher tendency to show psychosomatic symptoms. More directly, Robins and Reiger's (1991) research indicated that women who are not married show more psychosomatic symptoms rather than women who are married. Moreover, Kirmayer (1984) asserted that being separated or divorced -for women- is associated with experiencing psychosomatization more. In contrast, Katon (1993) stated that there is not a significant relationship between marital status and somatization. Yet, the findings of this study have parallels with the idea that married women have less psychosomatic symptoms than women who are not married. This finding might be considered to be a support for studies that identify marriage as a protective factor, rather than a risk factor. However, since being married itself cannot be considered separately from the quality of the relationship and the subjective meaning of being married to the partners, this association between marriage and somatization requires further investigation. Yet, this study indicates that this might be a promising area for further research.

In sum, the results showed that physical aspect of the quality of life, romantic relationship status, romantic relationship satisfaction and appraisal of emotions were significantly related with the frequency of psychosomatic symptoms. The ideas and findings gathered from several studies support the results of this study which indicate significance relationship between psychosomatization and other variables (physical life quality, romantic relationship status, romantic relationship satisfaction and appraisal of emotions). In addition to these, the results of the study can be also discussed in terms of the participant profile, which refers to young adult and well-educated females. In the socio-cultural frame, Turkish culture can be defined under the title of collectivist and patriarchal cultures whereas

young adult and well-educated population is in the process of individualization (Geert, 1991). Based on the findings of this study, the capacity for appraisal of emotions (identification and expression of emotions), high level of romantic relationship satisfaction and being married has an impact on reducing the level of psychosomatic symptoms in women who are part of this population. Although this population is increasingly becoming independent and individualized, they are still implicitly connected to their collectivist cultural roots. In that sense, romantic partnership might be identified as a micro version of that collective community. Based on this view, romantic relationship, especially marriage, can be considered as a "container" that provides a space where emotions can be expressed, reflected psychological distress and so reduces level of psychosomatic symptoms. Additionally, marriage can be also described as "social status". Being married -for women- in cultures such as Turkey can be a factor not only because the container role of marriage but also because it increases their status and self-esteem in the society. Yet, all of these factors cannot be considered independently of relationship satisfaction and emotional intelligence.

1. CLINICAL IMPLICATIONS

In terms of clinical implications, the findings of the study can be used in support of therapeutic process by clinicians. The physical life quality and romantic relationship status of the client who has psychosomatic complaints might be integrated in the therapeutic process in the course of evaluation phase. Yet, the relationship among psychosomatic symptoms and the capacity for appraisal of emotions and relationship satisfaction should be observed in detail through the whole therapeutic journey since these two dimensions require an in-depth understanding. In that sense, enabling emotions to be defined and expressed and encouraging client to develop awareness of internal structure of her own romantic relationship might be essential to interpret psychosomatic complaints.

Plus, couple therapy can enable to be comprehensively analyzed the internal dynamics between patients' psychosomatic symptoms and the relationship satisfaction, the capacity of appraisal of emotions, physical life quality. When the interpersonal dimension of relationship satisfaction and the capacity of appraisal of emotions are considered, it may be beneficial to work on the relationship between psychosomatic symptoms and the relationship satisfaction and the capacity of appraisal of emotions in the context of couple therapy process where both partners are involved.

From another perspective, the results of the study are also valuable for medical professions. A patient with a medically unexplained symptom should be evaluated in psychosomatic frame by the health care professionals who work in health institutions -hospital, primary health care center. Moreover, the predictive factors -relationship satisfaction, the capacity of appraisal of emotions, physical life quality- for psychosomatization can be also taken into account through the evaluation phase by health care professionals. In that sense, these patients should be refered to mental health professional in addition to medical treatment.

If both systemic and relational psychoanalytic perspectives are considered, it is not possible to independently evaluate intrapsychic pattern from the interpersonal relation since psychosomatization has a relational dimension even it seems as an individual disorder. In that sense, an integrative therapeutic approach which includes both systemic and relational psychoanalytic approach can provide a wide range of perspectives and flexibility in therapeutic intervention.

2. SUMMARY, LIMITATIONS & SUGGESTIONS

The aim of the study was to explore the relationship between psychosomatization level and relationship satisfaction, emotional processing and life quality through the women between the ages of 20 and 40, who have a romantic partner-

ship. According to the findings reported above; physical life quality, relationship status, romantic relationship satisfaction and appraisal of emotion were found as factors that are associated with psychosomatization. Physical aspect of life quality, among these variables, was found as the strongest predictive factor for psychosomatic symptoms, and it was followed by relationship status, relationship satisfaction and appraisal of emotion. In addtion to the significant results of this study, there are several limitations of the study and suggestions for further studies.

Firstly, the study conducted through women between the ages of 20 and 40, who have a romantic partnership can be carried out with a sample includes men and women to be able to observe gender differences. Besides that, the characteristic of the sample was quite homogeneous and it comprised of young adult and well-educated females. Future research can conduct the similar study through heterogeneous sample. Additionally, relationship duration can be considered as a evaluation criteria for relationship satisfaction. Plus, interaction effect of whether the participants are specifically sexually satisfied with their marriage or not can be integrated to the future studies. Moreover, both partners emotional processing can be measured in future researches to evaluate co-regulation instead of measuring one's emotional processing. Regarding the methodology, variables were measured through the instrument -Relation Assessment Scale (RAS), Emotional Intelligence Scale (EIS), World Health Organization Quality of Life Scale (WHOQOL-BREF-TR) and Somatization Scale(SS)- that based on participants' self-report. In addition to self-report based scales, projective instruments may be also used in future researches to evaluate participants' dynamics implicitly.

REFERENCES

Abisamra, N. (2000). The Relationship between emotional intelligence and academic achievement in eleventh graders, research in education. *FED*, 620-661.

Aisenstein, M. (2006). The indissociable unity of psyche and soma: a view from the Paris Psychosomatic School. *The International Journal of Psy choanalysis.* 87: 667–680.

Aisenstein, M., & Smadja, C. (2010). Conceptual framework from the Paris Psychosomatic School: a clinical psychoanalytic approach to on cology. *The International Journal of Psychoanalysis* 91(3): 621- 40.

Akhtar, S., & O'Neil, M. K. (2013). On Freud's "The unconscious". *The International Psychoanalytical Association Contemporary Freud: Turning Points and Critical Issues Series,* Karnac Books.

Alexander, F. (1950). *Psychosom. Med.*. New York: Norton.

American Psychiatric Association (2013). Cautionary Statement for Foren sic Use of DSM-5. In Diagnostic and Statistical Manual of Mental Disorders (5th ed.).

Austin E. J., Saklofske D. H., Huang S. H. S., & McKenney D. (2004). Measurement of trait emotional intelligence: testing and cross-vali dating a modified version of Schutte et al.'s (1998) measure. Pers Indiv Differ.

Barsky A. J., & Klerman G. L. (1983). Overview: Hypochondriasis, bodiliy complaints and somatic styles. *Am J Psychiatry*.140: 273-283.

Brackett, M. A., Warner, R. M., & Bosco, J. S. (2005). Emotional intelli gence and relationship quality among couples. *Personal Relation ships*, 12, 197-212.

Breur, J. & Freud, S. (1893). On the psychical mechanism of hysterical phe nomena: Preliminary communication from studies on hysteria. The

standard edition of complete psychological works of Freud, vol 2 (1893-1895), *Studies On Hysteria*, 1-17. 36(3): 555-62.

Bronstein, C. (2011). On psychosomatics: The search for meaning. *Internat. J. PsychoAnal*., 92:173–195.

Blunden, R. (1988). Quality of life in persons with disabilities: Issues in the development of services. In R. I. Brown (Ed.), Qualityof life for handicapped people (pp. 37-55). London: Croom Helm.

Borthwick-Duffy, S.A. (1992). Quality of Life and quality of care in mental Retardation. In L. Rowitz (ed) Mental Retardation in the Year 2000 (p.52-66). New York, Springer-Verlag.

Butler, E. A. (2011). Temporal interpersonal emotion systems: The "TIES" that form relationships. *Personality and Social Psychology Review* 15(4):367–393.

Cohen, S., Janicki-Deverts D., & Miller G. E. (2007). Psychological stress and disease. *JAMA*, 298(14): 1685–1687.

Curun, F. (2001). The effects of sexism and sex role orientation on rela tionship satisfaction. Unpublished Master Thesis, M.E.T.U. Ankara.

Denzler, B. (2002). A Critical Enquiry into The Psychoanalytic Theories and Approaches to Psychosomatic Conditions. *The International Journal Psy choanalysis*, 83: 931–934.

Deutsch, F. (1939). The choice of organ in organ neuroses. *Int J Psychoanal,* 20: 252-62.

Deutsch, F. (1952). Some Psychodynamic Consideration of Psychosomatic Skin Disorders–Plethysmo Graphic and Psychoanalytic Observations. *Psycho somatic Medicine.*14(4): 287-294.

Duncan, G. (2000). Mind–body dualism and the biopsychosocial model of pain: what did Descartes really say? *Journal of Medicine and Philosophy.* 25:485–513.

Dülgerler, Ş. (2000). İlköğretim okulu öğretmenlerinde somatizasyon ölçeği

geçerlik ve güvenirlik çalışması. (Unpublished master dissertation). Ege University, İzmir.

Emerson, E. (1985). Evaluating the impact of deinstitutionalization on the lives of mentally retarded people. *American Journal of Mental Deficiency*, 90(3), 277-288

Escobar, J. I., Burnam, M. A., Karno, M., Forsythe, A., & Golding J. M. (1987). Somatization in the community. Archives of *General Psychiatry*, 44, 713–718.

Escobar, J. I., Golding, M. J., Hough, R. L. (1987). Somatization in the communi ty: relationship to disability and use of services. *American Journal of Pub lic Health*, 77: 837-840.

Ferrans, C. E. (1990). Development of a quality of life index for patients with cancer. *Oncology Nursing Forum*, 17(3), 15-19.

Fidaner, H., Elbi, H., Fidaner, C., Eser, S. Y., Eser, E., & Göker, E. (1999). Yaşam kalitesinin ölçülmesi, WHOQOL-100 ve WHOQOL- BREF. *Psikoloji, Psikiyatri ve Psikofarmakoloji (3P) Dergisi*, 7(ek2), 5-13.

Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical consid erations in the treatment of a borderline patient. *International Journal of Psycho-Analysis*, 72,639-656.

Fonagy, P., Gergely, G., Jurist, E. L., Target, M. (2002). Affect regulation, mental ization and the development of the self. New York: Other Press.

Ford, C.V. (1983). The somatizing disorders: Illness as a way of life. New York: Elsevier.

Goleman, D. (1996). Emotional Intelligence: Why It Can Matter More than IQ , London, Bloomsbury.

Goleman, D. (1998a). What makes a leader? Harvard Business Review, 76, 93–102.

Gottman, J. M. & Levenson, R. W. (1986). Assessing the role of emotion in mar riage. *Behavioral Assessment, 8,* 31-48.

Gottman, J. M. & Levenson, R. W. (1988). The social psychophysiology of mar riage. *In P. Noller & M. A. Fitzpack (Eds.), Perspectives on Mar ital In teraction* (pp.182-200). Clevedon, England: Multilingual Matters Ltd. pro tocol development. J. Natl. Cancer Inst., 1992; 8: 57579

Gottman, John M., & Nan Silver. (1999). "Inside the Seattle love lab: The truth about happy marriages," in The Seven Principles for Making Marriages Work (Chapter One, 1-24). New York: Three Rivers Press (Random House, Inc.).

Gotay, C. C., Korn E.L., McCabe, M. S., Moore, T. D., & Cheson, B. D. (1992). Quality of life assessment in cancer treatment protocols: research issues in protocols development. *J Natl Cancer Inst*. 15; 84(8): 575-579.

Gubb, K. (2013). Psychosomatics today: A review of contemporary theory and practice. *Psychoanalytical Review*, 100, 103-142.

Hamilton, J., Compos, R., Creed, F. (1996). Anxiety, Depression and the Menagement of Medically Unexplained Symptoms in Medical Clinics, *Journal of Royal Collage of Physicians*, 30:18-20.

Hartley, L. (2004). Somatic Psychology, Body, Mind and Meaning. London: Whurr Publishers.

Hathaway, S. R., & McKinley, J. C. (1943). Manual for the Minnesota Multipha sic Personality Inventory. New York: Psychological Corporation.

Hendrick, S. S. (1988). A generic measure of relationship satisfaction. *Journal of Marriage and Family*, *50,* 93-98.

Hendrick, S. S., Hendrick, C. & Adler, N. L. (1988). Romantic relationships: Love, satisfaction, and staying togetger. *Journal of Personality and Social Psychology, 54*, 980-988.

Hofstede, G. H. (1991). Cultures and Organizations: Software of the Mind. Lon don, UK: McGraw-Hill.

Janicki, M. P (1997). Quality of Life for Older Persons With Mental Retardation. Quality of Life: Application to Persons with Dissabilities. *American Asso*

ciation on Mental Retardation. Washington. Vol. 2, 105-117.

Jarema, M. (1996). Quality of life examination as an alternative form of patient condition assessment. *New Medicine*, 3: 15-16.

Jemmott, J. B. & Locke, S. E. (1984). Psychosocial factors, immunologic media tion, and human suspectibility to infectious diseases: how much do we know? *Pscyhological Bulletin, 1,* 78-108.

Keltner, D., & Haidt, J. (2001). Social functions of emotions. In T. Mayne & G. Bonanno Eds.), Emotions: Current issues and future directions pp. (192-213). New York: Guilford Press.

Kielcott-Glaser, J. K., Fisher, L. D., Ogrock, P., Stout, J. C, Speicher, C. E., & Glaser, R. C. (1987). Marital quality, marital disruption, and immune func tion. *Psychosomatic Medicine.* 49. 13-34.

Kirmayer, L. J., (1984). Culture, affect and somatization. *Trans Psychiatr Res*, 21:159-88.

Kirmayer L. J., & Robbins J. M. (1991). Three forms of somatization in primary care: prevalence, co-occurrence, and socio-demographic characteristics. *J. Nerv. Ment. Dis,* 179, 647-655.

Kirmayer, L.J., Groleau, D., Looper, K.J., & Dao, M.D. (2004). Explaining Med ically Unexplained Symptoms. *Can. J. Psychiatry*, 49: 663-669.

Krystal, H. (1988). Integration and Self-Healing: Affect-Trauma-Alexithymia. The Analytic Press, Hillsdale, NJ.

Kurdek, L. A. (2005). Gender and marital satisfaction early in marriage: A growth curve approach. *Journal of Marriage and Family, 67*, 68-84.

Larson, R. (1978). Thirty years of research on the subjective well-being of older Americans. *The Gerontologist*, 33, 109-25.

Lavner J. A., & Bradbury T. N. (2010). Patterns of change in marital satis f a c t i o n over the newlywed years. *Journal of Marriage and Family,* 72:1171-1187.

Lipowski, Z. J. (1987). Somatization: The experience and communication of psy chological distress as somatic symptoms. *Psychotherapy & Psychosomat*

ics, 47, 160–167.

Maister, L., & Tsakiris, M. (2016). Intimate imitation: Automatic motor imitation in romantic relationships. *Cognition*, 152, 108-113.

Malouff, J. M & Nicola, S. S. & Thorsteinsson, E. B. (2014). Trait Emotional In telligence and Romantic Relationship Satisfaction: A Meta-Analysis. *The American Journal of Family Therapy*, 42:53-66

Mayer, J. D., Roberts, R. D., & Barsade, S. G. (2008). Human abilities: Emotional intelligence. *Annual Review of Psychology,* 59, 507–53

Matthews, G., Zeidner, M., & Roberts, R. D. (2002). Emotional intelligence: sci ence and myth. Cambridge, MA: MIT

McKenry, P. C., & Price, S. J. (2005). Families & change: Coping with stressful events and transitions. Thousand Oaks, Calif: Sage Publications.

Minuchin, S., Baker, L., Rosman, B. L., Liebman, R., Millman, L. & Todd, T. C. (1975). A conceptual model of psychosomatic illness in childhood. *Archives of General Psychiatry,* 32: 1031–1038.

Minuchins, S., Baker, L. & Rosman B. (1978). Psychosomatic Families: Anorexia Nervosa in Context. Cambridge, Mass. Harvard University Press.

Moore, J. E., & Chaney, E. F. (1985). Outpafient group treatment of chronic pain: Effects of spouse involvement. *Journal of Consulting and Clinical Psy chology.* 53(3). 326-334.

Nemiah, J. C., Freyberger, H., & Sifneos, P. E. (1976). Alexithymia: A view of the psychosomatic process, in ed. O. W. Hill, Modern Trends in Psychosomat ic Medicine, London: Butterworths, pp. 430-439.

North, C. (2002). Somatization Survivors of Catastrophic Trauma: A Method ological Review. *Environmental Health Perspectives.* 110 (4).

Petrides, K. V., & Furnham, A. (2003). Trait emotional intelligence: behavioural validation in two studies of emotion recognition and reactivity to mood induction. *European Journal of Personality*, 17, 39-57.

Prigerson, H. G., Maciejewski, P. K., & Rosenheck, R. A. (1999). The effects of

marital dissolution and marital quality on health and health service use among women. *Medical Care*, 37, 858–73.

Robins, L. N., & Regier, D. A. (1991). eds. Psychiatric Disorders in America: The Epidemiologic Catchment Area Study. New York: The Free Press,

Rusbult, C. E. & Buunk , B. P. (1993). Commitment processes in close relation ships: An interdependence analysis. *Journal of Social and Personal Rela tionships*, 10, 175-205

Sağduyu, A. (1995). Sağlık ocağına başvuranlarda somatizasyon. *Türk Psikiyatri Dergisi*, 6: 21-29.

Sayar, K. (2002). Tıbben açıklanamayan belirtiler. Türk Psikiyatri Dergisi, 13(3): 222-231.

Salovey, P., & Mayer, J. D. (1990). Emotional Intelligence. *Imagination, Cogni tion and Personality*, 9: 185- 211.

Sbarra, D. A., & Hazan, C. (2008). Coregulation, dysregulation, self-regu lation: An integrative analysis and empirical agenda for understanding adult at tachment, separation, loss, and recovery. *Personality and Social Psycholo gy Review.* 12(2):141–167.

Schutte, N. S., Malouff, J. M., Hall, L. E., Haggerty, D. J., Cooper, J. T., & Gold en, C. J. (1998). Development and validation of a measure of emotional intelligence. *Pers Indiv Differ,* 25(2): 167-177.

Sells, S. B. (1969). The definition and measurement of mental health. Washington DC: National Center for Health Statistics, U.S. Public Health Service.

Shaw, R., (1995). Mind-body Dualism: an historical perspective in its prevalence within contemporary medical discourse. *British Osteopathic Journal.* Vol XVII, 35.

Sifneos, P. E. (1973). The prevalence of "alexithymic" characteristics in psycho somatic patients. *Psychotherapy and Psychosomatics*, 22: 255-262.

Smadja, C. (2011). Psychoanalytic Psychosomatics. *The International Journal of Psychoanalysis.* 92 (1): 221-230.

Sofuoğlu, S. (1984). Psikosomatik Tıp Anlayışı ve Güncel Yaklaşımlar. *Türkiye Klinikleri*; 4(4).

Stern, D. N. (1985). The interpersonal world of the infant. New York: Basic Books.

Swartz, M., Landerman, R., George, L., Blazer, D., & Escobar, J. (1990). Somati zation disorder. In: Robins, L. N., and Regier, D. eds. Psychiatric Disor ders In America. New York: Free Press.

Taylor, G. J. (2003). Somatization and conversion: Distinct and overlapping con structs?. *Journal of American Academy of Psychoanalysis*, 487- 508.

Tatar, A., Tok, S., & Saltukoğlu, S. (2011) Gözden Geçirilmiş Schutte Duygusal Zeka Ölçeğinin Türkçe'ye Uyarlanması ve Psikometrik Özelliklerinin İncelenmesi. *Klinik Psikofarmakoloji Bülteni*, 21 (4), 325-338.

Thorndike, E.L. (1939). Your City. Harcourt, Brace, and Company, New York.

Uchino, B. N., Cacioppo, J.T., & Kiecolt-Glaser, J. K. (1996). The relationship between social support and physiological processes. Psychol Bull, 119: 488-531.

Videbeck, S. L. (2010). Psychiatric-Mental Health Nursing. Lippincott Williams & Wilkins.

Weissman, M. M., Myers, J. K., & Harding, P. S. (1978). Psychiatric disorders in a U.S. urban community: 1975-1976. *American Journal of Psychiatry,* 135: 459-462.

Zeph, S. (2014). Thoughts about Psychosomatic Symptom Formation : A Holistic Approach. *The Scandinavian Psychoanalytic Review*. Volume 37, 36-47.

Zhou, J., & George, J. M. (2003). Awakening employee creativity: The role of leader emotional intelligence. *Leadership Quarterly,* 14, 545-568.

APPENDIX A: Consent Form

Bilgilendirilmiş Onam Formu,

Bu araştırma İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Ahmet Eren Günsan'ın yüksek lisans tez çalışmasının bir parçası olup, Yrd. Doç. Dr. Alev Çavdar Sideris danışmanlığında yürütülmektedir. Araştırmanın amacı ilişkisi olan 20-40 yaş arasındaki kadınların ilişki tatminleri, bedensel yakınmaları ve yaşam kaliteleri arasındaki ilişkinin değerlendirilmesine yöneliktir.

Araştırmaya ilişkisi olan 20-40 yaş arası kadın bireyler katılabilmektedir ve katılım gönüllülük esasına dayanmaktadır. Araştırmanın hiçbir bölümünde isminizi, kimliğinizi sorgulayan herhangi bir soru bulunmamaktadır. Çalışma neticesinde elde edilen bilgiler araştırma çerçevesinde kullanılacak ve gizli tutulacaktır. Soruları yanıtlamaya başladıktan sonra herhangi bir sebeple rahatsızlık hissettiğiniz takdirde anketi doldurmayı bırakabilirsiniz.

Araştırmaya yönelik herhangi bir sorunuz olması halinde Eren Günsan (eren.gunsan@bilgi.edu.tr) ile iletişime geçebilirsiniz.

İlginiz ve katılımınız için şimdiden teşekkürler.

APPENDIX B: Demographic Form

1. Doğum tarihiniz: ..../...../.....

2. Doğum yeriniz (şehir ve ülke olarak):.....

3. Cinsiyetiniz: Kadın / Erkek

4. Mezun olunan en son okul/ üniversite:

İlkokul - Lise - Lisans - Yüksek Lisans - Doktora ve/ veya üzeri

5. Şu anda devam ettiğiniz okul:

Okumuyorum Lisans Yüksek Lisans Doktora ve/ veya üzeri

6. Kronik bir hastalığınız var mı? Var / Yok

7. Varsa nedir?

8. Şu anda mevcut bir hastalığınız ve/veya fiziksel bir rahatsızlığınız var mı?

Var / Yok

9. Varsa nedir?

10. Gelir düzeyiniz:
Alt Alt-orta Orta Orta- üst Üst

11. İlişkiniz var mı/ evli misiniz? Evet / Hayır

İlişkiniz varsa veya evliyseniz aşağıdaki soruları cevaplayınız.

12. Partnerinizle/ eşinizle (evlilik öncesi birlikteliğiniz dahil olmak üzere) ne kadar süredir birliktesiniz? ..... yıl ..... ay

13. Partnerinizin cinsiyeti: Kadın / Erkek / Diğer

14. Partnerinizle ilişki durumunuz nedir?

Flört / Sevgili / Sözlü / Nişanlı /Açık ilişki

15. Partnerimle / eşimle birlikte yaşıyorum.

Evet / Hayır

16. Partnerimle/ eşimle günün ..... saatini/ haftanın ..... gününü birlikte geçiriyorum.

17. Partnerinizle/ eşinizle ne sıklıkta yüz yüze görüştüğünüzü yazınız.

Haftada ..... kere veya ayda ..... kere veya yılda ..... kere.

18. Partnerinizle telefon veya diğer iletişim araçlarıyla ne sıklıkta görüştüğünüzü yazınız:

Günde ..... kere veya haftada ..... kere.

APPENDIX C: Relationship Assessment Scale (RAS)

1. Sevgiliniz ihtiyaçlarınızı ne kadar iyi karşılıyor?

Hiç karşılamıyor Tamamen karşılıyor

1 2 3 4 5 6 7

2. Genel olarak ilişkinizden ne kadar memnunsunuz?

Hiç memnum değilim Tamamen memnunum

1 2 3 4 5 6 7

3. Diğerleri ile karşılaştırıldığında ilişkiniz ne kadar iyi?

Çok daha İyi Çok daha kötü

1 2 3 4 5 6 7

4. Ne sıklıkla ilişkinize hiç başlamamış olmayı istiyorsunuz?

Hiçbir zaman Her zaman

1 2 3 4 5 6 7

5. İlişkiniz ne dereceye kadar sizin başlangıçtaki beklentilerinizi karşılıyor?

Hiç karşılamıyor Tamamen karşılıyor

1 2 3 4 5 6 7

6. Sevgilinizi ne kadar seviyorsunuz?

Hiç sevmiyorum Çok seviyorum

1 2 3 4 5 6 7

7. İlişkinizde ne kadar problem var?

Hiç yok Çok fazla problem var

1 2 3 4 5 6 7

APPENDIX D: Somatization Scale (SS)

Bu formda sıra ile numaralandırmış bazı sorular bulacaksınız. Her soruyu okuyarak kendi durumunuza göre DOĞRU ya da YANLIŞ olup olmadığına karar verin. Bu soruları sadece kendinizi düşünerek yanıtlayın.
Bu sorular birbirinin aynısı ya da tam tersi gibi gelebilir. Mümkünse bütün soruları cevaplandırmaya çalışın.

1. Çoğu zaman boğazım tıkanır gibi olur.	Doğru Yanlış
2. İştahım iyidir.	Doğru Yanlış
3. Başım pek az ağrır.	Doğru Yanlış
4. Ayda bir iki defa ishal olurum.	Doğru Yanlış
5. Midemden oldukça rahatsızım.	Doğru Yanlış
6. Çoğu kez midem ekşir.	Doğru Yanlış
7. Bazen utanınca çok terlerim.	Doğru Yanlış
8. Sağlığım beni pek kaygılandırmaz.	Doğru Yanlış
9. Hemen hemen hiçbir ağrım ve sızım yoktur.	Doğru Yanlış
10. Bazen başımda sızı hissederim.	Doğru Yanlış
11. Çoğu zaman başımın her tarafı ağrır.	Doğru Yanlış
12. Sağlığım birçok arkadaşımınki kadar iyidir.	Doğru Yanlış
13. Pek seyrek kabız olurum.	Doğru Yanlış
14. Ensemde nadiren ağrı hissederim.	Doğru Yanlış
15. Vücudumda pek az seğirme ve kasılma olur.	Doğru Yanlış
16. Çabucak yorulmam.	Doğru Yanlış
17. Pek az başım döner ya da hiç dönmez.	Doğru Yanlış
18. Yürürken dengemi hemen hemen hiç kaybetmem.	Doğru Yanlış
19. Soğuk günlerde bile kolayca terlerim.	Doğru Yanlış
20. Çoğu zaman yorgunluk hissederim.	Doğru Yanlış
21. Hemen her gün mide ağrılarından rahatsız olurum.	Doğru Yanlış
22. Tekrarlanan mide bulantısı ve kusmalar bana rahatsızlık verir.	Doğru Yanlış
23. Çoğu zaman bütün vücudumda bir halsizlik duyarım.	Doğru Yanlış
24. Son birkaç yıl içinde sağlığım çoğu zaman iyiydi.	Doğru Yanlış
25. Çoğu defa sabahları dinç ve dinlemiş uyanırım.	Doğru Yanlış
26. Çoğu zaman bana kafam şişmiş ya da burnum tıkanmış gibi gelir.	Doğru Yanlış
27. Çoğu zaman balım sıkı bir çember içindeymiş gibi hissederim.	Doğru Yanlış
28. Kalp ve göğüs ağrılarından hemen hemen hiç şikayetim yoktur.	Doğru Yanlış
29. Hayatımda hiçbir zaman kendimi şimdiki kadar iyi hissetmedim.	Doğru Yanlış

30. Kalbimin hızlı çarptığını hemen hemen hiç hissetmem ve çok seyrek nefesim tıkanır.	Doğru	Yanlış
31. Hiç felç geçirmedim ya da kaslarımda olağanüstü bir halsizlik duymadım.	Doğru	Yanlış
32. Ortada hiçbir neden yokken haftada bir ya da daha sık birdenbire her yanımı ateş basar.	Doğru	Yanlış
33. Vücudumun bazı yerlerinde çok defa yanma, gıdıklanma, karıncalanma ve uyuşukluk hissederim.	Doğru	Yanlış

APPENDIX E: Emotional Intelligence Scale (EIS)

Aşağıda çeşitli durumlara ilişkin ifadeler bulunmaktadır. Lütfen her bir ifadenin sizi ne ölçüde tanımladığını ya da her bir ifadeye ne ölçüde katıldığınızı aşağıda verilen ölçekteki rakamları kullanarak değerlendiriniz ve uygun olan numarayı (0-4 arasında) ilgili maddenin sağındaki boşluğa yazınız. 0 = Kesinlikle katılmıyorum 1 = Katılmıyorum 2 = Fikrim Yok 3 = Katılıyorum 4 = Kesinlikle katılıyorum

1. Kişisel sorunlarımı başkaları ile ne zaman paylaşacağımı bilirim.

2. Bir sorunla karşılaştığım zaman benzer durumları hatırlar ve üstesinden gelebilirim.

3. Genellikle yeni bir şey denerken başarısız olacağımı düşünürüm.

4. Bir sorunu çözmeye çalışırken ruh halimden etkilenmem.

5. Diğer insanlar bana kolaylıkla güvenirler.

6. Diğer insanların beden dili, yüz ifadesi gibi sözel olmayan mesajlarını anlamakta zorlanırım.

7. Yaşamımdaki bazı önemli olaylar neyin önemli neyin önemsiz olduğunu yeniden değerlendirmeme yol açtı.

8. Bazen konuştuğum kimsenin ciddi mi olduğunu yoksa şaka mı yaptığını anlayamam.

9. Ruh halim değiştiğinde yeni olasılıkları görürüm.

10. Duygularımın yaşam kalitem üzerinde etkisi yoktur.

11. Hissettiğim duyguların farkında olurum.

12. Genellikle iyi şeyler olmasını beklemem.

13. Bir sorunu çözmeye çalışırken mümkün olduğunca duygusallıktan kaçınırım.

14. Duygularımı gizli tutmayı tercih ederim.

15. Güzel duygular hissettiğimde bunu nasıl sonlandıracağımı bilirim.

16. Başkalarının hoşlanabileceği etkinlikler düzenleyebilirim.

17. Sosyal yaşamda neler olup bittiğini sıklıkla yanlış anlarım.

18. Beni mutlu edecek uğraşılar bulmaya çalışırım.

19. Başkalarına gönderdiğim beden dili, yüz ifadesi gibi sözsüz mesajların farkındayımdır.

20. Başkaları üzerinde bıraktığım etkiyle pek ilgilenmem.

21. Ruh halim iyiyken sorunların üstesinden gelmek benim için daha kolaydır.

22. İnsanların yüz ifadelerini bazen doğru anlayamam.

23. Yeni fikirler üretmem gerektiğinde duygularım işimi kolaylaştırmaz.

24. Genellikle duygularımın niçin değiştiğini bilmem.

25. Ruh halimin iyi olması yeni fikirler üretmeme yardımcı olmaz.

26. Genellikle duygularımı kontrol etmekte zorlanırım.

27. Hissettiğim duyguların farkındayımdır.

28. İnsanlar bana, benimle konuşmanın zor olduğunu söylerler.

29. Üstlendiğim görevlerden iyi sonuçlar alacağımı hayal ederek kendimi güdülerim.

30. İyi bir şeyler yaptıklarında insanlara iltifat ederim.

31. Diğer insanların gönderdiği sözel olmayan mesajların farkına varırım.

32. Bir kişi bana hayatındaki önemli bir olaydan bahsettiğinde ben de aynısını yaşamış gibi olurum.

33. Duygularımda ne zaman bir değişiklik olsa aklıma yeni fikirler gelir.

34. Sorunları çözüş biçimim üzerinde duygularımın etkisi yoktur.

35. Bir zorlukla karşılaştığım zaman umutsuzluğa kapılırım çünkü başarısız olacağıma inanırım.

36. Diğer insanların kendilerini nasıl hissettiklerini sadece onlara bakarak anlayabilirim.

37. İnsanlar üzgünken onlara yardım ederek daha iyi hissetmelerini sağlarım.

38. İyimser olmak sorunlar ile baş etmeye devam edebilmem için bana yardımcı oluyor.

39. Kişinin ses tonundan kendini nasıl hissettiğini anlamakta zorlanırım.

40. İnsanların kendilerini neden iyi ya da kötü hissettiklerini anlamak benim için zordur.

41. Yakın arkadaşlıklar kurmakta zorlanırım.

APPENDIX F: World Health Organization Quality of Life Scale (WHO-QOL-BREF)

1. Yaşam kalitenizi nasıl buluyorsunuz?

Çok kötü	Biraz kötü	Ne iyi, ne kötü	Oldukça iyi	Çok iyi
1	2	3	4	5

2. Sağlığınızdan ne kadar hoşnutsunuz?

Hiç hoşnut değil	Çok az hoşnut	Ne hoşnut, ne de değil	Epey hoşnut	Çok hoşnut
1	2	3	4	5

Aşağıdaki sorular son iki hafta içinde kimi şeyleri ne kadar yaşadığınızı soruşturmaktadır.

3. Ağrılarınızın yapmanız gerekenleri ne derece engellediğini düşünüyorsunuz?

Hiç	Çok az	Orta derecede	Çokça	Aşırı derecede
1	2	3	4	5

4. Günlük uğraşlarınızı yürütebilmek için herhangi bir tıbbi tedaviye ne kadar ihtiyaç duyuyorsunuz?

Hiç	Çok az	Orta derecede	Çokça	Aşırı derecede
1	2	3	4	5

5. Yaşamaktan ne kadar keyif alırsınız?

Hiç	Çok az	Orta derecede	Çokça	Aşırı derecede
1	2	3	4	5

6. Yaşamınızı ne ölçüde anlamlı buluyorsunuz?

Hiç	Çok az	Orta derecede	Çokça	Aşırı derecede
1	2	3	4	5

7. Dikkatinizi toplamada ne kadar başarılısınız?

Hiç	Çok az	Orta derecede	Çokça	Son derecede
1	2	3	4	5

8. Günlük yaşamınızda kendinizi ne kadar güvende hissediyorsunuz?

Hiç	Çok az	Orta derecede	Çokça	Son derecede
1	2	3	4	5

9. Fiziksel çevreniz ne ölçüde sağlıklıdır?

Hiç	Çok az	Orta derecede	Çokça	Son derecede
1	2	3	4	5

Aşağıdaki sorular son iki haftada kimi şeyleri ne ölçüde tam olarak yaşadığınızı ya da yapabildiğinizi soruşturmaktadır.

10. Günlük yaşamı sürdürmek için yeterli gücünüz kuvvetiniz var mı?

Hiç	Çok az	Orta derecede	Çokça	Tamamen
1	2	3	4	5

11. Bedensel görünüşünüzü kabullenir misiniz?

Hiç	Çok az	Orta derecede	Çokça	Tamamen
1	2	3	4	5

12. Gereksinimlerini zi karşılamak için yeterli paranız var mı?

Hiç	Çok az	Orta derecede	Çokça	Tamamen
1	2	3	4	5

13. Günlük yaşantınızda gerekli bilgilere ne ölçüde ulaşabilir durumdasınız?

Hiç	Çok az	Orta derecede	Çokça	Tamamen
1	2	3	4	5

14. Boş zamanları değerlendirme uğraşları için ne ölçüde fırsatınız olur?

Hiç	Çok az	Orta derecede	Çokça	Tamamen
1	2	3	4	5

Aşağıdaki sorularda, son iki hafta boyunca yaşamınızın çeşitli yönlerini ne ölçüde iyi ya da doyurucu bulduğunuzu belirtmeniz istenmektedir.

15. Hareketlilik (etrafta dolaşabilme, bir yerlere gidebilme) beceriniz nasıldır?

Çok kötü	Biraz kötü	Ne iyi, ne kötü	Oldukça iyi	Çok iyi
1	2	3	4	5

16. Uykunuzdan ne kadar hoşnutsunuz?

Hiç hoşnut değil	Çok az hoşnut	Ne hoşnut, ne de değil	Epey hoşnut	Çok hoşnut
1	2	3	4	5

17. Günlük uğraşlarınızı yürütebilme becerinizden ne kadar hoşnutsunuz?

Hiç hoşnut değil	Çok az hoşnut	Ne hoşnut, ne de değil	Epey hoşnut	Çok hoşnut
1	2	3	4	5

18. İş görme kapasitenizden ne kadar hoşnutsunuz?

Hiç hoşnut değil	Çok az hoşnut	Ne hoşnut, ne de değil	Epey hoşnut	Çok hoşnut

1 2 3 4 5

19. Kendinizden ne kadar hoşnutsunuz?

Hiç hoşnut değil Çok az hoşnut Ne hoşnut, ne de değil Epey hoşnut Çok hoşnut

1 2 3 4 5

20. Diğer kişilerle ilişkilerinizden ne kadar hoşnutsunuz?

Hiç hoşnut değil Çok az hoşnut Ne hoşnut, ne de değil Epey hoşnut Çok hoşnut

1 2 3 4 5

21. Cinsel yaşamınızdan ne kadar hoşnutsunuz?

Hiç hoşnut değil Çok az hoşnut Ne hoşnut, ne de değil Epey hoşnut Çok hoşnut

1 2 3 4 5

22. Arkadaşlarınızın desteğinden ne kadar hoşnutsunuz?

Hiç hoşnut değil Çok az hoşnut Ne hoşnut, ne de değil Epey hoşnut Çok hoşnut

1 2 3 4 5

23. Yaşadığınız evin koşullarından ne kadar hoşnutsunuz?

Hiç hoşnut değil Çok az hoşnut Ne hoşnut, ne de değil Epey hoşnut Çok hoşnut

1 2 3 4 5

24. Sağlık hizmetlerine ulaşma koşullarınızdan ne kadar hoşnutsunuz?

Hiç hoşnut değil Çok az hoşnut Ne hoşnut, ne de değil Epey hoşnut Çok hoşnut

1 2 3 4 5

25. Ulaşım olanaklarınızdan ne kadar hoşnutsunuz?

Hiç hoşnut değil Çok az hoşnut Ne hoşnut, ne de değil Epey hoşnut Çok hoşnut

1 2 3 4 5

Aşağıdaki soru son iki hafta içinde bazı şeyleri ne sıklıkta hissettiğiniz ya da yaşadığınıza ilişkindir.

26. Ne sıklıkta hüzün, ümitsizlik, bunaltı, çökkünlük gibi olumsuz duygulara kapılırsınız?

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1 2 3 4 5

27. Yaşamınızda size yakın kişilerle (eş, iş arkadaşı, akraba) ilişkilerinizde baskı ve kontrolle ilgili zorluklarınız ne ölçüdedir?

Hiç Çok az Orta derecede Çokça Aşırı derecede

1 2 3 4 5