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THE MODERATOR EFFECT OF MENTALIZATION ON THE LINK
BETWEEN ATTACHMENT AND SOMATIZATION

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Abstract

The main purpose of this study is to examine the relationship between somatic complaints that are one of the major crises in health care services and attachment styles. In addition, the moderator role of the mentalization capacity on the envisaged association between the attachment styles and somatic complaints of the persons were investigated. The research was carried out with the survey package presented on the internet. Through snowball sampling, 402 participants were included. The survey package was consisted of the Informed Consent Form, the Reflective Functioning Questionnaire (RFQ-54), the Levels of Emotional Awareness Scale (LEAS-4), the Experiences in Close Relationships-Revised (ECR-R) and the Somatization Scale (SS), respectively.

It has been hypothesized that the insecurity in the attachment will be related to the increase in somatic complaints. Attachment insecurity was addressed in regard to two dimensions as the anxious attachment and avoidant attachment. Among these dimensions, it has been suggested that anxious attachment is a stronger predictor of somatization rather than avoidant attachment. It was expected that the mentalization capacity has a moderator effect on this relation. In this context, while interpreting the mental processes in social relations, individuals can be under the influence of 'genuine mentalization', 'hypermentalization', or 'hypomentalization'. The last two were considered as the deficits in mentalization capacity as to what extent individuals are prone to being too certain about mental states or being too uncertain about mental states. These two dimensions were expected to be positively related with the somatization level. It was also aimed to investigate the relationship between the level of emotional awareness of the individuals and the level of somatization. However, the four items version of LEAS, which was used for the first time with Turkish participants, was not included in the analysis because of doubtful validity values.

The results of the study showed that both attachment anxiety and attachment avoidance were positively correlated with somatization. The

relationship between the sub-dimensions of mentalization and the level of somatization was statistically significant. As in an expected direction, hypometalization and somatization were positively related whereas the link between hypermetalization and the level of somatization were found to be negative. Moderation effect of mentalization was tested with stepwise regression analysis. In the most significant explanatory model of the variance, attachment anxiety, the health status, the health complaint rates of the mother, the educational attainment, the hypermentalization level and gender were included as significant predictors of the levels of somatization. The moderator role of mentalization capacity was not supported since this model did not involve the interaction of the sub-dimensions of mentalization capacity and the attachment. In the light of these results, theoretical and clinical findings that can be deduced were discussed and suggestions for future research were presented.

Keywords: somatization, attachment-anxiety, attachment-avoidance, hypermentalization, hypometalization, reflective functioning.

Özet

Bu çalışmanın temel amacı günümüzde sağlık hizmetlerinde önemli bir krize neden olan somatik şikâyetlerin bağlanma stili ile olan ilişkisini incelemektir. Bununla birlikte, öngörülen bu ilişkide zihinselleştirme kapasitesinin moderatör rolü test edilecektir. Kartopu örneklemiyle ulaşılan 402 katılımcı internet üzerinden yaygınlaştırılan anketleri doldurarak çalışmaya dahil olmuştur. Anket içeriği sırasıyla Bilgilendirilmiş Onam Formu, Demografik Bilgi Formu, Yansıtıcı İşleyiş Ölçeği (YİÖ), Duygusal Farkındalık Düzeyi Ölçeği (DFDÖ-4), Yakın İlişkilerde Yaşam Envanteri-II (YİYE-II) ve Somatizasyon Ölçeği (SS)'nden oluşmaktadır.

Bağlanmadaki güvensizliğin somatik şikâyetlerin artışıyla ilişkili olacağı beklenmiştir. Bağlanma güvensizliği kaygılı bağlanma ve kaçınmacı bağlanma olarak iki boyutta ele alınmıştır. Bu boyutlar arasından kaygılı bağlanmanın kaçınmacı bağlanma alt boyutuna nazaran somatizasyon düzeyi üzerinde daha güçlü bir yordayıcı olacağı öngörülmüştür. Zihinselleştirme becerisinin de bu ilişkide moderatör etkisinin olacağı düşünülmüştür. Bu bağlamda, kişiler sosyal ilişkilerdeki zihinsel süreçleri yorumlarken hakiki zihinselleştirme, hipermentalizasyon ve hypomentalizasyon etkisi altında olabilir. Bu süreçte ne oranda 'kesinlik' (hipermentalizasyon) ve 'belirsizlik' (hypomentalizasyon) etkisinde kaldıkları zihinselleştirme kapasitesindeki yetersizlikleri işaret eden iki alt boyut olarak değerlendirilmiştir. Bu iki boyutun da somatizasyon düzeyi ile pozitif yönlü bir ilişkide olması beklenmiştir. Aynı zamanda, bireylerin duygusal farkındalık düzeyi ile somatizasyon düzeyleri arasındaki ilişkinin de araştırılması amaçlanmıştır. Fakat Türk örneklemi ile mevcut araştırmada ilk kez kullanılan Duygusal Farkındalık Düzeyi Ölçeği'nin dört maddelik kısa versiyonunun geçerlilik güvenirliği beklenen düzeyde bulunmadığı için analiz sürecine dâhil edilmemiştir.

Araştırma sonuçları hem kaygılı hem de kaçınmacı bağlanmanın somatizasyon ile pozitif yönde istatistiksel olarak anlamlı bir ilişkide olduğunu

göstermektedir. Zihinselleştirme alt boyutları ve somatizasyon düzeyi arasındaki ilişki istatistiksel olarak anlamlı bulunmuştur. Hipermentalizasyon ve somatizasyon düzeyi beklenenin aksine negatif yönde ilişkiliyken, hipomentalizasyon ve somatizasyon ilişkisi pozitif yöndedir. Moderasyon ilişkisi adımsal regresyon yöntemiyle test edilmiştir. Somatizasyon düzeyindeki varyansı en kuvvetli açıklayan modelde sırasıyla kaygılı bağlanma, kişinin sağlık durumu, annenin ne oranda sağlığından şikâyetçi olduğu, kişinin eğitim durumu, hipermentalizasyon düzeyi ve cinsiyetin yordayıcı etkisi olduğu ortaya konulmuştur. Bu modele zihinselleştirme kapasitesi ve bağlanma alt boyutlarının etkileşimi dâhil olmadığı için zihinselleştirme kapasitesinin moderatör rolüne dair hipotez desteklenmemiştir. Mevcut çalışmadan elde edilen bu sonuçlardan çıkarım yapılabilecek teorik ve klinik bulgular tartışılmış ve gelecek araştırmalar için öneriler sunulmuştur.

Anahtar kelimeler: somatizasyon, kaygılı bağlanma, kaçınmacı bağlanma, hipermentalizasyon, hypomentalizasyon, zihinselleştirme.

CHAPTER 1: INTRODUCTION

Somatization refers to the perception and expression of stressful circumstances as bodily problems in response to psychological stress, and results in the act of seeking medical help without any organic explanation (Lipowski, 1988). This definition indicates that persons with psychosomatic disorders perceive physical problems as the source of their complaints, and do not attribute psychological causes to the existence and/or worsening of them. These somatic symptoms usually appear before the age of 30, and cause excessive distress, overutilization of healthcare services, and deficits in functionality (Kirmayer & Looper, 2006).

Even though it is not possible to collect precise prevalence rates for all conditions, psychosomatic manifestations are considered to be the most common cases in primary health care services. In this context, it can be perceived simultaneously as a financial, medical and social problem (Lipowski, 1988). Because of that, these bodily complaints have recently been described as a medical crisis due to their costly and time-consuming treatment requirements (Stuart & Noyes, 1999).

As it is typical for the multifaceted problems in psychiatry and general medicine, somatization is commonly accompanied by different psychiatric conditions, such as depression and anxiety disorders, schizophrenia, personality disorders, and substance use. Somatization increases distress and discomfort, and worsens the course of these disorders. It also makes the diagnoses of these psychiatric conditions more difficult by masking or altering the presentation of their symptoms (Lipowski, 1987, 1988).

Previous research indicates that there is no single theory for adequately explaining the concept of somatization. However, the consistent empirical studies showed that somatization refers to a symbolic way of communication and conflict-resolution (Kellner, 1990). Review studies advocate that somatization as

a response to stress and as a way of affect regulation needs to be considered in the scope of the developmental dimensions (Maunder & Hunter, 2001). Lipowski (1988) listed the developmental dimensions of somatization as genetic predisposition, learning, personality and environmental factors. In this regard, attachment theory as a comprehensive theory for biopsychosocial development has began to be interested in the relationship between attachment styles and somatization.

Attachment theory proposes that the internalization of the relations with primary caregivers during the early years of life shape the relatively persistent intrapsychic and interpersonal patterns. Bowlby (1973) emphasized that the inner representations that have been formed in the early attachment experience were based on two basic features: whether the attachment figure can respond to the needs of protection and support, and whether the individual perceives herself as worthy of getting help from others, especially from the primary caregivers. According to this theory, stress and threat activates the attachment schemas (Waller et al., 2004). The study of Ciechanowski and colleagues (2002) showed that individuals with different attachment styles respond to stress with different somatic symptoms and help-seeking behaviors. Their study showed that individuals with preoccupied and fearful attachment styles are more prone to manifesting somatic complaints as compared to secure and dismissive attachment styles. Similarly, the statistics of primary health care providers show that individuals with preoccupied attachment styles had a higher visit rate in comparison to the other attachment styles (Ciechanowski et al., 2002).

Moreover, Waller, Scheidt and Hartmann (2004) argued that the relationship between somatic patients and health care providers could be understood in regard to the relational patterns of different attachment styles. The results of their study illustrated that while dismissively attached individuals have higher rates of hospitalization, they do not attend their general control visits with practitioners. It might be argued that the high level of somatization in dismissively attached individuals could be derived from the deficits in recognition and

regulation capacity of adverse affectivity. On the other hand, the preoccupied individuals over-amplify their symptoms, and reflect unsatisfied caring needs to primary health care providers. In the light of these results, Waller and friends (2004) emphasized the importance of the awareness of insecure attachment strategies of somatic patients to handle the problematic interactions with health care services.

In addition to the sense of security and intimacy, attachment theorists have also focused on the concept of mentalization that is shaped in the primary caregiver-child relationship. As an intentional mental process, this capacity is used to make sense of self and others (Bateman & Fonagy, 2006). A high level of mentalization capacity makes it possible for an individual to flexibly experience and reflect emotions, wishes, plans and desires (Fonagy & Target, 2002). In this regard, secure attachment experiences are associated with the development of the mentalization capacity (Bateman & Fonagy, 2006; Allen, Fonagy & Bateman, 2008).

Mentalization capacity is subject to the child's observations and exploration of the minds of the attachment figures. The primary caregivers, who are unable to regulate his/her emotions, are misattuned and dissociated during their children's development process, thus these children cannot develop and/or improve the emotion regulation systems (Fonagy & Target, 2006). Smadja (2011) stated that only when mature mentalization is achieved; it is possible to recover from physical concerns and psychosomatic manifestations. The mirroring function of primary caregivers, which can be defined as the response to emotional states of their infants with the marked emotional images of their own mindset, contributes to verbalization and mentalization of the child's physical sensations. By doing so, the child can transform these bodily manifestations into psychological meanings (Fonagy et al., 2002).

As outlined above, the current study will focus on the associations between attachment style, mentalization capacity and somatization. The conceptual bases

and theoretical approaches will be included in the next section in order to understand how these three concepts are related to each other within the context of this study. Each concept will be explained in detail. To address as a complex phenomenon, somatization, a model is formulated whereby a person's level of mentalization capacity could moderate the relationship between his/her attachment style and their somatization tendency.

1.1.SOMATIZATION

1.1.1. The History of the Term “Psychosomatization”

The experience of soma is a matchless dimension that cannot be distinguished from all possible ways of life and humanity. This experience creates the subjectivity (Dejours, 2015). World, man, life and death instincts can be evaluated from different perspectives regarding the views of unity or the duality of psyche and soma (Aisenstein, 2006). Throughout the Modern Medicine history, physical complaints have been mainly evaluated in terms of mechanical and ethno-cultural model. In 19th century, scientific positivism and Cartesian dualism resisted the development of views on psychosomatization (Parman, 2005). From the perspective of mind-body dualism, the mind shapes the constant body, and gives life and function to it (Solano, 2010). On the other hand, the vitalism perspective suggested that the union of psyche and soma of human existence is revealed through the dynamism in human life (Parman, 2005). This approach leads to the birth of the psychosomatic concept, and points to the features of soma as thinking, feeling and relating (Solano, 2010).

As a main character of vitalism thought, the German psychiatrist Heinroth is the first person who used the term “psychosomatization” (as cited in Parman, 2005). Lipowski (1984) emphasized that the psychosomatic attribute points to the inseparable formation and the interdependence of the psychological and biological properties of human beings. Kreisner (1989) considered the birth of the

psychosomatic focus as a reaction to the modern medicine of 19th century, which distinguishes medicine into departments, promotes delimitation and specialization (as cited in Parman, 2005). According to this definition, psychosomatic medicine is a doctrinal and pathogenic conceptualization in which the psychic and conflicting aspects are included in the understanding of the development of physical illnesses (Parman, 2005).

In this regard, psychoanalysis advocated the duality of the drives instead of the duality of soma and mind, revealing that the thought processes are funded by the soma (Aisenstein, 2006).

1.1.2. The Psychoanalytic Perspectives on Somatization

Since the birth of psychoanalysis, interaction of psychic and somatic processes has been one of the central curiosities (Bucci, 1997). Herewith, many theories have been developed to investigate the multifactorial origins of somatic complaints (Lipowski, 1987). In the psychoanalytic literature, the term somatization refers to the unconscious defense, which blocks the experience of anxiety, and compels its indirect appearance in the form of physical symptoms (Stuart & Noyes, 1999).

In the next section, the different perspectives of different schools of psychoanalytic thought on somatization will be reviewed.

1.2.1.1. Freudian Perspective on Somatic Manifestations

Sigmund Freud focused on medically unexplained bodily manifestations throughout his works, although he does not focus directly on psychosomatic symptoms as we define it today (Aisenstein & Smadja, 2010; Smadja, 2011). He has referred to the mind-body integrity at three different focus points: the concept of body ego, instinctual drives, and the hysterical conversion (Meissner, 1997). According to Freud (1927), self is derived from bodily sensations, especially tactile sensations. Therefore, self can be considered as the mental reflection of the

body surface. He advocated that the functions of ego have evolved from the processes that are rooted in the physical organism. In the sense, Freud puts a person's own body at a distinctive place among other objects that is in interaction with and focuses on the concept of the body as both an object and an agent. The ego functions, superego, and other higher mental representations are shaped by bodily sensations throughout the developmental process (Meissner, 1997).

In 1915, Freud offered the drive theory. This theory based on the idea that there are innate psychological urges (instincts) which need to be satisfied in order to sustain the homeostasis of an organism. He conceptualized instincts as the “*psychical representative of organic forces,*” and located them as “*the frontier concept between the somatic and the mental*” (Freud, 1915, p.121). The presence of the concept of drive illustrated that his theory is based on bodily origin. In drive theory, instinctual drives have been derived from the components of both physiological manifestations, and psychic and mental representations. Despite continuous changes in his formulations of the instinctual drives, the emphasis on the body as the primary source of energy, and basis of all experiences had been maintained (Meissner, 1997).

In the light of his theoretical emphasis on drive economy, four types of somatic manifestations can be defined namely as conversions, somatic symptoms derived from actual neurosis, hypochondria and organic based somatic complaints (Aisenstein & Smadja, 2010; Smadja, 2011). Initially, the differentiation between psychoneurosis and actual neurosis is made based on the differences in the origins of physical complaints (Aisenstein & Smadja, 2010). Psychoneurosis causes hysterical conversions, whereas actual neurosis leads to somatic disorders. Conversion, which is derived from hysterical symptoms, is not anxiety-based. These can be evaluated as a sign of the conflict within the oedipal organization. In conversions, the regression mechanism operates, and symbolization is governed by the dynamic unconscious (Aisenstein&Smadja, 2010; Smadja, 2011).

The second somatic manifestation is the somatic symptoms of actual neurosis. In this regard, conversions in psychoneurosis are symbolic, and based on internal conflicts, whereas psychosomatic symptoms in actual neurosis have no symbolic meaning and do not originate from trauma (Gubb, 2013). The former speaks with the soma, whereas the latter suffers with the soma. Psychosomatic complaints are the physical consequence of repressed drives and emotions, while hysterical symptoms are the manifestation of inner conflicts (Parman, 2005). While the tissue is damaged in somatic illnesses, it does not occur in conversions (İkiz, 2012). There is no psychic representation in the presence of somatic manifestation of actual neurosis (Aloupis, 2005).

Another type of bodily complaints is clinically named as hypochondria. In hypochondriac symptoms, individuals insist on having bodily complaints in an unrealistic manner, without any physical or organic condition (Aisenstein & Smadja, 2010). Freud associated the hypochondriac anxieties with a suppressed narcissistic libido, which has been inadequate to influence the mind. In brief, the patients with hypochondriac complaints have not enough libidinal instincts to lead alterations on mind. Therefore, these symptoms are evaluated as a way to hide organically insufficient autoeroticism (Smadja, 2011).

Lastly, organic somatic complaints are perceived as the other subject of psychosomatic curiosity. Freud (1927) conceptualized these illnesses in two different ways: narcissistic regression, and the battle of the death vs. libidinal instincts. In the light of these distinctions, Freud emphasized that somatic manifestations can result in the disappearance of a neurotic state. In this context, he advocated that the physical and psychic tides depend on the nature of masochistic features as the gratification in the source of physical suffering or psychic humiliation (Freud, 1937).

According to the libido theory, Freud argued that there is double cathexis of somatic formations as self-preservation and sexual drives. In this regard, somatic symptoms of the actual neurosis refer to the deficiency of mental

sexuality due to an inadequacy of regression capacity. Somatic complaints point to the imbalance between this two-way cathexis. To substitute for the inadequacy of regression capacity, psychosomatic individuals use mainly the suppression mechanism despite its psychic cost (Aisenstein & Smadja, 2010; Smadja, 2011).

1.1.2.2. Post-Freudian Approaches on Psychosomatics

There are two approaches and theoretical foundations that dominate the literature after the Freudian approach on somatic manifestations. These theoretical bases are shaped in the Chicago School and the Paris Psychosomatic Institution. In this section, the views of the pioneers of these perspectives were presented respectively.

Alexander (1950), as the main theorist of Chicago School, focused on the links between particular emotions and physical symptoms. By doing so, he revealed the personality profiles that fit the specific somatic reactions. In regard to personality profiles of somatization, Dunbar (1955) focused on the importance of inheritance, previous health status, family life, out-of-home attitudes, and reaction to illness

Alexander (1950) also argued that in order for psychosomatic complaints to occur, it is necessary to combine three basic factors: a specific form of conflict, somatic predisposition, and a current conflictual situation. By his devoted studies on psychosomatic, he proposed “Chicago seven,” that is seven somatic manifestations namely as “peptic ulcer, ulcerative colitis, bronchial asthma, neurodermatitis, rheumatoid arthritis, essential hypertension and thyrotoxicosis” (as cited in Stora, 2014 p. xxi).

After the Second World War, French psychoanalysts turned their eyes to somatic diseases. Marty, along with the collaboration of Fain led the first studies in 1950s, to understand the situations of patients with chronic headaches, spinal pains and allergies better. The existence of unconscious and its role on the life and death movements that affects each individual's existence is the main theme of

Marty's psychosomatic economy approach (Debray, 2015). By following the economy principle, the Paris School associated somatization with the unbound affect (Gubb, 2003).

Marty and Fain (1963) thought that somatic functioning, which is a lack of meaning, is a substitute for adequate neurotic defenses (as cited in Gubb, 2003). Throughout the development of psychosomatic studies, different focus points within the Paris Psychosomatic Institution started to be born. According to Marty's (1968) evolutionist approach, the hierarchical organization and disorganization movements define the psychosomatic economy. The capacity of fixation-regression determines to what extent the individuals are vulnerable to serious somatic formations. The progressive disorganization refers to the devastated actual libidinal mechanisms in psyche. Marty (1998) focused on the pre-oedipal traumatic relations with primary caregivers to conceptualize the somatic formations in infants.

Comprehensively, de M'Uzan (1974) thought that psychosomatic functioning is derived from the withdrawal from psychic energy by the combination of the inadequacy of phantasy capacity, operational thinking, and "projective reduplication" (as cited in Smadja, 2011, p.225). In this regard, the common trait of psychosomatic patients is overstimulation, caused by a deficiency in stimulation barrier. Because of that, the ego withdraws from libidinal and erotic features of mind-body interactions toward early stages at which body works almost mechanically (İkiz, 2005).

By the development of the different schools of thought, the theoretical curiosity about somatic disorders has begun to focus on the meanings of these symptoms. Grinberg (1968) argued that acting-out patients need to have a reservoir for separation anxiety and unendurable pain. In this respect, bodily symptoms function as a container that cancels out the effects of object absence. In this regard, Atkins (1968) focused on ego disturbances in the neutralization of instinctual energy as a main factor in understanding psychosomatic complaints.

With a focus on the therapeutic sphere, Sperling (1968) perceived somatic symptoms in the context of transference phenomena, which serve as a compromise formation: the patient complies with analyst in reality, while unconsciously rebelling through soma. This process is named as “psychosomatic object relationship”.

In the same line with Sperling (1968), McDougall (1980) made connections between the failures of early object relations and the somatization tendency. According to McDougall (1980), somatization is rooted in the restricted ability to verbalize and fantasize with highly pragmatic thinking that is closely related to the facts about external reality. She suggested that the deficits in the internalization of caregiver’s transformative function intervene with individuation and self-regulation process.

1.1.3. The Diagnostic History of Somatization

In 1980, the category of somatic disorders, including medically unexplained symptoms and functional dysfunctions, was included in the Diagnostic and Statistical Manual of Mental Disorders-III. According to the DSM-III classifications of somatic problems, the absence of an organic disorder or pathophysiological mechanism to explain these somatic complaints was required, which means the existence of strong clues to the association of these disorders with psychological factors (American Psychiatric Association, 2013)

On the other hand, the diagnosis of somatoform disorder in DSM-IV includes physical symptoms that can be perceived as a repetitive medical condition, but which do not have a sufficient explanation with medical examinations. However, this approach had been criticized due to the lack of clear boundaries within the criteria. In this regard, the ‘Somatic Symptom and Related Disorders’ category has been established in DSM-V to describe the group of patients with somatic symptoms with the abnormalities in thoughts, affects, and behaviors. As an umbrella term, its purpose is to identify the majority of

diagnosed patients, such as somatization disorder, pain disorder, and hypochondriasis, according to the DSM-IV diagnostic criteria. An important difference is that the criteria of this diagnosis emphasize the positive symptoms, such as distress and dysfunction, rather than the absence of a medical explanation (APA, 2013).

The diagnostic categories of ‘Somatic Symptoms and Related Disorders’ in DSM-V are listed below:

1. Somatic Symptom Disorder [300.83] [F45.1]
2. Illness Anxiety Disorder [300.7] [F45.21]
3. Conversion Disorder (Functional Neurological Symptom Disorder) [300.11]
4. Psychological Factors Affecting Other Medical Conditions [316] [F54]
5. Factitious Disorder [300.19] [F68.10]
6. Other Specified Somatic Symptom and Related Disorder [300.89] [F45.8]
7. Unspecified Somatic Symptom and Related Disorder [300.82] [F45.9] (as cited in APA, 2013 p.xxi).

First of the DSM-V diagnoses, ‘Somatic Symptom and Related Disorder’ requires three important criteria. Criterion A is the presence of at least one physical complaint affecting the patients’ daily lives at significant level. Criterion B refers to anxiety about bodily complaints. This criterion is evaluated in terms of extreme and persistent ideas about these symptoms, having a continuously high level of anxiety about these symptoms, and spending excessive time and energy for health concerns. Lastly, according to Criterion C, even though the same bodily complaint is not expected to persist, the person must have ongoing somatic complaints for at least six months (APA, 2013).

Second category, the Illness Anxiety Disorder is specified with the actions for medical care whether seeking or avoiding. The third diagnosis in above-mentioned categories, Conversion Disorder is given in terms of acute or persistent symptom occurrence and the existence of psychological stressor. In particular, the

Conversion Disorder is associated with clinical distress, and guarantees a medical diagnosis. This category is also distinguished in response to the observed somatic paralysis, abnormal body movements, swallowing, speech-related symptoms, seizures in body parts, the deficits in sensory, specific sensory symptoms or mixed of these symptoms. However, clinical researchers revealed evidence of a discrepancy between the present symptom in conversive patients and their existing neurological or medical conditions (APA, 2013).

Fourthly, Psychological Factors Affecting Other Medical Conditions is given with the presence of organic symptoms. Besides, the psychological and behavioral factors are considered in terms of setting the tone of the disorders. This diagnosis is classified as mild, moderate, severe and extreme in regard to the severity of current symptoms. The main characteristic of the 5th diagnostic category, factitious disorder, is the deceptive behaviors and false statements about the medical or psychological symptoms. The sixth and seventh categories specified or unspecified other disorders that include somatic symptoms, but do not meet the specific criteria for the above-mentioned disorders in somatic manifestations (APA, 2013).

According to the DSM-V developers, the recent diagnostic system tries to provide the clinician a domain to focus on distress, abnormal thoughts, feelings, and behaviors rather than checking for the medical validity of these complaints. However, DSM-V is also evaluated as inadequate in regard to the criterion and predictive validity due to the exclusion of organic symptoms (Löwe et al., 2008).

1.1.4. Epidemiology of Somatization

1.1.4.1. Demographic Factors

APA (2013) reported that in general, the incidence of somatic tendency related symptoms in adults is between 5% and 7%. Gender distribution of this population is dominated by females. Females are more likely to report their symptoms. Somatic and medical disorders are seen together in the elderly people who have extreme concerns about their health. On the other hand, the coexistence

of medical and somatic disorders prevents the somatic diagnosis by evaluating these existing symptoms as depending on the age. Children are mainly suffered from one prominent symptom and do not show high anxious thoughts about their health. Parental response to these symptoms is critical to the evaluation of symptoms and necessity of medical help.

Regarding environmental context, low degree of educational attainment, unemployment, and low socioeconomic status can be evaluated as risk factors for experiencing somatic-related symptoms. In addition to negative affectivity, the childhood trauma, chronic illnesses and having a psychiatric disorder also increase the levels of somatic tendency (APA, 2013).

To see the cultural effects on the envisaged links between demographic factors and somatization, many studies were conducted. In Turkey, women were found to experience and report somatic complaints more than men (Karşlı, 2008; Özden, 2015). This is consistent with the prevalence rates reported by APA (2013).

In terms of age, there are contradictory findings. Karşlı (2008) reported that as age progresses, the incidence of psychosomatic disorders decreases. On the other hand, Ozaner (2011) suggested that somatization is more common in older ages. However, there are not sufficient and consistent research results confirming the link between age and somatization (Ozaner, 2011).

Another demographic variant that comes to mind is the marital status. Single participants were found to show more stress related somatic symptoms in comparison to participants with the romantic relationships (Karşlı, 2008). On the other hand, social risk factors for somatization can be listed as living alone, being a single parent, unemployment, and living in rural areas (Şahin et al., 2009). In addition to the low SES and low levels of educational attainment, somatization tendency is more prevalent in immigrant and minority groups (Ozaner, 2011; Uğur, 2015). Moreover, the education level of mother has also been reported to influence the somatization tendency (Özden, 2015).

The presence of certain health problems in individuals is also influential on the somatization tendency (Uğur, 2015). Moreover, Stuart and Noyes (1999)

emphasized the importance of modeling and argued that parental illness can be contributory to the development of somatization tendency. In this regard, the medical condition of the father is found to have an influence on somatization tendency in a Turkish university sample (Özden, 2015).

1.1.4.2. Cultural Aspects of Somatization

It is clear that cultural, intercultural and sociological differences also affect the characteristics of somatization, like other psychiatric disorders (Şahin et al., 2009). Culture is an important determinant for both parenting and language. Cultural experiences of the bodily sensations constitute symptom-specific vocabulary and, beyond that, bring about culture specific symptoms and explanations related to them (Kirmayer & Young, 1998). Some researchers associate these somatic symptoms with the lack of adequate vocabulary to describe psychological states (Escobar et al., 1987). In this regard, Baarnheim and Ekbländ's study (2003) with Turkish immigrant women living in Sweden indicated high levels of somatic inclination. The prevalence of the phrase of 'yürek kalkması' in the narratives of these people is noteworthy (as cited in Şahin et al., 2009 p. 189).

Somatization seems to be more common in collectivist cultures (Hofstede, 2003). The expression of distress through somatic manifestations is seen as a more immature and regressive attitude in Western cultures, whereas it is perceived as a tool of adaptation to the environment in Eastern cultures (Şahin et al., 2009). In industrialized societies, there is a common belief that those who are prone to somatization are from low socio-economic status, uneducated, and come from a religious background (Kellner, 1990). On the other hand, cross-cultural studies indicated that somatization is common in all cultures and societies at different prevalence rates (Şahin et al, 2009).

1.1.4.3. Trauma and Somatization

The link between trauma and somatization tendency has obtained considerable attention of researchers (Brown et al., 2005; Taycan et al., 2014). The study of Van Dijke and colleagues (2011) showed that the emotional abuse of preschool children by the primary relatives lead to a higher tendency to develop borderline personality disorder and somatoform disorders. In this regard, Waldinger and colleagues (2006) claimed that childhood trauma is highly related with the high incidence of somatic complaints and insecure attachment patterns. The results of Waldinger's (2006) study revealed that the associations between trauma, attachment and somatization are different in men and women. The link between the level of somatization and attachment in women is mediated by childhood trauma, whereas in men their significant effects are independent.

There are also some studies that examine the link between trauma and somatization in Turkey. In Eastern Turkey, Taycan and colleagues' (2014) study illustrated that women who are exposed to high level of traumatic stress, has shown multiple somatic symptoms that demonstrated significant comorbidity with major depressive disorder. The study also reported that women with somatization disorder had been exposed to childhood abuse at a higher incidence level.

Furthermore, Tolero (2014) studied the transmission effect of trauma over generations with the torture survivors of Turkey Military Coup in 1980 and their children. This study revealed that children with traumatized parents have more somatic complaints as compared to the children of non-traumatized parents. Moreover, in regard to the symptom severity of somatic complaints in the traumatic group, the level of effect of trauma on parents was positively correlated with the level of somatic tendency in the children.

1.2. ATTACHMENT

The theory of attachment (Bowlby, 1969) is based upon the idea that human infants have a biologically based, survival-oriented desire for caregivers' closeness. Based on repeated interactions with their caregivers, infants develop

representations of relational patterns that include images of self as worthy of care and of the attachment figure as present to meet the infant's needs. One of the pioneer research groups of Attachment Theory, Ainsworth and her colleagues (1978), developed a "Strange Situation" task to measure the non-verbal reactions of the infants at the pre-separation, separation and reunion processes with their mothers. In their longitudinal investigation, the researchers observed three types of attachment style of infants: secure, ambivalent and avoidant. The secure infants show signs of distress upon separation, whereas seek interaction with their mothers by the reunion. On the other hand, the ambivalent infants show anxiety-based behaviors in pre-separation phase, and their distress level intensified with actual separation. In this group, the reunion creates ambivalent behaviors in those infants who are seeking close interaction and resisting to connect with their mothers. On the other hand, the avoidant group does not show a notable response to separation; they ignore their caregivers in reunion phase or give ambivalent reactions towards reunion with mothers.

Infants with a secure attachment style are expected to have more harmonious peer relationships, be more self-directed, and successful in developmental and verbal tasks, and become more ego-resilient. However, ambivalently attached infants become less competent, less resistant and more prone to frustration. Those that were identified as avoidant become more aggressive and non-compliant.

In the course of the attachment studies, the role of parenting in the development of the child's attachment style has been linked through a number of different concepts. Initially, Ainsworth and his colleagues (1978) advocated that the maternal sensitivity is the most important determinant of the mother's ability to represent child's experiences in terms of mental states. However, De Wolff and Van Ijzendoorn's (1997) study detected only a moderate level of predictive influence of maternal sensitivity to correctly interpret and understand the child's reactions.

In contrast to the focus on the behavioral level, Main and his colleagues (1985) emphasized the importance of language and representation. They proposed that the integration of parents' own experiences and feelings within attachment forming enrich the attention and information processing, which lead to coherent speech and sensitivity. By doing so, the researchers have re-conceptualized attachment organization not only in infants, but also in older children and adults with regards to individual differences in mental representation of the interactions with attachment figures. In this longitudinal research, it was hypothesized that mental processes would differ from behavioral processes due to the function of distinctive internal working models of relationships. At the same time, the researchers put forward the insecure-disorganized group (Ainsworth et al., 1978; Main et al., 1985). The fourth group encompasses the coherently attached infants at reunion phase, whereas depressed and disorganized in other circumstances.

In this regard, Ainsworth and colleagues' (1978) study was criticized because maternal sensitivity is defined as an umbrella term, and needed to be narrowed down in its focus. In the same line with those critics, Meins and colleagues (2001) argued that the level of maternal sensitivity cannot be a sign of whether a mother corresponds correctly to child's needs and behaviors. Through exploring the link between the maternal sensitivity level and the child's emotion regulation skills in the case of excessive arousal, Slade et al. (2005) conducted a study to focus on the transmission of maternal attachment quality to a child. The results showed that the maternal sensitivity is a mediator of the relation between attachment style of mothers and their infants.

Therefore, Meins (1998) put forward a new conceptualization via the mind-mindedness term to focus on the maternal functioning to interpret infant's mental states. This term includes responding to the baby's point of view, reacting to baby's object-oriented actions, imitating baby's behaviors, encouraging them for autonomy, and well-matched comments about infants' behaviors. In order to investigate the coherent and disjointed aspects of these two concepts, Meins et al.'s (2001) study showed that the concept of mind-mindedness as compared to

maternal sensitivity is more predictive in determining which attachment style an infant has.

Furthermore, Lundy (2002) used the concept of 'interactional synchrony' to measure the differences between parents' sensitivity to infants' perceptions, and their ability to engage in attuned interactions. In this regard, Lundy (2002) hypothesized that the interactional synchronicity would mediate the link between the mind-related concepts of parental figures and the attachment security. While the studies were mostly focused on the mother-infant relationship, he also focused on the role of the paternal functions in child's attachment security in terms of the concept of interactional synchronicity. The results illustrated that depressive symptoms of mothers and the low degree of marital satisfactions of fathers have a significant influence on the interactional synchronicity between parents and infants. In a meta-analysis study, De Wolff and Van Ijzendoorn (1997) also showed that the father-infant relationship has an influence on the formation of infants' attachment style, but less than the mother-child relationship.

In the light of attachment style development in infancy obtained from Bowlby's theoretical basis and Ainsworth and colleagues' studies, Main et al. (1985) developed a measure namely as Adult Attachment Interview (AAI) to get knowledge about the adults' attachment representations. According to AAI narratives, the attachment categorization of adults is adopted from the classification in Strange Situation. Therefore, the four categories namely as autonomous (secure), anxious-avoidant, anxious-ambivalent and disorganized are defined (Hesse, 2008).

On the other hand, Bartholomew and Horowitz (1991) utilized a self-report measure to test the attachment dynamics in adulthood relationships. For classification of adult attachments, the model of self and other has been considered in regards to positive and negative attitudes. By doing so, four attachment classification were defined. First of all, the individual is defined as securely attached with regards to positive views about both self and other. A

positive view of self whereas the negative view of others refers to dismissive attachment dynamics. Thirdly, adults are classified as preoccupied if they perceive themselves in negative ways while showing positive attitudes towards others. Fourthly, the negative views of both self and others state the fearful attachment.

1.2.1. Attachment Perspectives on Somatization

Attachment theory puts emphasis on the intersubjective realm in the primary caregiver and child (Bateman, & Fonagy, 2006; Gubb, 2013). This theory as a social developmental approach focuses on the important role of this relationship regarding the development of appropriate emotion regulation strategies. Attachment theorists put emphasis on two propositions about somatic patients. Firstly, in the early years, negative experiences in childhood contribute to the occurrence of somatic behaviors. Secondly, somatization behavior is a sign of incompatible communication in reply to environmental stress sources (Stuart & Noyes, 1999).

Since emotional regulation capacity plays a vital role in the emergence of somatic behaviors, it is necessary to focus on attachment for a better conceptualization of somatization (DePaulo, 2010; Maunder & Hunter, 2001). The introduction of the concept of 'skin-ego' representing the two layers of the psychic envelope revealed by Anzieu (1989). This concept refers to the experiences of the body surface to represent self in the early stages of development. Further, the second layer of the psychic envelope was referred as the tactile sensations and voices of the mother as a mirroring function of infant's bodily states. The conceptual basis of the skin-ego concept has promoted the curiosities on the role of attachment in the somatic experience (cited in Dejours, 2015 p.93).

Stuart and Noyes (1999) hypothesized that negative experiences in childhood have considerable effects on the developmental process of attachment style, which can be a risk factor for somatic symptoms. They suggested that the internalized representations of the relations with primary caregiver are the

indicative root from childhood trauma to the somatic preoccupation in adulthood. Once the care-seeking behavior is displayed, the interpersonal reaction of the attachment figures majorly determines whether that behavior will be strengthened. Conditional caregiving, loss experiences, inadequate maternal care, and the punitive and rejecting attitudes of caregivers can be counted as factors that contribute to the tendency to somatize. In the case of these factors, insecure attachment takes the form of care-demanding behaviors. Furthermore, insecurely attached individuals especially anxious ones are more sensitive to external threats, and show more fixed behavioral patterns. Thus, chronic illness may constitute a model of seeking self-care, by impairing the child's sense of efficacy and bodily integrity (Stuart & Noyes, 1999).

Care-seeking is closely related to attachment (Stuart & Noyes, 1999). Attachment behaviors are shaped to gain or sustain proximity to others, especially primary caregivers (Bowlby, 1977). In this regard, the behavior of searching for medical help in somatic patients is a repetition of the pattern of behavior in which one tries to find out the security and comfort reactions of others (Stuart & Noyes, 1999).

Bowlby (1977) came up with the concept of 'working model,' which refers to the internal schemas of child about self and others that provide the child with more predictable outcomes of his/her own behaviors. In this respect, chronic illnesses could be prolonged to meet attachment needs. From this point of view, the attachment figures' reactions to these illnesses have a key role in determining whether this maladaptive behavior continues or not (Stuart & Noyes, 1999). Besides childhood illness, parental illness is another contributory factor to adult somatization. Through modeling, children whose parents have chronic diseases during early phases of development are expected to be more prone to develop illness behavior in adulthood (Stuart & Noyes, 1999).

1.2.2. The Studies on Attachment and Somatization

There are many studies conducted on the link between somatization and insecure attachment styles. Taylor et al. (2000) proposed three predictor variables of symptom display, namely psychiatric diagnosis, attachment style, and symptom attribution. Their study with medical care seekers in primary health services revealed that insecure attachment and concomitant psychiatric stress are more common in individuals with somatic symptoms than individuals with organic symptoms, with the highest rates being in individuals with psychiatric symptoms.

Particularly, the most powerful link was seen between preoccupied and fearful attachment style and symptom display (Ciechanowski et al., 2002). The study with women at the health maintenance services showed that symptom reporting and health-care utilization has the strongest correlation with preoccupied attachment.

Supporting the above findings, Waldinger et al. (2006) conducted a community-based study to see the mediation effect of insecure attachment style on the relation between childhood trauma and adult somatization. Controlling the income, age and current relational violence, the results showed that insecure attachment style in females mediates the link between childhood trauma and the level of somatization. Further, fearful attachment style demonstrated the strongest mediation effect. On the other hand, for men, insecure attachment style as one of the significant predictor of the level of somatization did not mediate the relationship between childhood trauma and somatization.

On the other hand, the study of Waller and colleagues (2004) conducted a study with healthy controls and patients who has met the criteria for somatoform disorders. Their study reported that the dismissive attachment representations in somatoform patients are about two times more often than the preoccupied style. The results of this study also demonstrated that insecurely attached people are more likely to utilize health care services. In this respect, preoccupied individuals

tend to seek help from a person rather than an institution, whereas dismissively attached individuals are more inclined to utilize hospital services instead of practitioner services (Waller et al., 2004).

Parallel with Waller and colleagues (2004), Ciechanowski and colleagues (2002) have emphasized the underlying mechanisms of attachment, which has an effect on the somatization tendency and symptom reporting. According to them, the self-perception and the perception of others are the key determinants in developing somatic behaviors. Their study showed that the people with negative views towards others have been less likely to focus and report the somatic complaints. On the other hand, individuals with negative self-view have been more prone to report somatic symptoms as a tendency to focus on negative self-efficacy.

Stuart and Noyes (1999) also advocated that negative emotions after stressful experiences can intensify or de-escalate somatic complaints. According to their stance, the stress-induced events activate attachment behavior mechanisms, which shape one's somatic formations. In the light of this view, DePaulo (2010) conducted complementary studies to examine the relationship between attachment style and somatization by taking the negative emotional awareness and expressions into consideration. The results showed that attachment style and emotional awareness are contributory factors in somatization process. Further, the results also indicated that the awareness and expressions of emotions could be overwhelmingly differentiated in reference to attachment style under stress conditions (DePaulo, 2010). In this respect, securely attached individuals disclose their emotions in line with their needs, whereas preoccupied ones exaggerate their negative emotions to gain support from their caregivers. On the other hand, dismissive people, due to the possibility to being evaluated unfavorably, show little negative emotional expressions.

1.3.AWARENESS AND REGULATION OF AFFECT

As innate parts of humans' unique nature, emotional awareness is a determiner of our capacity to adapt. Therefore, the deficits in emotional awareness and affect regulation have been mainly associated with psychopathology (Silberschatz & Sampson, 1991). Kellner (1990) considered somatic disorders as an alteration in the body in terms of accompanied emotions. In regard to main construct in the current study, Lipowski (1988) associated somatization with the levels of emotional awareness and regulation capacities. Sifneos (1973) emphasized the difficulty in analytic consultation with somatic patients because of the dearth of the intrapsychic awareness and the scarcity of effective tones in the somatic patient's narratives.

Throughout the history of research, there are a lot of studies on the basis of emotional awareness. Some of these emphasized the presence or absence of affect regulation and expression, which derived from the Freudian concept of repression capacity of affective states. According to the view of those studies (e.g. Weiss, 1989; Greenberg & Safran, 1989), in the case of conflicts, the ways of emotional expression such as words or images illustrated the repression capacity in which those states keep away from consciousness (Silberschatz & Sampson, 1991). On the contrary, contemporary psychoanalytic approach on affect focuses on the transformative functions of these representations from somatic states to symbolized mental states (Lecours & Bouchard, 1997).

In terms of cognitive developmental process, the ability to articulate and abstract affect develops in five stages (Lecours et al., 2007). First, the descriptive level, called as the 'disruptive impulsion', conveys feelings in a non-organized symptomatic manner, rather than using an emotional expression. Secondly, the 'modulated impulsion' refers to the expression of action preparedness when an emotional expression is not fully reflected. At this stage, a spontaneous but circumstantial response is transmitted. In the third phase, called as 'mental externalization', a person is aware of his affects but nevertheless cannot tolerate

them. Fourthly, in the 'appropriation level', the person possesses affects which can be internalized, tolerated and perceived in the scope of subjectivity. At the last stage named as 'meaning association', the affect can be flourished by more complex interactions within mental representations. In that case, the individual is aware of the present affect and its underlying cause. Affect is interpreted as a product of the mind at the later stages, although it is perceived as a fact in the former stages.

There are three different methods of representation and these processes correspond to the components of affect. In *somatic modality*, the automatic internal body speaks. On the other hand, the definition of the behavior appears in the *motor modality*. Progressively, the objective process of affect is included in the *verbalization* and is transferred at a level that is common (Lecours et al., 2007).

According to the cognitive-developmental theory of Lane and Schwartz (1987), in the same line with Lecours et al. (2007), emotions are transformed by the successive ways of differentiation and integration. They formulated five levels of emotional awareness as (1) bodily sensations, (2) action tendency, (3) single feeling, (4) blend of individual feelings, and (5) blend of blended emotions. The developmental transformation of emotional awareness, which allows experiencing emotions in more flexible and adaptive ways, is on the continuum from implicit to explicit, from the first two levels to the latter three levels (Subic-Wrana, 2011).

As mentioned above, the cognitive perspectives agreed on the developmental road for the emotional awareness from the somatic modality to more comprehensive verbal expressions of mental states. Therefore, the somatic experience is the first line to establish emotional awareness.

1.3.1. Emotional Awareness and Somatization

Emotional awareness is the first phase of affect regulation (Taylor et al., 1997). Bucci (1978) argued that the deficits in the integration of various aspects of emotion system cause physical and mental problems. The deficits in emotional regulation can result in the development of somatization (Waller et al., 2004; Weardon et al., 2003).

In this regard, affect regulation is linked with the concept of alexithymia (Waller & Scheidt, 2006), which can be defined as the difficulties that one is experiencing in recognizing the feelings of himself/herself, and in separating them from his/her physical sensations. The concept of alexithymia can also be defined as an externally oriented approach to thinking. The third conceptualization of alexithymia can be made as a difficulty in expressing emotions (Gucht & Heiser, 2003).

In the majority of the studies on somatization, its relation to the concept of alexithymia is emphasized (Gucht & Heiser, 2003; Weardon, et al., 2003; Bailey & Henry, 2007). These studies have shown that the level of alexithymia is significantly higher in individuals with somatic complaints than control groups. However, when studies focus on different aspects of alexithymia, the results vary. In this regard, the particular dimension of the difficulty in identifying emotions is a stronger predictor of somatization tendency rather than the total level of alexithymia (Gucht & Heiser, 2003; Rief, Heuser & Fichter, 1996). However, the studies demonstrated that the externally oriented thinking dimension of alexithymia has no consistent and significant effect on somatization tendency (Rief, Heuser & Fichter, 1996).

The above-mentioned studies are based on Toronto Alexithymia Scale (TAS). However, TAS has been criticized for not taking the affective aspects of alexithymia into account. Therefore, alternative measures were developed to examine not only the cognitive aspect, but also the emotional aspect of

alexithymia. The new measures have included more subscales- namely fantasizing and emotionalizing, considering that the TAS does not meet all the aspects of measuring alexithymia. Thus, alexithymia has been started to be classified as Type 1 and Type 2. In this regard, Type 2 refers to a cognitive deficit in affect regulation, while Type 1 refers to both an affective and cognitive deficit. According to Type 1 and Type 2 distinction, studies on the relationship between alexithymia and somatization also showed different and conflicting results. For example, the studies of Larsen et al. (2003) suggested that somatization tendency is associated more strongly with Type 2 alexithymia than Type 1. In contrast, Lane and Schwartz (1987) argued that Type 1 alexithymia is related with the somatization, but not Type 2 (Bailey & Henry, 2007).

In regard to the levels of emotional awareness model, Lane and Schwartz (1987) claimed that the individuals with the lowest level of emotional awareness focus on physical senses instead of conscious emotions. In comparison to healthy controls, individuals with somatoform disorders performed poorly on the Level of Emotional Awareness task (LEAS) (Subic-Wrana et al., 2010). Parallel with this result, the clinical studies with different somatic complaints (e.g. irritable bowel syndrome and fibromyalgia) supported the inverse relationship between LEAS scores and the severity of somatic manifestations (Lane et al., 2005). In this regard, Subic-Wrana and colleagues (2005) conducted a study with six different clinical groups namely as somatoform disorders, psychological problems related to somatic disorders, depression, anxiety and compulsive-obsessive disorders, adjustment disorders and eating disorders. At the beginning of the study, individuals who suffered from somatoform and psychologically related disorders, scored lower on LEAS than patients with the rest four clinical groups. The results also showed that the mean scores of somatic patients on LEAS are in between second (action tendency) and third (one distinct emotion) levels of emotional awareness. Further, only the performances of somatoform patients improved through multimodal psychodynamic treatment methods independent of negative affectivity (Subic-Wrana et al., 2005). However, Bailey and Henry (2007)

suggested that the levels of emotional awareness and somatization are mediated by negative affectivity.

1.4. MENTALIZATION

Mentalization refers the implicit and explicit reflective attempts to be aware of and concerned about the mental states of self and others' and these mental states' links with the behaviors (Bateman & Fonagy, 2004; Fonagy & Target, 2006). This concept has been operationally defined as a measurable indicator of the capacity of attachment based mentalization (Fonagy, 2006).

Mentalization includes many cognitive processes such as interpretations of emotions, attention, understanding individual states, thinking about the state of minds. It consists of reflections about the inner world and the relational world. The development of these functions gives the child the ability to separate the inner world from the outside, and to separate the individual processes from the interpersonal contexts (Fonagy, 2006). As a metacognitive concept, the capacity of mentalization refers to thinking over thoughts. It can be evaluated as the analogy of the concept of mind-mindedness. This skill is a result of the process in which the circumstances in the psychic life define its absence or existence. As an intentional stance, this includes the capacities to plan and desire. It is the whole of the explicit and implicit hypotheses to interpret both our own and others' actions and thoughts (Holmes, 2006).

Throughout psychoanalytical research history, mentalization is diversely defined and measured as the formative factor on the link between attachment styles and psychopathology development. Three approaches are dominated in the research field. Firstly, Fonagy and Target (1997, 2002) proposed the operational definition for mentalization as the reflective function, which means the evolution of representations of psychological states in developmental root. In other words, it can be described as a fundamental component of psychic mechanism and a psychological process underlying perceptions and interpretations of self and

others in terms of their mental states (Fonagy et al., 2002). On the other hand, object relational theorists emphasized the relation between the mental states of therapists and patients. In this regard, the variations in therapeutic interaction are based on the ego attitudes toward affective experiences. These differences are defined in terms of maturity, defensive function and individuals' capacity to observe their own activities. Thirdly, mentalization involves elaborations of emotional experiences in regard to the complexity and quantity of representations. Through this function, self is comprehensively protected and regulated (Bouchard et al., 2008).

Marty (1998), during his works on the somatization in 70s, proposed the concept of mentalization to indicate the quantitative and qualitative aspects of the psychic representations, their verbal expressions, and their links with affective world. He advocated that the assessment of mentalization can be achieved by taking into consideration of three angles namely as depth, fluidity and permanence. According to him, these representations open the door to free associations, internal and external reflections of thoughts therefore play an important role in the relationships with others (Marty, 1998).

On the other side, Fonagy (2008) regarded this concept as a deliberate mental state of the humans, mostly as a function of the preconscious. According to him and his colleagues, the concept of mentalization goes beyond a cognitive function, and comprehends the attachment world and the development of self (Weinberg, 2006).

In the present study, mainly Fonagy and colleagues' conceptualization of the mentalization is adopted, yet other perspectives were also taken into consideration for a broader understanding. Hereby, mentalization refers to the ability to participate in ourselves and others' intentional mental states such as needs, wishes, beliefs and feelings while trying to understand the behavior of ourselves and others (Allen, Fonagy & Bateman, 2008; Bateman & Fonagy, 2006). Accordingly, empathy is something that a person can feel towards

someone else, whereas mindfulness is usually directed towards mental states of the self. Beyond the introspection and empathy, reflective functioning includes the ability to create meaning (Fonagy et al., 2002). It facilitates the person to become aware of their desires, emotions, and wishes and to see the others' actions as intentional. Therefore, Fonagy (2006) located the concept of mentalization at the point of intersection between emotional intelligence, empathy and mindfulness.

Mentalization is not an innate ability; it is shaped by development (Fonagy & Luyten, 2009). In this respect, Marty (1998), argued that the basic inadequacies in mental representations take the source from the early stages of development. According to him, the disabilities in children's sensory motor functions, deficiencies in maternal functions, and imbalanced responses of mothers towards infant's emotional reactions can be counted as those developmental ruptures. In the same vein, attachment theorists suggested that the development of representation varies especially in relation to the quality of the attachment relationships. The ruptures in attachment relations and early trauma impair the development of mentalization along with coherent self-structure (Fonagy & Luyten, 2009). As one of the foundations of mentalization capacity, the mirroring responses of the trusted others play an important role in the development of affect regulation and self-control (Fonagy & Luyten, 2009; Target & Fonagy, 2002). In this regard, the state and trait features of mentalization vary according to emotional stimulation and interpersonal relationships (Fonagy & Luyten, 2009).

As a multi-dimensional concept, mentalization can be understood more clearly through four distinctions regarding the polarities of implicit-explicit, internal-external, cognitive-emotional, and self-other oriented (Fonagy & Luyten, 2009). To begin with, implicit mentalization as an automatic process is based on non-verbal communication, is not conscious or thought-based. On the other hand, as verbal and reflective capacity, explicit mentalization is based on conscious process (Satpute & Lieberman, 2007). From a developmental point of view, the former is mostly shaped during the first two years, whereas the latter is only observable starting with the age of four (Carpendale & Lewis, 2006). In this

respect, physiogenetic studies illustrated that the explicit mental process activates brain regions that are dependent on linguistic development and symbolization, whereas the automatic cognitive process depends on older brain regions as the basis of sensory motor activities (Fonagy & Luyten, 2009). Some studies revealed that the increased levels of emotional arousal may cause an increase in the automatic mentalization process while leading suppression in controlled mentalization capacity (Mayes, 2006).

Secondly, the external-focused mentalization relies on the observable characteristics of the actions of self and others whereas internal-focused mentalization can be viewed as second-order representations of these external processes (Fonagy, Gergely & Target, 2007). As the third polarity, theory of mind and empathization states the independent processing in mentalization. The theory of mind mechanism directs the agent-attitude representations, while empathizing is based on self-affective states (Baron-Cohen & Chakrabarti, 2008). Lastly, two separate neural circuits are shared to know self and the others. These two circuits correspond to the mirror neuron system, which is bodily-based and automatic response stimulators, and to the cortical midline system, which is more abstract and symbolic (Lieberman, 2007).

Bouchard et al. (2008) advocated that mentalization as a complex concept should be defined by taking into consideration of three dimensions. First, mentalization capacity provides the ability to mature affective regulatory system over low-level defensive procedures. Secondly, the mentalization process via verbal elaboration, transformations and objectification furnish abstract perception. Lastly, mental processes form the emotional and relational exchanges of humans.

The concept of reflective function (RF) as the operationalized term for mentalization has been put forward to investigate and treat borderline and related personality disorders by associating them with inadequate mentalization and excessive emotional arousal (Bateman & Fonagy, 2006; Fonagy et al, 1998; Fonagy et al., 2016). In this regard, difficulties in mentalization should not be

confused with low mental capacity. In this context, studies on people with Asperger Syndrome show high cognitive abilities despite low mental capacity (Baron & Cohen, 1995). The capacity of mentalization belongs to preconscious. At the medial point between id and ego, preconscious has three critical roles in this function that are the transparency of representations, the fluidity between representations and the sustainability of those functions. Debray (2001) suggested that the capacity of mentalization plays especially role in the coping with anxiety and the resolution with inner conflicts and relational conflicts with others.

1.4.1. Attachment Style and Reflective Functioning

As mentioned above, reflective function is a measurable indicator of the capacity of attachment based mentalization (Fonagy, 2006). The reflection functioning is assessed on the basis of recognition of the nature of mental states, how much the energy is spent to understand the mental state behind the behaviors, the acknowledgment of the developmental processes behind the mental states, and the identification of the mental processes in the object-relational context (Holmes, 2006). As a deficit in mentalization, the equivalence mode in which the responses are directly shaped by self-referential motives is mostly derived from the disorganized and fearful attachment styles (Holmes, 2006).

The reflections of primary caregivers on children's global emotional states make children more sensitive to categorical differences between their emotional states (Gergely & Watson, 1996; Subic-Wrana, 2011). As a decoupling function, the automatic face display of the caregivers for the child's emotional expression provides the reference line for him to distinguish between his own internal condition and the others' internal states.

In accordance with polarities of mentalization capacity, Luyten and Fonagy (2009) conceptualized the link between mentalization capacity and attachment history. The activation of adverse attachment background in current

relationship context causes mentalization process to switch from explicit to implicit, from prefrontal areas to primal brain circuits.

On the other hand, the neuroimaging study conducted by Bartel and Zeki (2004) showed that activation in the parts of the brain related to mentalization is decreased in response to the stimuli that activate the attachment background. While secure attachment enhances mental capacity, it also lessens people's need to recognize what is going on around them. In this context, the influence of attachment on mentalization depends both on the quality of attachment style and on the dynamics of emotional diversity, which is effective on these relationships (Fonagy, 2006).

In regard to the emotional states of attachment, Fonagy (2006) defined three situations that determine whether mentalization improves within the different attachment activations. Firstly, love-related activation leads to suppression of negative affect and stimulate the capacity of mentalization. On the other hand, fear-related activation inhibits the activation of mentalization due to inducing negative affect. Lastly, secure and stable attachment reduces mental activation, if we do not have to check the other's credibility in distant relationships, which can result in damage to our close and secure relationships. This approach is parallel to evolutionary psychology. While secure attachment guarantees the trust, the ability to survive encourages consideration about motivations.

Fonagy (2006) also focused on three important points about the quality of attachment for a better understanding of this paradoxical link between attachment and mentalization. While a negative affect at moderate level requires certain mental capacity, because it has unavoidable conflicts and threats, secure attachment provides emotional encouragement so that mentalization can evolve. Securely attached individuals hold the basic levels of positive emotions that allow for an interest in mentalizing. At the same time, the mentalization capacity of parents has a critical importance for the child to develop this capacity in both

genetic and environmental contexts. The study of Main (2000) illustrated that securely attached adults have more flexibility in response to attachment-based stress, and are able to create more coherent narratives regarding their conflictual relationships.

The association between positive relationships and mentalization is not a linear one (Fonagy, 2006). Some studies showed that the improvement in mentalization capacity can lead to adverse relational effects, such as increase in the sensitivity towards relational aggression, and the behaviors in bullying and teasing (Dunn, 1988; Sutton, Smith & Swettenham, 1999).

The ones with disorganized attachment track the minds of others that annihilate the sense of self-agency. These mental states create an intolerable alien in self-representations. To get rid of this alienation, the threatened aspects of the self are re-externalized through attachment figures, rather than be internalized and contained (Fonagy, 2006). Slade and his colleagues' study (2005) showed that the mentalization capacity of parents of the children with disorganized attachment is considerably lower than securely attached ones.

Affect regulation capacity is improved to the extent of mentalization capacity. Besides the adjustment of affects, the mentalization capacity has a vital role in regulating the self. The coherent self of child can be formed within the frame of the experience of being imprinted on attachment figures' minds (Fonagy, 2006). Many studies have shown that the development of the child's ability to interpret behavior through mental concepts is closely related with the parents' perceptions about emotions, the rate of affects in the family debates, the parents' views about parenting, and the traits of parental control (Dunn, Brown & Beardsall, 1999; Meins et al., 2012; Ruffman, Perner&Parkin, 1999; Vinden, 2001).

MacBeth et al. (2011) investigated a study to see the relationship of reflective function and attachment style and their effects on the first phase of psychosis. The analyses showed that people with a secure attachment and insecure/ preoccupied style display significantly higher levels of reflective functioning than those with insecure/dismissing style. However, there was no

significant difference on the reflective functioning scores between securely attached people and individuals with insecure/preoccupied style.

1.4.2. Mentalization Capacity and Psychopathology

Fonagy and Luyten (2009) associated borderline personality pathology with the pre-mentalization modes of social cognition. They suggest that interpersonal conflicts, which boost emotional stress, impair mentalization capacity. According to them, the conflictive background of subject might inhibit the full development of mentalization. Thus, the conflicting internal states could be forced to be externalized. By doing so, incoherent self-states are revealed, and could cause the symptoms which are experienced by individuals with borderline personality disorder.

In addition to the improvement in borderline symptoms and traits, researches on mentalization-based treatment methods showed that depression and self-harm attitudes have been efficiently declined. The successful treatment outcomes derived from the development of mentalization capacity together with the reduction of attachment avoidant responses (Rossouw & Fonagy, 2012). With regard to the link between depression and mentalization, Taubner et al. (2011) conducted a study to test the mentalization difference between patients with chronic depression and healthy controls. They reported that depressive patients, while considering about the experience of loss, tend to have a lower level of mentalization than controls. However, there is no significant difference in global levels of RF between these two groups. The study also revealed that the therapeutic alliance of highly reflective patients is easier to build than the low RF patients.

By taking attachment into consideration, Bouchard et al. (2008) conducted a study to examine the relationship between psychopathology and mentalization. Besides, they compared the different measures and operational definitions of

mentalization as reflective function, mental states, and verbal reflections of affect. The attachment style and verbal reflections of mental representations largely explained the variations in Axis I psychopathology. On the other hand, the results also showed that despite the differences in operational definitions, the effect of mentalization function on Axis II psychopathology was stronger than the association between attachment style and Axis I diagnosis.

Taubner et al. (2013) investigated the link between the mentalization capacity, psychopathic tendency and aggressive behavior in a male sample. The results showed that RF moderates the link between psychopathic traits and aggressive expression. Thus, the individuals with psychopathic tendencies express more aggressive behaviors when they have low level of reflective functioning. On the other hand, Rothschild-Yakar et al. (2010) examined the effect of mentalization capacity and family relations on the formation of eating disorders. The analyses indicated mentalization as a protective factor that has a reducing effect on symptomatology of eating disorders, despite the inadequacy of the relationship with parents.

Recently, Fonagy and colleagues (2016) have scrutinized the relationship between mentalization and psychopathology through different dimensions of the impairments in mentalization. To do so, they put forward the two-dimensional deficits of reflective functioning. Firstly, hypomentalization states the incapacity to recognize and interpret the complex mental states of self and other. Therefore, individuals with hypomentalization are more prone to concrete thought processes. On the opposite side, hypermentalization as a synonym of excessive mentalization refers to the tendency of focusing on overly detailed aspects. This tendency has a risk of blurring the external reality. The mentalization capacity means the genuine mentalization states in which individuals can recognize the opaqueness of intentional mental processes. This capacity requires humility about the knowing mental states of others.

These studies revealed that mentalization capacity is a determinant on the formation and the severity of psychopathology in individuals with adverse backgrounds. Thereby, the link between mental capacity and specific pathologies can lead to the implementation of more functional treatment modalities. The focus of the current study is born from this motivation. In the light of the distinction outlined above, the current study investigates the link between somatization and attachment in regard to the hypermentalization and hypomentalization tendencies. In the following section, the studies related to the relationship between mentalization and somatization, which is the primary focus of this study, will be presented.

1.4.3. Mentalization and Somatization

Affect is a psychobiological process whose action tendency derives primarily from the somatic components. Through socialization with the controlled and automatic mentalization processes, the somatic-behavioral constituents are collated with the mental representations of affect that lead the improvements of coping mechanisms (Fonagy et al., 2012; Lecours et al., 2007; Krystal, 1988).

MacLean (1949) focused on the importance of symbolical encoding of experiences. He argued that the somatic symptom formation derives from discontinuity of the connection between neocortex and limbic system. In this regard, he supported that somatizing patients misinterpret the implicit signs of emotional arousal and perceive them as bodily malfunctions because of deficiency in transferring process into explicit mode of emotional process.

McDougall (1980) conceptualized psychosomatic complaints as inadequate psychological capacity for one's will and agency activities. She associated these complaints with impaired symbolic representations of needs and corresponding effects. In this regard, Marty and M'Uzan (1963) put emphasis on cognitive style of somatizing patients and suggested that their cognitive style is preoccupied with concrete aspects about external reality and distant from fantasy

(as cited in Subic-Wrana, 2011). Nemiah, Freyberger, and Sifneos (1976) primarily focused on the deficiency in verbalization capacity of somatizing patients.

Bucci (1997) defined the concept of referential activity which refers to the link between non-symbolic and symbolic channels. She suggested that the level of dissociation of bodily symptoms from symbolic representations gradually forms the somatic complaints. In this respect, somatization results from the basic principle of the energy exchange in the originally closed system, and is compensated for lower discharge, even when the links with the energetic concept is ignored. The object that is attacked or feared is displaced onto the body or parts of the body. Therefore, the defense mechanism of emotional system blocks the emergence of expectations and desires towards object. (Bucci, 1997; Mc Dougall, 1980) Thus, the lack of symbolic focus and regulation leads to the prolongation and repetition of activation and the final effects on physiological systems becoming more critical.

In addition to Bucci (1997), Lane and Schwartz (1987) reported that consciously emotional awareness is not possible, since emotion is only implicitly organized. With regard to this, Fonagy and his colleagues (1996, 2002) have described mentalization as not only a subconscious process, but also a conscious process. Thus, mentalization also includes the ability to think about thinking. In this regard, goal-oriented processes of physical reality constitute the primary mentalization process, while the ability of theory of mind belongs to the secondary mentalization process (Frith & Frith, 2006).

Taylor et al. (1997) hypothesized a causal link between emotional cognitive processing, irregularity of the affective system, and dysregulation of behavioral and physiological systems. Subic-Wrana et al.'s (2010) conducted a study to explore the relationship of the individuals with somatization to their difficulties in recognizing and expressing their own emotions and in challenging the minds of others. Controlling for age, sex and educational level, they compared

the performances of healthy controls and somataform patients on the tasks of mentalization and emotional awareness. The results showed that individuals with high levels of somatic preoccupation performed worse on mentalization test and had lower levels of emotional awareness, whereas their scores did not differentiate on goal directed behaviors. On another study by Zunhammer et al. (2015), the mentalization ability which was measured with Frith-Happe animation task was found to be lower in the patients with chronic pain than healthy control groups. The assessment procedure has been scored in terms of the response time and the level of their intentional attributions to moving triangles. In the mentioned study, mentalization was conceptualized in regard to the two dimensions of theory of mind, namely the interpretation of social interaction and goal-directed behavior. The patients with chronic pain detect lower reference to interpret social interaction whereas do not differ in the definition of the goal directed movements as compared to healthy controls (Zunhammer et al., 2015).

The level of emotional awareness is also used to see whether the ability to identify and describe emotions differs between the patients with chronic pain and the healthy controls. The results showed that the total score of emotional awareness is lower in chronic pain patients than controls. On the other hand, the total score is significantly correlated with the total words used in task, but did not differ between two groups (Zunhammer et al., 2015). The studies showed consistent results, which suggested that the lower level of affective mentalization in patients with a wide spectrum of somatic disorders might generate a mechanism for somatization (Stonminton, Locke & Ritenbaugh, 2013; Subic-Wrana et al., 2005; Zunhammer et al., 2015).

CHAPTER 2: THE CURRENT STUDY

In the light of the literature, the current study sought to extend our understanding of somatization tendency through the relative contribution of the deficits in mentalization and the role of attachment style in a Turkish sample.

The main aim of the study is to elucidate a potential moderator effect of the mentalization capacity on the link between attachment and somatization. In this respect, the relations between the levels of somatization, attachment insecurity, and the deficits in mentalization will be studied. Mentalization capacity is included with two dimensions, namely hypermentalization and hypomentalization. Attachment style is assessed in terms of attachment anxiety and attachment avoidance (see Figure 1). Exploring the relations between these constructs would be expected to propose clinical implications to improve therapeutic practices with somatic patients.

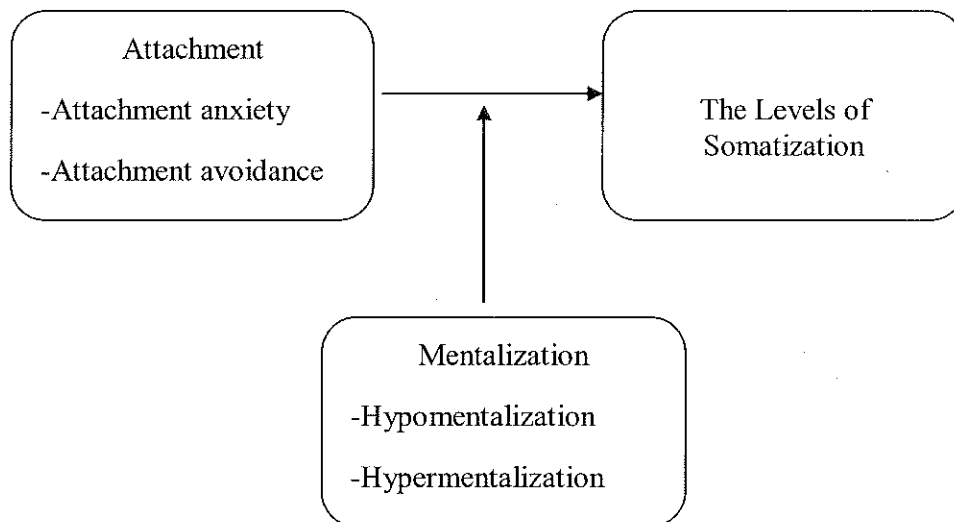


Figure 1. The Hypothesized Moderation Effect of Mentalization

2.1. HYPOTHESES

Hypothesis 1: The attachment insecurity is expected to be positively related with the levels of somatization. The level of somatization is expected to be positively correlated with both attachment anxiety and attachment avoidance dimensions of the attachment security.

Hypothesis 2: The levels of mentalization capacity and the level of somatization are expected to be related. Both dimensions of the deficits in mentalization, hypermentalization and hypomentalization, are expected to be positively correlated with the levels of somatization.

Hypothesis 3: Attachment anxiety is expected to be a stronger predictor of the level of somatization as compared to attachment avoidance.

Hypothesis 4: The relationship between the level of somatization and attachment insecurity is expected to be stronger, when hypomentalization is high.

Hypothesis 5: When the level of hypermentalization is high, stronger association between attachment insecurity and somatization is expected.

2.2. METHOD

2.2.1. Participants

Data on a voluntary basis were on hand for 402 participants, following the exclusion of those who had not completed all the measures of relevance to the study variables. The age of the participants ranged from 18 to 63 years ($M = 29.38$, $SD = 8.874$). Regarding their gender, 27.9 % of the participants were male, and 71.8% were female.

Most of the participants had a high level of educational attainment. More than half of the participants (58%) had a BA degree, 32% had an MA or PhD degrees, while only 8% of participants were high school graduates, and 7% were primary school graduates.

In regard to relationship status, 35% of the participants were involved in a relationship, 32% had no relationship, 28% were married, and 4% were categorized as other.

Almost half of the participants (48%) defined their socio-economic status as Middle, whereas 28% defined as Upper Middle, 18% as Lower Middle, 4% as Lower, and 2% as Upper.

2.2.2. Instruments

Participants were administered a survey package including the Reflective Functioning Questionnaire (RFQ-54) for measuring the levels of the mentalization, the Levels of Emotional Awareness Scale (LEAS-4) for testing the ability to recognize and describe emotional process, the Experiences in Close Relationships Questionnaire-Revised (ECR-R) for evaluation the attachment, and the Somatization Scale for determining the levels of somatic symptom occurrence.

2.2.2.1. Demographic Information Form

The Demographic Form was created by the researcher in order to gather data about the background characteristics of the participants. The form included questions regarding the participants' gender, age, educational attainment, perceived socio-economic status, relationship status, number of siblings, birth order, acute and chronic health conditions, familial health conditions, childhood illnesses and perceived childhood trauma (see Appendix B).

2.2.2.2. The Reflective Functioning Questionnaire (RFQ-54)

RFQ-54 has been developed by Fonagy and Ghinai (2008) as a self-report measure to assess an individual's capacity to mentalize internal and external processes. Fonagy and Target (1977) operationalized the mentalization capacity with the reflective function which is evolved from the psychic representations of mental process. The measure consists of 54 items scored on a 7-point Likert scale (1: strongly disagree to 7: strongly agree). Previous studies showed that it has good internal reliability as indicated by a Cronbach's α of .82; and good convergent construct validity, correlating positively with measures of related constructs, such as mindfulness, $r = .40$, $p < .001$, and cognitive empathy, $r = .48$, $p < .001$ (Fonagy et al., 2016). Throughout the process, 26 of the items began to be used to generate independent scores for two sub-dimensions, the

hypermentalization and hypomentalization. Hypermentalization refers to 'being too certain about mental states of self and others,' whereas hypomentalization indicates a state of 'being too uncertain about mental states of self and others'. For both dimensions, higher scores indicate greater impairment in Reflective Functioning.

The Turkish version of the RFQ-54 was obtained from the website of the creators of the scale (www.ucl.ac.uk/psychoanalysis/research/rfq). Reliability and validity information for the Turkish version was not available yet. In this study, Cronbach alpha coefficients for both dimensions will be calculated to check the internal consistency of the scale. Further, the results of this study will provide initial evidence for the validity of the Turkish version of RFQ-54 (see Appendix C).

2.2.2.3. The Level of Emotional Awareness Scale (LEAS)

The Level of Emotional Awareness Scale (LEAS) is a projective performance scale that is designed by Lane et al. (1990) to measure emotional verbalization. It consists of 20 emotion-provoking items. For each item, participants are asked to define their emotions, or emotions that are possible for both themselves and the other person. Participants' responses are scored by independent raters using a manual (see Lane et al., 1990). The total score of the scale ranges from 0 to 100. Scores from 0 to 20 indicate the Level 1, whereas scores from 81 to 100 indicate Level 5. In this respect, low scores indicate deficits in complex emotional verbalization, and refer to tendency to use sensory motor experiences to express emotional experiences. According to the cognitive developmental process, the first level indicates bodily sensations, and the second level refers to the body in action. Progressively the third level means that the narrative of emotional process includes a single emotion. Fourth level points to a blend of emotions, whereas the fifth level refers to the blends of blended feelings (Lane et al., 1987). The reliability test of original study indicated that the internal

consistency coefficient was .81, and the inter-rater reliability was .84 (Lane et al., 1990).

The measure was translated to Turkish by Kuzucu (2008). The 20-item Turkish version had satisfactory internal consistency ($\alpha = .85$), and test-retest reliability ($r = .78$). Subic-Wrane and colleagues (2014) constructed two different versions (version A & version B) of LEAS-4 by selecting the items with highest discriminatory power from two halves of the original version. The Cronbach alpha levels of versions A and B were found as .684 and .683, respectively. In the current study, the version A was used with the same calculation procedures as the original. The total scores obtained from the LEAS-4 range from 0 to 20 (Subic-Wrana et al., 2014).

The LEAS scores of participants were coded in terms of three categories as self, other and total by six psychology undergraduate students under the supervision of both researchers and two graduate students in clinical psychology. Since this is the first study to use the 4-item version of LEAS with a Turkish sample, a pilot study was conducted as a preliminary test for inter-rater reliability of LEAS-4. The scores of LEAS-4 which were received from the coders, denoted a high inter-rater reliability ($r = .96$). The version used in this study is presented in Appendix D.

2.2.2.4. The Experiences in Close Relationships-Revised (ECR-R)

ECR-R is a measure of attachment that includes 36 items rated on a 7-point Likert scale (1: totally disagree to 7: totally agree). Half of the items assess attachment-related anxiety, and the other half assess attachment-related avoidance, providing continuous scores on both dimensions. The Anxiety and Avoidance sub-scales have high internal consistency, $\alpha = .95$ and $\alpha = .93$, respectively. In addition to the continuous scores on 2 dimensions, the scores of the questionnaire can be used to obtain a 4-group categorization, using the median scores for avoidance and anxiety. Participants are categorized as 'secure' when their scores lower than the median for both avoidance and anxiety. The

preoccupied label is given if their score is less than the median for avoidance but more than the median for anxiety. Dismissing label is ascribed if their scores are above the median for avoidance subscale, whereas below the median for anxiety. Lastly, the fearful label is given when both anxiety and avoidance subscale scores are above the median.

The Turkish version of the questionnaire, adapted by Selçuk et al. (2005), also demonstrated high internal consistency for both Anxiety and Avoidance dimensions; $\alpha = .90$ and $\alpha = .86$, respectively. For the Turkish version, test-retest reliability coefficients were also high for both dimensions; $r = .82$ for Anxiety and $r = .81$ for Avoidance (Selçuk et al., 2005). The scale is presented in Appendix E.

2.2.2.5. Somatization Scale (SS)

In order to assess the level of somatization, the Somatization subscale of the Minnesota Multiphasic Personality Inventory (MMPI) was used. It consists of 33 items that require the participants to respond as “Yes” or “No”. The feasibility test is conducted by Dülgerler (2000) with primary school teachers to develop the Turkish norms for somatization scale. The internal consistency coefficient of the Turkish version of the scale was .83, and test-retest reliability was .996 (Dülgerler, 2000). The scale is given in Appendix F.

2.2.3. Procedure

Before the data collection procedure, an ethical approval was received from Ethics Committee Board of Istanbul Bilgi University. All data was gathered via an online survey software (www.surveymonkey.com), the link to which was shared via e-mail and social media posts. Participants initially received an Informed Consent Form (see Appendix A) to ask for voluntary participation. In this form, they were briefly informed about the purpose of the study, confidentiality of the data, and their right to quit at any point. Researchers' contact information was also provided, and participants were encouraged to communicate with the researcher if they had any questions or concerns about their

participation. Upon their approval of the Informed Consent Form, the instruments listed above were presented in the same order to each participant. It took approximately 20-25 minutes to fill in all the questionnaires.

2.2.4. Data Analysis

Following descriptive analyses, Pearson correlations and Spearman correlations were tested between the measures of interests. To analyze variance components of the level of somatization, step-wise regression analyses were performed with two dimensions of attachment, two dimensions of deficits in mentalization and their interaction of these four. The demographic factors as gender, educational attainment, current health status and parental health and somatic conditions were also tested in the model. The step-wise regression analyses were performed with the exclusion criteria as having a current physical health problem. Therefore, 47 participants were not included. All analyses were performed by using SPSS v.22.

2.3. RESULTS

In the result section of the study, the preliminary analyses were presented initially. At this stage, the reliability and descriptive analyses on the measures of interest were reported. In addition, the background characteristics of participants have looked at. Finally, the analyses, related to the hypotheses were reported.

2.3.1. Preliminary Analyses

The dependent variable of the hypotheses of this study is the level of somatization, measured by the Somatization Scale. The independent variable is attachment insecurity, which is operationalized as Attachment Avoidance and Attachment Anxiety. The hypothesized moderator is the impairment of

mentalization, indicated by two dimensions of Reflective Functioning Questionnaire (RFQ-54): Certainty and Uncertainty. In addition to the self-report measure of mentalization, emotional verbalization was also assessed using a short version of Level of Emotional Awareness measure (LEAS-4).

In preliminary analyses, first the internal consistency for each scale was examined in order to check the reliability of the measures. Further, since this is the first study to use RFQ-54 and LEAS-4 with a Turkish sample, their correlation with each other, and with the attachment scores were reported as potential evidence for their validity, and also to identify possible multicollinearity for further analyses. Descriptive statistics for the measures are also presented.

Second, certain background characteristics of the participants were summarized. Since current and previous health-related issues are of direct importance to this study, these variables will be presented in detail.

Finally, in order to identify possible confounds and/or predictors in terms of participants' backgrounds, the association between demographic characteristics and somatization were checked prior to hypothesis testing.

2.3.1.1. Reliability Analyses and Descriptive Statistics of the Scales

Preceding the data analysis, the internal consistency for each of these scales was calculated. Further, since this is the first study to use RFQ-54 and LEAS-4 with a Turkish sample, their correlation with each other, and with the attachment scores were reported as potential evidence for their validity, and also to identify possible multicollinearity for further analyses.

Cronbach coefficients for each measure are listed in Table 1. All scales and subscales used in this study yielded high reliability coefficients with alpha values ranging from .78 to .91. Exceptionally, the Cronbach alpha level of LEAS-4 was slightly below the acceptable level.

Table 1 Reliability Coefficients (Cronbach's α) for Scales in the Study

	Cronbach's α
Somatization Scale	.866
Reflective Functioning Questionnaire (RFQ)	
RFQ Certainty	.905
RFQ Uncertainty	.819
Experiences in Close Relationships-Revised (ECR_R)	
Attachment Avoidance	.913
Attachment Anxiety	.891
Levels of Emotional Awareness (LEAS)	.638

To obtain additional evidence for the validity of the LEAS-4, the Pearson Correlation coefficients were calculated to inspect the relationship between LEAS-4, RFQ-54 and Attachment. However, LEAS-4 scores were weakly correlated with all of the relevant measures: RFQ Certainty ($r = -.117$), RFQ Uncertainty ($r = -.036$), Attachment Anxiety ($r = -.025$), and Attachment Avoidance ($r = -.134$). Thus, due to questionable reliability and validity, LEAS-4 was excluded from further analyses.

As reported above, all other scales had high internal consistency. The distributions of all the variables were slightly negatively skewed, indicating relatively low levels of somatization and insecure attachment, and high level of mentalization, but both the skewness and kurtosis scores were within the acceptable range of ± 2 , and the variances were adequate for analysis. The descriptive statistics for each scale are presented in Table 2. Only one participant

was a significant outlier on the Somatization Scale, and was excluded from the data.

Table 2 Descriptive Statistics for all Measures

	<i>Min</i>	<i>Max</i>	<i>Mean</i>	<i>SD</i>
Somatization Scale	0	31	11.56	6.28
Reflective Functioning Questionnaire (RFQ)				
RFQ Certainty	1	75	27.21	14.80
RFQ Uncertainty	0	49	12.40	9.18
Experiences in Close Relationships-Revised (ECR_R)				
Attachment Avoidance	1	6.17	2.84	1.12
Attachment Anxiety	1.22	6.83	3.70	1.09

2.3.1.2. Background Characteristics of the Participants

As reported in the Participants section, the majority of the participants in this study were female, highly educated, and from a Middle or Upper Middle socio-economic background. In this section, the participants' history in terms of childhood trauma, parental health issues and personal health issues will be summarized.

One of the 402 participants was excluded from analysis due to being outlier in the criterion variable of the study. Of the 401 participants of the study, 249 (62%) reported that they had a traumatic experience before the age of 20. For 77% of the participants who experienced a trauma, it was a single event, whereas the remaining 23% experienced repeated and/or multiple traumatic events. Both

the perceived level of violence and perceived impact were rated on a 5-point Likert scale. The mean the level of violence was 4.02 ($SD = .983$) and the mean perceived impact was 3.80 ($SD = 1.132$).

Regarding the health of their parents, participants were asked to report whether their parents had a health problem, and rate how much they complained about health issues as well as how much participants were affected by these issues on 7-point scales. Approximately half of the participants reported that their mother (54%) and father (50%) had health issues. Regarding how much they complained about their health, mothers ($M = 3.14$, $SD = 1.95$) had a slightly higher mean than fathers ($M = 2.20$, $SD = 1.63$). In terms of the effect felt by the participants, both mother's health issues ($M = 3.71$, $SD = 2.01$) and father's health issues ($M = 3.10$, $SD = 1.97$) were rated as having a moderate impact; again, the mean rating was slightly higher for the mother.

Participants' health conditions were assessed by several questions asking about the existence and impact of health issues during childhood, chronic disorder(s) and acute disorder(s). For each of these, participants first indicated whether they have such a health issue, and if they have, they were further requested to report the type of their health issue and rate the perceived effect of it on a 7-point scale. The descriptive statistics are reported in Table 3.

Table 3 Frequencies and Percentages of Participants Who Reported the Health Issue and Descriptive Statistics of the Issue's Perceived Affect

	Freq.	Percent.	<u>Perceived Effect</u>	
			Mean	SD
Health Problem in Childhood	75	18.7	4.22	1.95
Chronic Disease	106	26.4	3.75	1.84
Acute Health Issues	83	20.7	4.04	1.07

To distinguish between the reported symptoms of current medical health problem or the somatic tendency, the reported acute and/or chronic health conditions were classified into three categories: disorder with physical origin (e.g. Familial Mediterranean Fever, scoliosis), with a psychosomatic aspect -trigger or exacerbating influence- (e.g. back pain, bruxism, migraine), and mental disorder (e.g. Obsessive-Compulsive Disorder, Major Depressive Episode). Since the Somatization Scale used in this study is based on a self-report of bodily symptoms regardless of their origin, existence of a physical disorder was thought to be a confounding factor in understanding the associations between psychological aspects of somatic symptoms. Since for the participants with acute or chronic physical health issues, the variance in Somatization Scale would not have reflected the psychosomatization, 47 participants who reported such conditions were excluded from analyses that investigate the relationship between the psychological factors and level of somatization. The impact of the remaining conditions, namely health problem with a psychosomatic aspect ($N = 91$) and mental disorder ($N = 10$), on the reported level of Somatization will be discussed in the next section.

In present sample, attachment categorization was not heterogeneous. The participants were dominated by fearfully attached individuals (34%). Only 32% of participants reported fewer scores than the medians of attachment avoidance and attachment anxiety and met criteria of 'secure' attachment. The other 17% of them were categorized as the dismissively attached. With lesser than the expected proportion, 16%, of the participants were preoccupied (Sümer&Güngör, 1999). The scale developers suggested that the variation in attachment could be detected better with dimensions instead of with four-level categorization. Therefore, the attachment construct in current study has been evaluated with regards to anxiety and avoidance dimensions rather than categorical classification (Fraley & Waller, 1998).

2.3.1.3. Background Characteristics and Somatization Level

In order to identify whether the level of somatization significantly differed due to background characteristics, mean comparisons were conducted. The means for categories of gender, educational attainment, SES, childhood trauma, relationship status, and the health condition were compared. For the variables with an uneven size and/or variance across categories, Independent Samples t-test was used, and for the other variables that affirm equality of variance and/or have more than two categories One-way ANOVA's were conducted. Further, the correlations between the impact ratings and Level of Somatization were inspected via Spearman correlation coefficients, due to the ordinal nature of the ratings.

Regarding gender, an independent t-test showed a highly significant difference in the levels of somatization between female and male participants, $t(354) = -3.274$, $p = .001$, with female participants showing a higher level of somatization ($M = 11.95$, $SD = 6.48$) than male participants ($M = 9.56$, $SD = 5.17$). In terms of educational attainment, the participants who have university and above degree ($M = 10.91$, $SD = 5.94$) showed significantly less somatization tendency in comparison to participants from below the bachelor degree ($M = 14.87$, $SD = 7.78$), $t(351) = -3.48$, $p = .001$.

On the contrary to expectations from extant literature, the levels of participants' perceived socio-economic status were not significantly related with the level of somatization, $F(3,354) = 65.145$, $p = .150$. The highest level of somatic symptoms was observed in Lower Middle SES ($M = 12.77$, $SD = 6.44$). Age and relationship status was also not significantly related to somatization in this sample.

When the participants with or without a traumatic experience were compared, it was observed that the traumatized participants ($M = 11.79$, $SD = 6.60$) did not significantly differ from non-traumatized participants ($M = 10.51$, $SD = 5.52$). However, a weak but significant correlation was observed between the impact rating of trauma and somatization, $r_s = .173$, $p = .011$.

The association of the complaint level and impact ratings of parental health conditions with the levels of somatization was also examined via Spearman's Rho. The results illustrated that the levels of complaint had weak, yet significant correlations with somatization for both the maternal health condition, $r_s=.285$, $p=.000$, and paternal health condition, $r_s=.153$, $p=.004$. The perceived impact on the participant was significant only for maternal health condition, $r_s=.169$, $p=.001$.

Finally, the association between the reported health problem of the participants and the level of somatic symptoms was compared. Since there were only 10 subjects in the mental disorder category, it was combined with the category of health issues with a psychosomatic aspect. Participants who reported a psychological or psychosomatic disorder ($M = 14.099$, $SD = 6.22$) were found to have a significantly higher level of somatic symptoms as compared to participants who did not report any disorders ($M = 10.17$, $SD = 5.87$), $F(1,352) = 31.312$, $p < .01$. Regarding the perceived impact of the health condition, the Spearman correlation was significant only for the impact of the chronic disorder, $r_s=.372$, $p = .001$; not significant for the impact of childhood disorder or acute health issues.

To sum up, in this sample the level of somatization was found to be associated with Gender, Educational Attainment, both Mother's and Father's perceived level of complaining about their health, and the existence and impact of a health condition.

2.3.2. The Relationship between Mentalization, Attachment and Somatization

2.3.2.1. Correlations among Mentalization, Attachment and Somatization

The first hypothesis of this study expected a positive correlation between attachment insecurity and somatization. As the attachment insecurity as two dimensions, Attachment Anxiety and Attachment Avoidance, it was expected that both will be positively correlated with somatization. In order to evaluate the direction and strength of these associations Pearson correlation coefficients were calculated (see Table 4). As expected, a significant positive correlation was found

between the Attachment Anxiety and the number of reported somatic symptoms $r(354) = .321, p < .001$. A weaker, but still significant, positive correlation was found between Attachment Avoidance and the level of somatic symptoms, $r(354) = .170, p < .001$.

Table 4 Pearson Correlation Coefficients among Somatization Scale, Certainty and Uncertainty scores of RFQ-54, and Avoidance and Anxiety Dimensions of ECR-R ($N = 354$)

	Somatization	Certainty	Uncertainty	Avoidance	Anxiety
Somatization	1	-.176**	.189**	.170**	.321**
Certainty	-.176**	1	-.493**	-.254**	-.310**
Uncertainty	.189**	-.493**	1	.246**	.261**
Avoidance	.170**	-.254**	.246**	1	.406**
Anxiety	.321**	-.310**	.261**	.406**	1

** Correlation is significant at the 0.01 level (2-tailed).

The second hypothesis of this study expected a relationship between mentalization capacity and level of somatization. As operationalized in this study, the second hypothesis expected positive correlations between somatization and two indicators of impaired mentalization: Uncertainty (hypomentalization) and Certainty (hypermentalization). For this hypothesis, again Pearson correlations were examined (see Table 4). There was a weak positive correlation between Uncertainty (hypomentalization) and somatization, $r(354) = .189, p < .000$, supporting the first part of the second hypothesis. However, on the contrary to the hypothesized positive correlation, a negative correlation was observed between the level somatization and Certainty (hypermentalization), which refers to being too certain about mental states of self and others ($r(354) = -.176, p < .001$).

2.3.2.2. Factors that Predict Somatization and the Moderator Role of Mentalization

The third hypothesis suggests a comparative inspection of Attachment Anxiety and Attachment Avoidance with regard to Somatization; expecting anxiety to be a stronger predictor. Further, Hypotheses 4 and 5 refer to the moderator role of mentalization in the attachment insecurity – somatization association. The fourth hypothesis expects a stronger positive association between attachment insecurity and somatization, when hypomentalization is high. On the other hand, the fifth hypothesis expects stronger association between attachment insecurity and somatization, when the hypermentalization is high. These hypotheses require an assessment of the conditional linear associations between measures of attachment insecurity (Avoidance and Anxiety) and somatization, as well as calculations of the two-way interactions between two dimensions of attachment insecurity (Certainty and Uncertainty) and two measures of attachment insecurity. Further, in addition to the hypothesized variables, the preliminary analyses demonstrated that several demographic variables (gender, level of education, levels of maternal and paternal health complaints and the existence of a psychosomatic/mental health condition) were also possible predictors of somatization. Thus, a regression analysis was conducted, in order to be able to (1) obtain comparative predictive power of Anxiety and Avoidance, (2) include interaction terms, and (3) to be able to see the controlled effect of the hypothesized variables and demographics.

A stepwise multiple regression analysis was carried out with somatization as the dependent variable; and Attachment Avoidance, Attachment Anxiety, Uncertainty (hypomentalization), Certainty (hypermentalization) and four interactions terms (Avoidance*Uncertainty, Avoidance*Certainty, Anxiety*Uncertainty, Anxiety*Certainty) as independent variables. The existence of a health condition, gender and education were also entered as binary variables, and the maternal and paternal health complaint ratings were included in the

model. All continuous scores were standardized before the calculation of interaction terms and analysis.

A summary of the models generated by the stepwise regression procedure is presented in Table 5. In the final model, explaining approximately 25% of the variance in somatization, six of the variables entered the equation: Attachment Anxiety, Health Condition, Maternal Health Complaint Rating, Educational Level, Certainty (Hypermentalization), Gender, $F(5,345) = 4.075, p < .05$.

In line with the extant literature, the attachment anxiety as a risk factor for increased somatization, predicts somatization significantly over and above the psychosomatic/psychological condition, maternal health condition, the educational level, the level of hypermentalization, and gender, ($R^2\text{change} = .102$). The psychosomatic/ psychological condition entered the equation as the second strongest predictor ($R^2\text{change} = .069$). The rest of the variables that entered the equation generated less than .05 change in the explained variance. In the last step, gender entered the model, resulting in the cumulative R^2 of 26.1%.

The inclusion of the Attachment Anxiety as a strong predictor of Somatization and exclusion of Attachment Avoidance from the model supports the Hypothesis 3 that ascribed anxiety a more important role than avoidance in terms of predicting somatization. Hypothesis 4 and 5, which expected mentalization to moderate the relationship between attachment and somatization, was not supported. None of the interaction terms was included in the significant model in stepwise regression analysis.

The regression coefficients and standardized beta values are presented in Table 6. The further inspection of the model suggests that object of measurement increased 1.348 for each Attachment Anxiety unit of measure and 3.087 for each psychological health condition unit of measure. Besides them, one unit increase in the ratings of how much the mother complaints about her health led 1.256 increases in the level of somatization. Being a primary or high school graduate rather than a university graduate caused 3.592 increases in the level of somatization. On the other hand, the .702 decrease in somatization were occurred

for each increased unit of being too certain about mental states of self and others.
In addition, being a female raised 1.325 unit of the somatization.

Table 5 The Model Summary of Stepwise Regression Analysis

Model	R	R ²	Adjusted R ²	SE of the Estimate	R ² Change	F Change	df1	df2
1	.319 ^a	.102	.099	5.91627	.102	39.570	1	350
2	.413 ^b	.171	.166	5.69168	.069	29.166	1	349
3	.465 ^c	.216	.209	5.54239	.045	20.054	1	348
4	.490 ^d	.240	.231	5.46445	.024	10.999	1	347
5	.503 ^e	.253	.242	5.42689	.013	5.820	1	346
6	.511 ^f	.261	.249	5.40293	.009	4.075	1	345

a. Predictors: (Constant), Attachment Anxiety

b. Predictors: (Constant), Attachment Anxiety, Health Condition

c. Predictors: (Constant), Attachment Anxiety, Health Condition, Maternal Health Complaint Rating

d. Predictors: (Constant), Attachment Anxiety, Health Condition, Maternal Health Complaint Rating, Educational Level

e. Predictors: (Constant), Attachment Anxiety, Health Condition, Maternal Health Complaint Rating, Educational Level, Certainty (Hypermentalization)

f. Predictors: (Constant), Attachment Anxiety, Health Condition, Maternal Health Complaint Rating, Educational Level, Certainty (Hypermentalization), Gender

e. Dependent variable: The Level of Somatization.

Table 6 Stepwise Regression Analysis for Variables Predicting Somatization (*N*=352)

	<u>Unstandardized</u>		<u>Standardized</u>		T	Sig.
	<u>Coefficients</u>	<u>B</u>	<u>SE</u>	<u>Coefficients</u>	<u>Beta</u>	
Constant		9.146	.576			.000
Attachment Anxiety		1.348	.313		.215**	.000
Psych. Health Condition		3.087	.651		.224**	.000
Maternal Health Complaint		1.256	.299		.202**	.000
Educational Attainment		3.592	1.006		.166**	.000
RFQ Certainty		-.702	.304		-.113*	.021
Gender		1.325	.656		.095*	.044

Note: The scores of Attachment Anxiety and Certainty subscale of RFQ (hypermentalization) were standardized.

2.3.3. Summary of the Results

The current study attempted to search the possible moderator effect of the mentalization capacity on the link between attachment and somatization. However, the results failed to provide support for an interaction effect between mentalization and attachment on the level of somatization. Therefore, the moderator analysis of mentalization was not confirmed.

Statistical analyses investigating the link between attachment and somatization illustrated that the attachment anxiety is a stronger predictor rather than the attachment avoidance for the level of somatization. On the other hand, the hypermentalization was found as a significant predictor of somatization rather than hypomentalization. In conflict with the hypothesis of the study, the correlation between hypermentalization and somatization was found in a negative direction.

Moreover, the proposed positive correlation between attachment insecurity and hypomentalization was supported. In contrast to the expectations of this study, the link between hypermentalization as a deficit in mentalization and attachment insecurity was in a negative way.

Although the attachment anxiety and the hypermentalization capacity have a significant effect on somatization, their interaction was not significant, suggesting that the attachment anxiety and hypermentalization level were significant predictors of the somatization independently from each other.

In addition to the mentalization capacity and attachment, gender, educational attainment, current health conditions and the level of health complaints of the mother were found as significant predictors of somatization.

2.4. DISCUSSION

Deficits in the capacities of emotional regulation bring with the formation of somatization (Waller et al., 2004; Weardon et al., 2003). The emotional awareness and the strategies of regulation are shaped within the quality of the interaction with primary caregivers (DePaulo, 2010). As detailed in the Introduction section, the link between attachment and somatization has been recurrently worked in the scientific studies, (Ciechanowski et al., 2002; Waller et al., 2004). Many theorists pointed out that one of the important variables in this relationship is the capacity of mentalization (McDoughall, 1980; Marty, 1998). For this reason, the main aim of the present study is to examine how the level of somatization in insecurely attached individuals is related to the capacity of mentalization.

To clarify the etiology of somatization tendency, four main research questions were tried to be explored: (1) whether attachment insecurity was predictive of high levels of somatization; (2) whether attachment insecurity would be associated with higher level deficits in the reflective functioning (3) whether individuals with low deficits in mentalization would show lower levels of somatization; and (4) whether reflective functioning moderated the relationships between attachment style and somatization.

2.4.1. Discussion of the Main Findings

2.4.1.1. Somatization and Background Factors

In the current study; correlation and mean comparison analyses were conducted to understand the associations between background characteristics and somatic complaints. The mean level of somatization in this study was consistent with the previous studies conducted in Turkey using the same measure (Özden, 2015).

The present study supported that the female participants in comparison to men have higher levels of somatization. In the related literature, it was reported that some of the psychosomatic diseases are seen more often in women, while others are more prevalent in men. Therefore, it can be said that some previous research findings supported the current findings related to the effect of gender on the level of somatization, and others are not compatible with these findings (Karşlı, 2008). The consistent study results on the gender difference in somatization could derive from females' tendency to express themselves more than men in the frame of cultural gender roles (Kirmayer & Young, 1998). On the other hand, biological mechanisms can be evaluated as an alternative explanation of this tendency. The hormonal mechanism in females and dysregulations of HPA axis due to the stressful circumstances may lead the high occurrence of the symptoms of depression, anxiety and somatization (Nolen-Hoeksema, 2001).

The studies conducted in Turkey reported that somatization was more frequent in groups with lower socioeconomic status and educational attainment (Ozaner, 2011). A study with the university students in Turkey revealed that the mother's educational level as an aspect of socioeconomic status was found to be significantly related with the level of somatization (Özden, 2015). In parallel with the current results related to the demographic factors, Özenli and his colleagues (2009) supported the link among being female, the educational status of the mother and the verbal abuse in the family environment and the prevalence of somatization. The consistent high prevalence of somatization in females can be argued in the frame of strictly defined gender roles in lower socio-economic groups. However, the current study failed to support the significant link between low socioeconomic status and high somatization. The inconsistency could have resulted from measuring the perceived level of socioeconomic status instead of monthly-income, educational levels of parents and the features of family environment. Participants of the current study came predominantly from the middle or middle-high socioeconomic backgrounds or were highly educated. Therefore when the results are evaluated, the homogeneity of the sample needs to be taken into account.

The cultural environment in which the person grows determines the content and frame of interaction. In addition, socio-cultural class, education level and belongingness of a subculture affect the rate of expressing emotional distress as somatization. People from lower levels of economic and educational backgrounds struggle with financial problems, on the one hand inadequate education on the other. The intellectual development of most of these people does not encourage them to express their emotional states. Therefore, people from these groups usually have psychosocial censorship, and experience difficulty in dealing with stress. The restricted sociocultural environment blocks the alternative communication options. In the case of that, individuals begin to use their own bodies as a way of communication. Moreover, bodily complaints can bring with secondary gain since they are usually responded with protective care (İlal, 1999). In the current study, the level of somatization of primary school and high school graduates were found to be higher than the individuals with university degree as consistent with previous results (Uğur, 2015).

Karlı (2008) reported that people who are not in romantic relationship show more somatization tendency. Additionally, Nakao and colleagues (2001) conducted a study with married, single, divorced and separated women and men to examine the effects of gender and marital status on somatic symptoms. They reported that overall symptom level was found as generally higher in women than men. Besides, married individuals have fewer physical and psychological problems than single individuals. However, there are also relevant findings that married individuals showed higher levels of somatization (Preston, 1995). On the other hand, Katon (1993) mentioned that there is no relationship between marital status and somatization (as cited in Uğur, 2015 p.18). In the same line with Katon (1993), the results of the present study did not find any significant relationship between somatization and relationship status. The influence of the marital status can be moderated by the socioeconomic status. The inconsistency in the results needs to be interpreted considering this possible effect.

The beliefs about organic basis and vulnerability are linked with increased occurrence of psychosomatic symptoms and health care utilization (Rief et al.,

2014). In the present study, the current medical conditions were found as a predictor of somatization. Among the perceived impact of chronic, acute and childhood illness, only for the ratings for chronic illness are significantly correlated with the somatization level. In the Turkish university samples, Özenli and colleagues (2009) supported the association between chronic illness and high levels of somatization. Both chronic illness and somatic complaints could be evaluated as a response to stress. Gouila and colleagues (2012) conducted a study to compare the levels of anxiety, depression, and somatization between the patient groups with chronic illnesses and controls. Their result supported that individuals with chronic illness have a higher tendency in somatization. In this context, Stuart and Noyes (1999) evaluated the chronic illness as a threat to self-efficacy and bodily integrity. Therefore, the link between chronic and somatic disorders as a vulnerability to stress needs be considered in the frame of genetics, coping mechanisms, social environment, and personality.

Many theories argued that somatization is a consequence of modeling or social learning of illness behavior. Bass and Murphy (1995) and Craig and colleagues (1993) reported that the parents of somatic patients had a high rate of physical disease. In the present study, the levels of health complaints of both mother and father were found significantly but weakly related with the somatization tendency.

In regard to the perceived impact of parental health conditions on participants, exclusively the impact of mother's health was significantly associated with the level of somatization. The primary caregivers in Turkey are usually the mothers. In this context, the deficits in emotional and bodily regulations of primary caregivers could inhibit their recognition of and ability to meet the child's needs. The unmet needs in childhood might bring forth the maladaptive behavioral patterns mapping the road to high symptom reports in adulthood.

The somatization tendency and reported childhood illness illustrated a weak, but significant positive correlation. Stuart and Noyes (1999) explained this relation on the basis of the practices of caregivers that lead the perception of illness as a way of receiving care and intimacy. Craig and colleagues (1993)

strongly suggested the secondary gain potential of the somatic symptoms. They argued that a psychosomatic individual with childhood illness more prone to seeking a secondary gain from these symptoms instead of neutralizing coping strategies to stressful life events.

The link between somatization and childhood trauma is highly investigated. The consistent result in previous studies illustrated that the prevalence of somatization is high in the individuals who are raised in an emotionally distant, a physically abusive and an unsupportive family environment (Waldinger, 2006; Taycan et al., 2014; Van Dijke et al., 2011; Brown e. al., 2005). In the current study, the participants' somatization levels did not differentiate at a significant level with regards to being traumatized. However, when the perceived effect was taken into consideration, a weak but significant correlation was obtained. Parallel with these findings, Brown, Schranf and Trimble (2005) reported that the levels of violence and the duration of emotional abuse which define the impact of a traumatic event are more significantly related with somatization.

2.4.1.2. The Associations between Attachment, Mentalization and Somatization

According to the results of the cross-cultural studies, the highest prevalence among Turkish participants had been predicted as secure attachment (Sümer &Güngör, 1999). Except for the dismissively attached participants, even the same measure for attachment categorization was adopted, the proportions of the attachment categories in the present study have not been in the same line with previously reported in the general population (Sümer &Güngör, 1999). The researchers argued that categorization in terms of the continuous score of ECR-R might be a risk for the precision and statistical power of measurement. In the light of the suggestions of scale developers, the variance in attachment is predicted better with dimensions instead of categorization. In the present study, the link between somatization and two dimensions of attachment insecurity rather than categorical classification were investigated.

In the same line with previous researchers, the results of the current study revealed a significant positive link between attachment insecurity and somatization, implying that individuals who had inconsistent, insufficient, instable experiences with a primary caregiver in early attachment process more frequently report somatization complaints.

Particularly, the anxiety dimension of attachment insecurity found as a stronger predictor of somatization rather than the avoidance dimension. Parallel with this finding, Ciechanoski and his colleagues (2002) reported that the individuals with preoccupied and fearful attachment styles show more somatic tendency in compare with secure and dismissively attached ones. Stuart and Noyes (1999) proposed that insecurely attached individuals particularly the highly anxious ones are more vulnerable to distress and behave in inflexible and rigid patterns. On the other hand, Waller and colleagues (2004) reported that dismissively attached individuals who obtained higher scores in avoidance but lower in anxiety dimensions are more likely to report somatic symptoms than preoccupied ones. The conflicted results of these studies could be rooted in different measures of attachment.

In this context, Ciechanoski and colleagues (2002) interpreted the prevalence of somatization in regard to the negative views of self and others. By doing so, they reported that individuals with a negative view of others (dismissing and fearful attachment styles) are less likely to report their symptoms because of the fear of rejection. Therefore, the dismissively and fearfully attached individuals are expected to show lower tendency to focus to and report somatic symptoms as compared to preoccupied ones. On the other hand, individuals with a negative view of self have a tendency to report more somatic symptoms as a result of the focus on negative affect.

Bass and Murphy (1995) advocated that these maladaptive patterns and attitudes threaten the relational worlds of individuals. In this context, the problematic relationship between the somatic patients and healthcare providers

can be explained with regards to the insecure attachment strategies (Waller et al., 2004). In this regard, the study of Ciechanoski and his colleagues (2001) resulted that dismissively attached individuals have difficulties for treatment adherence by evoking anger in health professionals. On the other hand, individuals with preoccupied attachment style show their extreme needs for intimacy and support from others and reflect themselves as more vulnerable. At the beginning, these attempts provide intensive medical care from professionals, while they provoke rejecting responses in long run (Waller et al., 2004).

The second research hypothesis addressed whether people with high-level deficit in mental states reported more somatic symptoms. This hypothesis of the study was partially confirmed. In line with the first part of the hypothesis, there was a significant positive link between uncertainty levels in mentalization with the level of somatization. In previous researches, this deficit in mentalization which is perceived as concrete thinking were associated with the borderline personality disorder, eating disorders which have high comorbidity rates with somatic disorders. Moreover, being too uncertain about the mental states of self and others is accompanied with the high level of depression, problems in anger management, deficits in affect regulation, lower life satisfaction and problems in relational context. In addition to this, the internally based mentalization constructs, namely mindfulness and perspective taking, were found negatively correlated with being too uncertain about the intentional mental states (Fonagy et al., 2016).

The excessive effort of mentalization as pseudomentalization could also cause a risk for the occurrence of psychopathology (Fonagy et al., 2016). However, the expected positive relation was reversed between the level of somatization and the level of certainty in mental states. The somatization scores were found to be significantly lower in participants who are too certain about mental states of self and others. Despite being a mentalization deficit, the certainty level of participants in the current study demonstrated lower levels of somatization. In the same line with present findings, the latest study of Fonagy

and his colleagues (2016) reported that the certainty level obtained from the RFQ-54 was found as positively correlated with the externally-based mentalization and anger control. Anger management and psychosomatization is negatively associated (Özden, 2015). Consistent with the current results, these studies showed that being too certain about mental states of self and others has not always been related to the impairments. On the contrary to the current results, both clinical observations and scientific investigations indicated that somatic patients have a tendency to exhibit rigid hypermentalization. These studies also revealed that even though somatic patients' narratives are highly sophisticated, their words are filtered from affective states. In this regard, hypermentalization hides their denial mechanism regarding the importance of the inner process on self and others (Luyten et al., 2013). Subic-Wrana and colleagues (2010) pointed out that the hypermentalization levels of individuals refer not to the total impairment in emotional awareness, but to a deficiency in recognition the link between emotional states and bodily sensations.

However, the lower certainty scores in the reflective functioning of highly somatizing participants in the current results still have been interesting. These results can be explained with the participants' who are highly certain about mental states tendency to perceive themselves as good-mentalizers (Fonagy et al., 2016). Therefore, their responses to self-report measure could be biased as an attempt to act as genuine mentalizers.

2.4.2. Clinical Implications

The study findings reported that the patients with high levels of somatization applied to both outpatient and inpatient medical services two times more often than non-somatizing ones (Barsky et al., 2001). The treatment of somatization involves the physical, psychiatric and psychosocial assessment of the patient. In the treatment of somatization, the aim should be to develop the ability to cope with these symptoms, not to remove them (Şahin, 2007). In spite of extreme financial and energy costs, treatments for somatic disorders have been found modestly effective among a disproportionally large number of patients

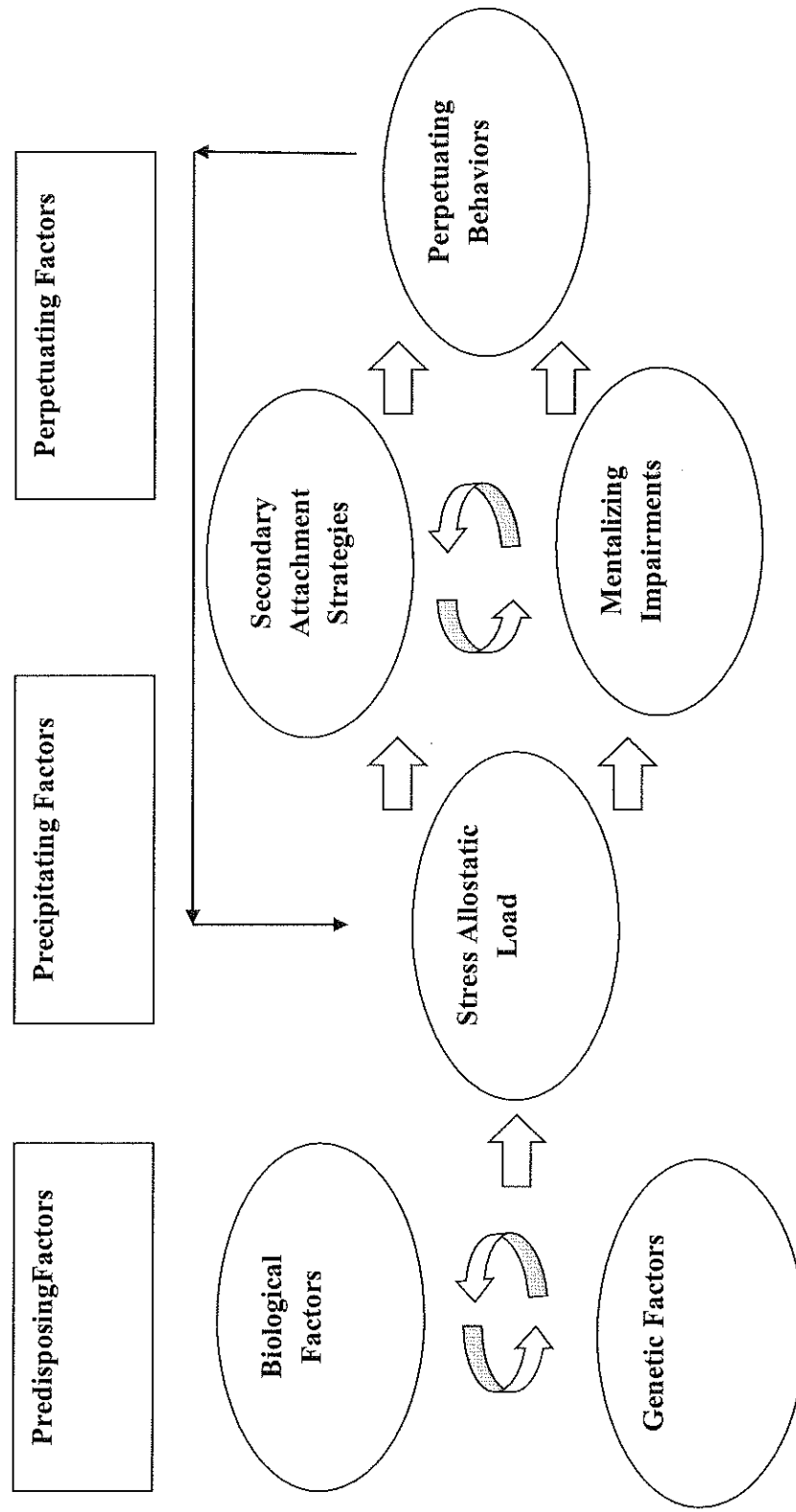
(Luyten et al., 2012). This result emphasized the need to develop more effective treatments, especially in the long run. Therefore, more evidence-based treatment approach should be obtained through gaining knowledge about the etiology of somatization.

From this point of view, the current study focused on the mentalization-based treatment (MBT) approach on somatization. As a contemporary psychodynamic approach, MBT is based on the attachment and mentalization theories through focusing on being extremely vulnerable to stress because of the use of hyperactivation or deactivation strategies of related attachment patterns (Luyten et al., 2012).

MBT practices both with group and individual modalities have been firstly implemented with the borderline personality disorders. Later on, this methodology was used with antisocial personality disorders, substance use, and eating disorders. Besides, the mentalization-based prevention treatments were implemented with mothers at risk and their children (Bateman & Fonagy, 2008).

Mentalization is dynamic and multifactorial capacity that is formed in secure attachment experiences. For evaluating the mentalization capacity of the patients, the attachment history and the behaviors under the stressful events which lead to attachment activations should be better conceptualized to define the steps of treatment. Either with being too depending or being too avoidant, the somatic patients lead intolerable countertransference reactions as irritation, helplessness, anger in both the psychotherapist and medical care providers (Maunder & Hunter, 2008). Therefore, the clinicians need to have the knowledge about the function of the secondary attachment strategies to interpret their emotional reactions towards those challenging patients. This knowledge provides benefits to clinicians to define treatment goals independent from the patients' lifelong expectations particularly on relational basis (Waller et al., 2004). Additionally, the attachment background of patients answer the health providers' questions of why some group of patients could not benefit from the treatment process or not even attempt to engage in medical or psychological care.

In the light of previous findings, it can be argued that somatic disorders derived from the vicious cycles of maladaptive interactions with environment. Luyten and colleagues (2012) proposed a model of somatization which categorizes the risk factors as predisposing, precipitating and perpetuating. As the main constructs of present study, the attachment and mentalization capacity is included in perpetuating category. By intensifying mentalizing impairments, the secondary attachment strategies cause further distress and behavioral patterns that sustain symptoms and complaints in addition to relational conflicts (see Figure 2).



In regard to psychopathology, the psychoanalytic perspectives usually focused on the deficits in embodied mentalization (Maunder & Hunter, 2008). Particularly, alexithymia and impairments in emotional awareness have been emphasized ((Beutel et al., 2008). On the other hand, the mentalization-based perspective has narrowed its attention and focus more on specific experiences and complaints. In addition, the deficits in mentalization have been seen as a result rather than the cause of the somatic disorders. In this regard, the impairments in mentalization capacity have been perceived as the consequence of the highly aroused and stress induced interpersonal context.

In this regard, the therapist in MBT has an active stance in exploring the patients' experiences related to their subjectivity. Their mentalizing role is based on the encouragement of the patients to be interested in the intentional mental states behind their experiences instead of the ruminative thoughts. At the beginning, the therapist has a function on the self-reflective stance. The therapist clarifies and elaborates the causes and consequences of patients' behaviors and their accompanied feelings. Later on, the therapist draws a link between actions and affective states. Throughout the therapeutic process, the therapist needs to be qualified to differentiate genuine mentalization from hypermentalization and psychic equivalent to mentalization.

2.4.3. Limitations and Recommendations for Future Studies

Although the current study reached its fundamental goals, there were some inevitable limitations. The cross-sectional design might be evaluated as the main limitation. It has not provided causal inferences. Somatization and mentalization as the main subjects of the study were measured at one point in time. However, they are not static constructs and might be fluctuated over time in terms of life circumstances. Because of that, the current design brings with temporal limitations of the generalizability of the results.

Thanks to its practicality and cost-efficiency, the participants were obtained by chain referral sampling. Since a non-clinical sample was used, individuals who did not apply to medical care were also included in the current study. However, this method did not guarantee the representativeness of the sample; because participants were obtained by the networks of the participants who had already been participated.

As the initial study with the measure of Reflective Functioning Questionnaire-54, the reliability of the measure for the use in Turkish population was supported. However, the utilization of self-report measures could be counted as another limitation in the current design. In this regard, the Experiences in Close Relationships-Revised Questionnaire and Somatization Scale did not provide any information about the unconscious defenses and unconscious affect regulation strategies of participants. Even though many psychological researches use self-report scales by trusting the reflectiveness of emotional state, it should be kept in mind that emotional manifestations are complex phenomenon as consisted of behavioral, cognitive and physiological dimensions (Brandley & Lang, 2000). Therefore, further research should include implicit measures to collect information about the individuals' attachment background and somatization tendency. The knowledge about the regulative patterns of the different attachment styles could enhance our investigations and improve the treatment strategies for patients with somatic disorders (Hunter & Maunder, 2001).

The examinations of medical conditions of the participants were also based on the self-report measures. These reports can be biased because of the existing pattern of attachment styles. To clarify information about the health conditions, some confirmation strategies can be conducted such as medical reports, the comments of general practitioners and so on. In addition, the evaluation of medical and psychological treatment histories of the participants was not in depth. In this regard, their treatment process may have an effect on the lower levels of symptom report. Controlling the medicine and psychotherapy effect in the future

studies will allow researchers to take into account the possible effects on the psychosomatic state of the individual.

The levels of emotional awareness tried to be measured by LEAS-4, an implicit performance test. However, the reliability of the 4-item version has been found doubtful. Therefore, this version of LEAS had inhibited to carry out a thorough analysis of the emotional awareness of participants. In Turkish adaptation study, the 20 items version of LEAS has promised better reliability levels (Kuzucu, 2012). Therefore, it can be used in further studies to see the link between emotional awareness and the constructs of the current study.

The data collection was implemented with online surveys. Therefore, the emotional reactions of the survey package could not be controlled. By considering this, the retrospective questions about trauma were not detailed because of preventing the participants from the re-traumatization. Considering the negative effects that can result from being a part of a study, researchers in future studies can better examine the traumatic experiences of participants in regard to their tendency of somatization.

The current study identified attachment style and mentalization capacity as significant constructs related to somatization. However, the stepwise regression model only explained for 21.6 % of the total variation in the number of somatic symptom reports. More than half of the variance left unexplored. In the previous literature, the researchers advocated stress, emotional regulation capacities and negative affect as contributory factors for the association between attachment and somatization. Some of them revealed that when stress induction was conducted, the attachment activation and its effect on the psychopathology could be understood better (Stuart & Noyes, 1999). Therefore, further studies can conduct a quasi-experimental design to analyze the link between attachment, mentalization and somatization by controlling the levels of stress.

Furthermore, data regarding the psychosomatic characteristics of the parents was based solely on the perception of the participant. By doing so, the

ratings could also be biased due to the attachment strategies. Not only the medical conditions of parents but also their attachment styles and the mentalization capacities can be included in further studies to reach more holistic results.

For more specific and direct links between attachment and somatization, the importance of the externalization and internalization processes behind the symptom development was emphasized (Dozier et al., 1999). Therefore, further research can study the more homogeneous somatic disorders by categorizing them in regard to their underlying mechanisms. Therefore, more specific links can be drawn between attachment and somatization under the consideration of externalization or internalization processes.

Preferably in a longitudinal design, the exploration of the associations between the mentioned constructs should be replicated, with a more comprehensive set of measures (mixed procedure with interviews and self-reports), with more homogeneous clinical and non-clinical groups. Furthermore, the clinical researches needs to be focused on whether the effectiveness of psychotherapy with psychosomatic patients can be boosted by working through with hypermentalization and hypomentalization processes of patients in therapeutic sphere.

CHAPTER 3: CONCLUSION

The current research aimed to evaluate how the level of somatization is related to mentalization and attachment styles together. The findings of the research, in general, have revealed that people with high somatization levels have a high level of attachment insecurity and a high level of hypomentalization, but a low level of hypermentalization. Particularly, the predictor roles of these constructs on somatization were restricted with attachment anxiety and hypermentalization. In addition to them, gender, educational level, health status, the health complaints of mother were found to be effective predictors on the levels

of somatization. However, the expected moderator effect of mentalization was not supported.

This study brings evidence for the integrity of soma and psyche. It points to the relationship between psychic mechanisms and somatic complaints. The results of this study suggest that mental health professionals might benefit from focusing on the secondary attachment strategies while working with clients with somatic illnesses, and focus on developing the ability of clients to interpret intentional mental states of self and others. On the other hand, for medical practitioners, taking into consideration of these mechanisms when faced with somatic patients with highly frustrating unexplained symptoms allows them more effective treatment steps and provide more collaborative relationship between patient and medical care.

With cultural norms, Turkish people have a tendency to highly somatize. To handle these high prevalence rates, the current study recommends practicing the mentalization-based treatment approach with somatic patients on an individual basis. Besides, pre-intervention strategies at society level could be developed to raise the mother's capacity to mentalize their children's mental states. In addition to this, the education system can be redesigned to encourage the genuine mentalization capacity of children, especially in relational context. These steps mentioned above would be expected to decrease the high prevalence levels of somatization in society.

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APPENDICES

APPENDIX A: Bilgilendirilmiş Onam Formu

Sayın Katılımcı,

İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Gizem Köksal'ın Yrd. Doç. Dr. Alev Çavdar Sideris'in danışmanlığında yürütmekte olduğu tez çalışmasına katılımınızı rica ediyoruz.

Çalışmanın amacı katılımcıların ilişki tarzları, duygusal farkındalıkları ve bedensel şikayetlerine dair bilgi toplamaktır.

Çalışma kapsamında çeşitli anketleri doldurmanız istenecektir. Çalışmaya katılım tamamıyla gönüllülük temelinde olmalıdır. Ankette sizden kimlik belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak ve sadece araştırmacılar tarafından grup halinde değerlendirilecektir. Bireysel herhangi bir değerlendirme yapılmayacaktır. Kişisel bilgileriniz araştırmadan çıkan herhangi bir yayın ya da sunumda kullanılmayacaktır.

Anketler, genel olarak kişisel rahatsızlık verecek soruları içermemektedir. Araştırmaya katılımın katılımcıya herhangi bir zarar vereceği ön görülmemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakıp çıkmakta serbestsiniz. Araştırmamıza gönüllü katılım gösterirseniz, sizden ricamız soruları olabildiğince samimi ve eksiksiz yanıtlamanızdır.

Çalışma hakkında daha fazla bilgi almak için sorularınızı araştırmayı yürüten Gizem Köksal'a gzmkoksal@gmail.com adresi üzerinden iletebilirsiniz.

Araştırmamıza katkıda bulunduğunuz için teşekkür ederiz.

- ☐ *Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum.*

APPENDIX B: Demografik Bilgi Formu

A.Kişisel Bilgiler

1.Yaş: _____

2.Cinsiyet: _____

3. Eğitim seviyenizi işaretleyiniz (Eğitiminize devam ediyorsanız içinde bulunduğunuz eğitim seviyesini işaretleyiniz)

İlköğretim	
Lise	
Üniversite-Lisans	
Üniversite-Yüksek Lisans/Doktora	
Diğer (Lütfen belirtiniz.)	

4. Kendinizi aşağıdaki gelir seviyelerinden hangisinin içinde görüyorsunuz?

Alt	
Alt-Orta	
Orta	
Orta-Üst	
Üst	

5. İlişki durumunuzu belirtiniz.

Bekarım, ilişkim yok	
Bekarım, ilişkim var	
Evliyim	
Boşandım	
Eş kaybı yaşadım	
Diğer	

B.Sağlık Bilgileri:

1. Kronik bir hastalığınız var mı?

Evet _____ Hayır _____

Evet ise, lütfen belirtiniz _____

Evet ise, bu hastalığınızın hayatınızı ne oranda etkilediğini aşağıdaki tabloya göre değerlendiriniz.

Hiç etkilemiyor

Tamamen etkiliyor

1	2	3	4	5	6	7
---	---	---	---	---	---	---

2. Mevcut bir hastalığınız ve/veya fiziksel bir sağlık şikayetiniz var mı?

Evet _____ Hayır _____

Evet ise, lütfen belirtiniz _____

Evet ise, bu sağlık şikayetinizin hayatınızı ne oranda etkilediğini aşağıdaki tabloya göre değerlendiriniz.

Hiç etkilemiyor

Tamamen etkiliyor

1	2	3	4	5	6	7
---	---	---	---	---	---	---

3. Çocukluk ve gençlik yıllarınızı düşündüğünüzde önemli bir sağlık sorununuz var mıydı?

Evet _____ Hayır _____

Evet ise, lütfen belirtiniz _____

Evet ise, bu sağlık şikayetinizin hayatınızı ne oranda etkilediğini aşağıdaki tabloya göre değerlendiriniz.

Hiç etkilemiyor

Tamamen etkiliyor

1	2	3	4	5	6	7
---	---	---	---	---	---	---

4. Son 6 ay içerisinde sađlık birimlerine ka kere bařvurdunuz? _____
5. Sađlık birimlerine yaptığınız bu bařvuruları göz önünde bulundurduğunuzda tedavi memnuniyetinizi ařağıdaki tabloya göre deđerlendiriniz.

Hi Memnun Deđilim

ok Memnunum

1	2	3	4	5	6	7
---	---	---	---	---	---	---

C.Aile Bilgileri:

Bu bölümde aile bireylerinizle ilgili bilgiler istenecektir. Eđer bahsedilen kiřilerden biri(leri) řu anda yařamıyorlarsa, lütfen soruları, o veya onlar hayatta iken ki durumları önüne alarak cevaplandırınız. Eđer annenizi ok küçük yařta kaybettiyseniz, “anne” olarak sorulan soruları, “size bakım veren kiři”yi (akraba, üvey anne, bakıcı anne, bakıcı, vb.) düşünerek yanıtlayınız. Aynı řekilde, eđer babanızı ok küçük yařta kaybettiyseniz, “baba” olarak sorulan soruları, “baba figürü yerine geen kiři”yi (akraba, üvey baba, vb.) düşünerek yanıtlayınız.

1. a)Ka kardeřsiniz? _____ b)Dođum sıranız? _____

2.Annenizin eđitim durumu: _____

3.Annenizin bilinen bir sađlık sorunu var mı?

Evet _____ Hayır _____

Evet ise, aıklayınız _____

Bu sađlık problemi annenizin günlük hayatını nasıl etkiliyor?

Hi etkilemiyor

Tamamen etkiliyor

1	2	3	4	5	6	7
---	---	---	---	---	---	---

4. Çocukluk ve gençlik yıllarınızı düşündüğünüzde annenizin önemli bir sağlık sorunu var mıydı?

Evet _____ Hayır _____

Evet ise, açıklayınız _____

Bu sağlık problemi annenizin günlük hayatını nasıl etkiliyordu?

Hiç Etkilemiyordu Tamamen Etkiliyordu

1	2	3	4	5	6	7
---	---	---	---	---	---	---

5. Anneniz siz çocukluk ve gençlik yıllarındayken sıklıkla fiziksel sorunlardan (baş ağrısı, mide ağrısı, halsizlik, kalp çarpıntısı, uyuşma vb.) şikayet eder miydi?

Hemen hemen hiç Her zaman

1	2	3	4	5	6	7
---	---	---	---	---	---	---

6. Babanızın eğitim durumu: _____

7. Babanızın bilinen bir sağlık sorunu var mı?

Evet _____ Hayır _____

Evet ise, açıklayınız _____

Bu sağlık problemi babanızın günlük hayatını nasıl etkiliyor?

Hiç etkilemiyor

Tamamen etkiliyor

1	2	3	4	5	6	7
---	---	---	---	---	---	---

8. Çocukluk ve gençlik yıllarını düşündüğünüzde babanızın önemli bir sağlık sorunu var mıydı?

Evet _____ Hayır _____

Evet (açıklayınız) _____

Bu sağlık problemi babanızın günlük hayatını nasıl etkiliyordu?

Hiç Etkilemiyordu Tamamen Etkiliyordu

1	2	3	4	5	6	7
---	---	---	---	---	---	---

9. Babanız siz çocukluk ve gençlik yıllarındayken sıklıkla fiziksel sorunlardan (baş ağrısı, mide ağrısı, halsizlik, kalp çarpıntısı, uyuşma vb.) şikayet eder miydi?

Hemen hemen hiç Her zaman

1	2	3	4	5	6	7
---	---	---	---	---	---	---

D.Gelişimsel Süreçte Yaşanan Travmatik Olaylar

Çocukluğunuzda ve ilk gençliğinizde (20 yaşından önce) sizi derinden etkilediğini düşündüğünü travmatik bir olay yaşadınız mı? (Tanık olunan ve maruz kalınan doğal afetler, kazalar, aile içi/dışı şiddete tanık olma ya da maruz kalma, taciz/tecavüz, işkence, savaş, terör, sevilen/yakın olunan birinin kaybı, ait hissedilen bir yerin kaybı vb.)

Evet _____ Hayır _____

Evet ise, travmatik olarak deneyimlediğiniz birden fazla olay yaşadıysanız lütfen tüm olayların etkisini/şiddetini birlikte değerlendiriniz.

Bu olayı/olayları yaşadığınızda kaç yaşındaydınız? _____

Bu olayı/olayları sizin için ne şiddette yaşandığını 1 ile 5 arasında bir sayı vererek derecelendiriniz

Hiç şiddetli değildi

Çok şiddetliydi

1	2	3	4	5
---	---	---	---	---

Hayatınız boyunca sizi ne oranda etkilediğini düşündüğünüzü 1 ile 5 arasında bir sayı vererek derecelendiriniz.

Hiç Etkilemedi

Tamamen etkiledi

1	2	3	4	5
---	---	---	---	---

APPENDIX C: Yansıtıcı İşlevi Ölçeği (RFQ-54)

Lütfen aşağıdaki cümleleri dikkatlice okuyunuz. Her bir cümle için, cümleye ne kadar katıldığınızı ifade etmek üzere 1 ile 7 arasında bir numara seçip cümlelerin yanına yazınız. Cümleler üzerinde çok fazla düşünmeyin- ilk tepkiniz genellikle en iyisidir. Teşekkür ederiz.

1'den 7'ye kadar olan aşağıdaki ölçeği kullanın:

Kesinlikle	1	2	3	4	5	6	7	Kesinlikle
Katılmıyorum								Katılıyorum

1. ___ İnsanların düşünceleri benim için bir bilinmezdir.
2. ___ Bir başkasının ne düşündüğünü ya da nasıl hissettiğini anlamak benim için kolaydır.
3. ___ Ben değiştikçe ebeveynlerimin zihnindeki resmi de değişir.
4. ___ İnsanların duygu ve düşünceleri hakkında çok fazla endişelenirim.
5. ___ Davranışlarımın başkalarının duyguları üzerindeki etkisine dikkat ederim.
6. ___ Başkalarının duygu ve düşüncelerini anlamam uzun zaman alır.
7. ___ Yakın arkadaşlarımın ne düşündüğünü tam olarak bilirim.
8. ___ Ne hissettiğimi her zaman bilirim.
9. ___ Kendimi nasıl hissettiğim, bir başkasının davranışını nasıl yorumladığımı kolayca etkileyebilirim.
10. ___ Birisinin gözlerinin içine bakarak nasıl hissettiğini anlayabilirim.
11. ___ En iyi arkadaşlarımın tepkilerini bazen yanlış anlayabileceğimi fark ediyorum.
12. ___ Ne hissettiğim konusunda sıklıkla kafam karışır.
13. ___ Rüyalarımın anlamını merak ederim.
14. ___ Bir başkasının aklından geçenleri anlamak benim için asla zor değildir.
15. ___ Ebeveynlerimin bana karşı davranışlarının, onların yetiştirilme biçimiyle açıklanmaması gerektiğine inanıyorum.

16. ___ Neyi neden yaptığımı her zaman bilmem.
17. ___ İnsanların başkalarına verdiği tavsiyelerin, genellikle kendi yapmak istedikleri şeyler olduğunu fark ettim.
18. ___ İnsanların aklından neler geçtiğini anlamak benim için gerçekten zordur.
19. ___ Diğer insanlar bana iyi bir dinleyici olduğumu söyler.
20. ___ Sinirlendiğimde, neden söylediğimi gerçekten bilmediğim şeyler söylerim.
21. ___ Sıklıkla başkalarının davranışlarının ardında yatan anlamı merak ederim.
22. ___ Diğer insanların duygularını anlamlandırmak için gerçekten çok çabalarım.
23. ___ Sıklıkla, istediğim şeyleri yapmaları için insanları zorlamak zorunda kalırım.
24. ___ Genellikle yakınlarım, yaptığım şeyleri neden yaptığımı anlamakta zorluk çekerler.
25. ___ Eğer dikkatli olmazsam, bir başkasının hayatına çok fazla karışabileceğimi hissediyorum.
26. ___ Başkalarının duygu ve düşünceleri benim için kafa karıştırıcıdır.
27. ___ Bir başkasının ne yapacağını çoğunlukla tahmin edebilirim.
28. ___ Güçlü duygular genellikle düşüncelerimi bulanıklaştırır.
29. ___ Anladım ki, birisinin tam olarak ne hissettiğini bilmek için bunu ona sormam gerekir.
30. ___ Bir kişi hakkındaki sezgilerim neredeyse hiç yanlış çıkmaz.
31. ___ İnanıyorum ki, insanlar kendi inanç ve deneyimlerine bağlı olarak bir durumu çok farklı şekillerde görebilirler.
32. ___ Bazen kendimi bir şeyler söylerken bulurum ve onları neden söylediğim hakkında hiç fikrim olmaz.
33. ___ Davranışlarımın ardındaki nedenler üzerine düşünmeyi severim.
34. ___ Normalde insanların aklından geçenleri tahmin etmede iyiyimdir.
35. ___ Hislerime güvenirim.

36. ___Sinirlendiğimde, sonradan pişman olacağım şeyler söylerim.
37. ___İnsanlar duyguları hakkında konuştuklarında kafam karışır.
38. ___İyi bir zihin-okuyucuyumdur.
39. ___Sık sık zihnim boşmuş gibi hissedirim.
40. ___Eğer güvensiz hissedersen, diğerlerini sinirlendirecek şekilde davranırım.
41. ___Başkalarının bakış açılarını anlamakta zorlanırım.
42. ___Genellikle diğer insanların tam olarak ne düşündüğünü bilirim.
43. ___Güçlü duygular beslediğim şeyler hakkındaki hislerimin bile zamanla değişebileceğini öngörebilirim
44. ___Bazen neden yaptığımı gerçekten bilmediğim şeyler yaparım.
45. ___Duygularımı dikkate alırım.
46. ___Bir tartışmada, diğer kişinin bakış açısını aklımda tutarım.
47. ___Bir başkasının düşünceleri hakkındaki içgüdülerim genellikle çok doğrudur.
48. ___İnsanların davranışlarının nedenlerini anlamak onları affetmeme yardımcı olur.
49. ___Herhangi bir durumu değerlendirmenin DOĞRU bir yolu olmadığını düşünüyorum.
50. ___İçgüdülerimden çok mantığımla hareket ederim.
51. ___Çocukluğuma dair çok şey hatırlamıyorum.
52. ___Başkasının aklından geçenleri tahmin etmeye çalışmanın bir anlamı olmadığına inanırım.
53. ___Benim için insanın davranışları söylediklerinden daha önemlidir.
54. ___Diğer insanların, çözmeye kalkışmak için fazla karmaşık olduklarına inanırım.

APPENDIX D: Duygusal Farkındalık Düzeyi Ölçeği (LEAS-4)

Lütfen aşağıdaki durumlarda neler hissedebileceğinizi belirtiniz. Sizden istenen yanıtlarınızda yalnızca “hissetme” kelimesini kullanmanızdır. Yanıtlarınız kısa ya da nasıl hissedebileceğinizi açıklamak için gerektiği kadar uzun olabilir. Her bir durumda bahsedilen diğer bir kişi bulunmaktadır. Lütfen belirtilen diğer kişinin de nasıl hissedebileceği ile ilgili düşüncenizi belirtiniz.

1. Birkaç aydır bir proje üstünde oldukça fazla çalıştınız. Teslim ettikten birkaç gün sonra, patronunuz çalışmanızın mükemmel olduğunu söylemek için yanınıza uğruyor. Nasıl

hissedersiniz? Patronunuz nasıl hisseder?

2. Patronunuz çalışmanızın kabul edilemez olduğunu ve geliştirilmesi gerektiğini söylüyor. Nasıl hissedersiniz? Patronunuz nasıl hisseder?

3. Bir arkadaşınızla yeni bir iş girişimine başlamak için birlikte para yatırma konusunda anlaştınız. Birkaç gün sonra yalnızca arkadaşınızın fikrini değiştirip değiştirmedığını öğrenmek için arkadaşınızı aradınız. Nasıl hissedersiniz? Arkadaşınız nasıl hisseder?

4. Hem çekici hem de zeki birisine aşık oldunuz. Bu kişi maddi açıdan iyi durumda olmasada, bu sizin için önemli değil geliriniz yeter düzeyde. Evliliği konuşmaya başladığınızda, onun aslında oldukça varlıklı bir aileden geldiğini öğrendiniz. İnsanların onunla sadece parası için ilgileneceğinden korktuğundan, bunun bilinmesini istemediğini söyledi. Nasıl hissedersiniz? O nasıl hisseder?

APPENDIX E:Yakın İlişkilerde Yaşantılar Envanteri-II (ECR-R)

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Bu araştırmada sizin ilişkinizde yalnızca şu anda değil, genel olarak neler olduğuyla ya da neler yaşadığınızla ilgilenmekteyiz. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Eğer halihazırda bir romantik ilişki içerisinde değilseniz, aşağıdaki maddeleri bir ilişki içinde olduğunuzu varsayarak cevaplandırınız. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 7 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

Hiç -----Karasızım/Fikrim yok----- Tamamen
katılmıyorum katılıyorum

1	2	3	4	5	6	7
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1. Birlikte olduğum kişinin sevgisini kaybetmekten korkarım.	1	2	3	4	5	6	7
2. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim.	1	2	3	4	5	6	7
3. Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım.	1	2	3	4	5	6	7
4. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissedirim.	1	2	3	4	5	6	7
5. Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım.	1	2	3	4	5	6	7

6. Romantik ilişkide olduğum kişilere güvenip inanmak konusunda kendimi rahat bırakmakta	1	2	3	4	5	6	7
7. Romantik ilişkide olduğum kişilerin beni, benim onları önemsedığım kadar önemsemeyeceklerinden endişe duyarım.	1	2	3	4	5	6	7
8. Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır.	1	2	3	4	5	6	7
9. Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim.	1	2	3	4	5	6	7
10. Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem.	1	2	3	4	5	6	7
11. İlişkilerimi kafama çok takarım.	1	2	3	4	5	6	7
12. Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim.	1	2	3	4	5	6	7
13. Benden uzakta olduğunda, birlikte olduğum kişinin başka birine ilgi duyabileceği korkusuna kapılırım.	1	2	3	4	5	6	7
14. Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım.	1	2	3	4	5	6	7
15. Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım.	1	2	3	4	5	6	7
16. Birlikte olduğum kişiyle kolayca yakınlaşabilirim.	1	2	3	4	5	6	7

17. Birlikte olduğum kişinin beni terk edeceğinden pek endişe duymam.	1	2	3	4	5	6	7
18. Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez.	1	2	3	4	5	6	7
19. Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur.	1	2	3	4	5	6	7
20. Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım.	1	2	3	4	5	6	7
21. Terk edilmekten pek korkmam.	1	2	3	4	5	6	7
22. Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir.	1	2	3	4	5	6	7
23. Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm.	1	2	3	4	5	6	7
24. Birlikte olduğum kişiye hemen hemen her şeyi anlatırım.	1	2	3	4	5	6	7
25. Romantik ilişkide olduğum kişiler bazen bana olan duygularımı sebepsiz yere değiştirirler.	1	2	3	4	5	6	7
26. Başımdan geçenleri birlikte olduğum kişiyle konuşurum.	1	2	3	4	5	6	7
27. Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.	1	2	3	4	5	6	7

28. Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim.	1	2	3	4	5	6	7
29. Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, “gerçek ben”den hoşlanmayacağından korkarım.	1	2	3	4	5	6	7
30. Romantik ilişkide olduğum kişilere güvenip inanma konusunda rahatımdır.	1	2	3	4	5	6	7
31. Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelenendirir.	1	2	3	4	5	6	7
32. Romantik ilişkide olduğum kişiye güvenip inanmak benim için kolaydır.	1	2	3	4	5	6	7
33. Başka insanlara denk olamamaktan endişe duyarım.	1	2	3	4	5	6	7
34. Birlikte olduğum kişiye şefkat göstermek benim için kolaydır.	1	2	3	4	5	6	7
35. Birlikte olduğum kişi beni sadece kızgın olduğumda önemser.	1	2	3	4	5	6	7
36. Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar.	1	2	3	4	5	6	7

APPENDIX F: Somatizasyon Ölçeği- SS

Bu formda sıra ile numaralandırılmış bazı sorular bulacaksınız. Her soruyu okuyarak kendi durumunuza göre Doğru ya da Yanlış olup olmadığına karar verin. Bu soruları sadece kendinizi düşünerek yanıtlayın. Bazı sorular birbirinin aynısı ya da tersi gibi gelebilir. Mümkünse soruları cevaplandırma çalışın.

Somatizasyon Ölçeği	Doğru	Yanlış
1. Çoğu zaman boğazım tıkanır gibi olur.		
2. İştahım iyidir.		
3. Başım pek az ağrır.		
4. Ayda 2 defa ishal olurum.		
5. Midemden oldukça rahatsızım.		
6. Çoğu zaman midem ekşir.		
7. Bazen utanınca çok terlerim.		
8. Sağlığım beni pek kaygılandırmaz.		
9. Hemen hemen hiçbir ağrı ve sızım yok.		
10. Bazen başımda sızı hissederim.		
11. Çoğu zaman başımın her tarafı ağrır.		
12. Sağlığım pek çok arkadaşımın ki kadar iyidir.		
13. Pek seyrek kabız olurum.		

14. Ensemde nadiren ağrı hissedirim.		
15. Vücudumda pek az seyirme ve kasılma olur.		
16. Çabucak yorulmam.		
17. Pek az başım döner ya da hiç dönmez.		
18. Yürürken dengemi hemen hemen hiç kaybetmem.		
19. Soğuk günlerde bile kolayca terlerim.		
20. Çoğu zaman yorgunluk hissedirim.		
21. Hemen her gün mide ağrılarından rahatsız olurum.		
22. Tekrarlanan mide bulantısı ve kusmalar yaşarım.		
23. Çoğu zaman bütün vücudumda bir halsizlik duyarım.		
24. Son birkaç yıl içinde sağlığım çoğu zaman iyi idi.		
25. Çok defa sabahları dinç ve dinlenmiş olarak uyanırım.		
26. Çoğu zaman bana kafam şişmiş ya da burnum tıkanmış gibi gelir.		
27. Çoğu zaman başım sıkı bir çember içindeymiş gibi hissedirim.		
28. Kalp ve göğüs ağrılarından hemen hemen hiç şikayetim yoktur.		
29. Hayatımda hiçbir zaman kendimi şimdiki kadar iyi hissetmedim.		
30. Kalbimin hızlı çarptığını hemen hemen hiç hissetmem ve çok seyrek nefesim tıkanır.		
31. Hiç felç geçirmediğim ya da kaslarımda olağan üstü bir halsizlik duymadım.		

32. Ortada hiçbir neden yokken haftada bir ya da daha sık birdenbire her yanıma ateş basar.		
33. Vücudumun bazı yerlerinde çok defa yanma, gıdıklanma, karıncalanma ve uyuşukluk		