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THE EXPLORATION OF THE ROLE OF MENTALIZATION ON THE RELATIONSHIP BETWEEN NARCISSISTIC TRAITS AND PSYCHOSOMATIC COMPLAINTS IN LATE ADOLESCENCE

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The Exploration of the Role of Mentalization on the relationship between Narcissistic Traits and Psychosomatic Complaints in Late Adolescence

Geç Ergenlikte Narsisistik Özellikler ve Psikosomatik Şikayetler Arasındaki İlişkide Zihinselleştirmenin Rolünün Araştırılması

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LIST OF ABBREVIATIONS

FFNI-SF: The Short Form of the Five-Factor Narcissism Inventory

IPSO: Paris Psychosomatic School

NPD: Narcissistic Personality Disorder

RF: Reflective Functioning

RFQ-54: The Reflective Functioning Questionnaire 54

RFQ-8: The Reflective Functioning Questionnaire 8

SES: Socioeconomic Status

ABSTRACT

Adolescence is a crucial stage in human development. The problems of late adolescence, however, are understudied in Turkey. Adolescents with somatization problems might experience various issues in their school and daily lives. The narcissism and mentalization are two critical dimensions of somatization problems in late adolescents. Each of them was theoretically discussed and empirically investigated in the literature. There are, however, limited studies that examined the associations between narcissism, mentalization, and somatization problems. The main aim of this study was to understand the possible role of mentalization deficits on the link between vulnerable narcissistic traits and psychosomatic complaints in the late adolescence. The second aim was to explore the predictors of somatization. The participants of this study consisted of 495 late adolescents, and they were reached via an online survey, through convenient sampling method. In the survey, the informed consent form, the Somatization Scale (SS), the Short Form of the Five-Factor Narcissism Inventory (FFNI-SF), the Reflective Functioning Questionnaire (RFQ-54), and demographic information form were given respectively. The results of the study showed that vulnerable narcissism was a predictor of somatization in late adolescents. It was also found that the association between vulnerable narcissism and somatization was partially mediated by mentalization deficit, more specifically by hypomentalization. Further analyses revealed that somatic complaints of the mother, perceived trauma history, and younger age are other predictors of somatization. The results of this study might help further understanding of somatization problems and might advance relevant intervention programs for late adolescents.

Keywords: Somatization, Vulnerable Narcissism, Grandiose Narcissism, Hypomentalization, Hypermentalization

ÖZET

Ergenlik, insan gelişiminde çok önemli bir aşamadır. Bununla birlikte, geç ergenlik döneminin sorunları Türkiye'de az çalışılmış bir alandır. Somatizasyon sorunları olan ergenler, okullarında ve günlük yaşamlarında çeşitli sorunlar yaşayabilirler. Narsisizm ve zihinselleştirme, geç ergenlerde bedenselleştirme problemlerini anlamak için iki kritik boyuttur. Her biri literatürde teorik olarak tartışılmış ve ampirik olarak araştırılmıştır. Bununla birlikte, narsisizm, zihinselleştirme ve somatizasyon sorunları arasındaki ilişkileri inceleyen sınırlı sayıda çalışma vardır. Bu çalışmanın temel amacı, zihinselleştirme kapasitesindeki yetersizliklerin geç ergenlik dönemindeki kırılgan narsisizm özellikleri ile psikosomatik şikayetler ilişkisindeki olası rolünü anlamaktı. İkinci amaç ise somatizasyonun yordayıcılarını keşfetmekti. Çalışmanın katılımcıları 495 geç ergenden oluşmakta olup, bu katılımcılara uygun örnekleme yöntemi ve çevrimiçi anket yoluyla ulaşılmıştır. Araştırmada sırasıyla bilgilendirilmiş onam formu, Somatizasyon Ölçeği (SS), Beş Faktör Narsisizm Ölçeği Kısa Formu (FFNI-SF) ve Yansıtıcı İşleyiş Ölçeği (RFQ-54) ve demografik bilgi formu verilmiştir. Çalışmanın sonuçları geç ergenlerde kırılgan narsisizmin somatizasyonun bir yordayıcısı olduğunu göstermiştir. Ayrıca, kırılgan narsisizm ile somatizasyon arasındaki ilişkiye, zihinselleştirme kapasitesindeki bir yetersizliğin, daha spesifik olarak “belirsizliğin” (hipomentalizasyon) kısmi aracılık ettiği bulunmuştur. İleri analizler annenin somatik şikayetlerinin, algılanan travma tarihçesinin ve genç yaşta olmanın somatizasyonun diğer yordayıcıları olduğunu ortaya çıkarmıştır. Bu çalışmanın sonuçları geç ergenlerde somatizasyon sorunlarının daha iyi anlaşılmasına yardımcı olabilir ve ilgili müdahale programlarını geliştirebilir.

Anahtar Kelimeler: Somatizasyon, Kırılgan Narsisizm, Büyüklenmeci Narsisizm, Hipomentalizasyon, Hipermentalizasyon

CHAPTER 1

INTRODUCTION

Narcissistic traits have been indicated to be increasing in adolescence. It was claimed to be the disorder of our age, and even an epidemic of the contemporary era (Twenge & Foster, 2008; Twenge et al., 2008; Twenge & Campbell, 2009; Twenge & Foster, 2010; Twenge et al., 2014). The Diagnostic and Statistical Manual of Mental Disorders-V (2013, p. 669) describes predominant characteristics of *Narcissistic Personality Disorder (NPD)* as follows: "grandiosity, need for excessive admiration, lack of empathy." Narcissistic pathology has two phenotypes, including grandiose (Kernberg, 1975, 2004) and vulnerable (Kohut, 1971, 1977). While DSM-V (APA, 2013) emphasizes the grandiose phenotype of Kernbergian conceptualization (1975, 2004), it misses vulnerable phenotype. Narcissistic personality patterns in adolescence might be seen in a spectrum that ranges from realistic pride, accomplishment seeking to a desire for entitlement, need for admiration, lack of empathy for others. (Lapsley & Aalsma, 2006; Ritter & Lammers, 2007; Lingiardi & McWiliams, 2017). Thus, they could range from healthy narcissistic traits to narcissistic personality disorder. Furthermore, narcissistic features that were prevalent in this period might not indicate that adolescents would develop NPD (APA, 2013, p. 671). Hence, heighten narcissistic traits might be transitory rather than signs of psychopathology.

Mentalization refers to the ability to understand and interpret the mental processes of the self and others, and it is operationalized as a reflective functioning capacity (Fonagy & Target, 1997; Fonagy et al., 2004; Allen et al., 2008). The mentalization capacity has been found to develop through young adulthood and to be low in adolescents when compared with adults (Cropp, 2019). Hypersensitivity to self and others' mental states is another trait of adolescents' mentalization (Lingiardi & McWiliams, 2017). In addition to this, the integration of mental state knowledge and language might be impaired in this period (Lingiardi & McWiliams,

2017). Mentalization has been indicated to play an important role in human psychology. Researchers found that metalization was a protective factor and an important tool in the treatment of psychosomatic symptoms (Smadja, 2011; Aisenstein, M., & de Aisemberg, 2010; Marty, 201; Aydoğan, 2018; Ballespí et al., 2019; Bizzi et al., 2019).

The two primary mentalization deficits that were discussed in the literature were hipermentalization and hipomentalization (Fonagy et al., 2016). *Hipermentalization* refers to being too confident in mental states of self and others, while *hipomentalization* refers to being too uncertain on mental states of self and others (Fonagy et al., 2016). Hipermentalization is pseudomentalizing or excessive mentalizing. Hipomentalization is concrete thinking in a *psychic equivalent mode* of functioning (Luyten et al., 2012). These mentalization deficits were associated with different psychopathologies, including narcissism and somatization (Luyten et al., 2012; Lingiardi & McWiliams, 2017; Ballespí et al., 2019; Bizzi et al., 2019). In the literature, hypermentalizing was found to be significantly correlated with grandiose narcissism, while hipomentalizing, was found to be significantly related to vulnerable narcissism in adolescence ((Duval, Ensink, Normandin, & Fonagy et al., 2018; Gagliardini & Colli, 2019).

"Somatization" has been described as the bodily symptomatic manifestation of the undischarged affects and drives, psycho-social distress, and emotional problems (Lipowski, 1987a). For example, people might have many symptoms like headache, back pain, numbness, insomnia, chest pain, cough, fatigue, and seek medical treatment in the absence of organic pathology (Lipowski, 1987a; Meissner, 2006). Therefore, individuals with somatic complaints do not attribute emotional and psychological causes for their complaints, and they go to primary health care services rather than psychological and psychiatric services. The somatization problems have been indicated to cause a financial, social, and medical burden on society, economy, and health system (Lipowski, 1987b, 1988; Kirmayer & Robbins, 1991; Spaeth, 2009; Sicras et al., 2009).

Adolescence is a transitional period between childhood and adulthood. It consists of rapid changes in cognitive, physical, biological, socioemotional development (Steinberg, 2007; Santrock, 2013; Santrock, 2015). Adjustment to these immense changes is challenging, and they create emotional turmoil in adolescents (Steinberg, 2007; Santrock, 2013; Santrock, 2015). In recent years, *late adolescence* has been indicated to extend to the period between the ages of 18-24 and includes inherent stresses and in-betweenness experiences between adolescence and adulthood (Jaworska & MacQueen, 2015; Sawyer et al., 2018; McDonagh et al., 2018). This period has been described to comprise "delayed timing of role transitions, including completion of education, marriage, and parenthood," a transition to employment, financial independence (Jaworska & MacQueen, 2015; Patton et al., 2016; Teipel, 2017; Sawyer et al., 2018, p. 1; McDonagh et al., 2018). In this study, mentalization, narcissism, and somatization in the late adolescence will be discussed, and the relationship between them will be investigated.

In the world, psychosomatic complaints in adolescence have been increasing, and this is a warning for public health problems (Ibeziako & Bujoreanu, 2011; van Geelen & Hagquist, 2016; Potrebny et al., 2017; Hagquist et al., 2019). Psychosomatic problems have been observed in the late adolescence because of modern neoliberal competitive life (pursuing good university, department, job, concepts of consecrated performance, efficiency, effective uses of time) and developmental bodily preoccupations (Parman, 2005; Agras et al., 2007; Marty, 2012). In studies done with patients diagnosed with somatization disorders, 27% of patients' symptoms in Turkey and 30% in Europe were found to be unrelated with an organic pathology (Sağduyu et al., 1997; Black & Andreasen, 2014). In children and adolescents who were referred to primary health care services, 25-50% of them showed somatization problems (Malas et al., 2017).

The current study aims to examine the relationships between mentalization deficits, specifically hipomentalization, narcissistic traits, and psychosomatic complaints in the late adolescence period. In the first section, the literature on

narcissism and narcissistic subtypes will be reviewed. In the second section, mentalization, hypermentalization, hypomentalization, and the link between mentalization and narcissism will be presented. In the third section, theories on somatization will be reviewed. The fourth section of the study will focus on late adolescence, and narcissism, mentalization and somatization in the late adolescence. Finally the relationship between somatization and mentalization, somatization and narcissism will be reviewed, and the associations between narcissism, mentalization and somatization will be presented.

1.1. NARCISSISM

The *Narcissism* concept comes from myths of Ovid "Narcissus" in Greek mythology (Gabbard, & Crisp, 2018). The following story is one of the various versions of this myth. A handsome boy who is called "Narcissus" was loved by all the nymphs. One day he rejected the desperate advances of a nymph named Echo. Echo felt shame and grief for being rejected, and she disappeared. Goddess Artemis heard this and punished Narcissus with love that will never be satisfied. One day, he fell in love with his reflection on the water when he was looking at the lake. He does not understand that it is his reflection. He thought that he found his ideal love and partner. He cannot, however, find a response to his passion and became melancholic and dropped into the lake. His image, an idealized version of himself, brought him death. Where he fell, the narcissus flowers bloomed (Akhtar & Thomson, 1982; Gabbard, & Crisp, 2018; Cooper, 1986).

Narcissism is one of the most studied psychopathologies in psychology, psychodynamic psychology, and psychiatry. From 2010 to 2017, every year around 350 academic articles published about narcissism (Miller et al., 2017). Narcissism was also stated to be the disorder and the "pandemic" of the contemporary era (Twenge & Foster, 2008; Twenge et al., 2008; Twenge & Campbell, 2009; Twenge & Foster, 2010; Twenge et al., 2014; Campbell & Twenge, 2015; Erten, 2016).

Freud developed the narcissism concept during his psychoanalytic psychotherapies. He borrowed the narcissism concept from Nacke, who conceptualized it as a person's treatment of his/her body as a sexual object (Baranger, 2018; Fonagy, 2018). Freud (1905) in this article " *Three essays on the theory of sexuality*" began to define narcissism as a sexual object choice of homosexuals and later defined as a sexual perversion, in his article "*On Narcissism: An Introduction*," (Freud, 1914; Fonagy, 2018). In his writing, Freud pointed out the megalomania of schizophrenic people and typical developmental features of children who have omnipotent thoughts, animism, primitive thinking. According to him, the megalomania of schizophrenic people emerged through changing the object of libido (Freud, 1914). In addition to this, Freud builds up a developmental perspective on narcissism, from the normal developmental phase of childhood to the psychopathology of adulthood. He considers narcissism in four different dimensions, narcissism as perversion, as a developmental stage, as a choice of object and as a libidinal cathexis to self (Kayaalp, 2013). He introduced "primary narcissism and secondary narcissism" concepts (Freud, 1914). For Freud, primary narcissism is a normal phase, kind of biophilia, rather than a sexual perversion. It is a transitory stage between autoeroticism and object-love (Freud, 1914). According to him, the infant firstly invests libido (cathexis) to self and to his own body, rather than his mother or another caregiver. The first object relation is not founded with mother but as a form of autoeroticism. The baby and the other is not differentiated yet libido invested to self. When this phase ends, the baby chooses to canalize his/her love to his/her mother. This is a normal developmental line if everything goes well with the caregiver/ the object. However, if the baby experiences neglect, violation, rejection from his/her caregivers, due to experience of frustrations, feelings of worthlessness, he/she might re-invest libido to the self. Thus, as he/she cannot invest in caregivers who are not trustful, secondary narcissism emerges. (Freud, 1914).

Narcissism concept remained, but transformed from sexual perversion to libidinal cathexis to self, from the state of regression to interpersonal model, as well as it was discussed as self-esteem problems (Akhtar & Thomson, 1982; Anlı, 2010).

Normal and pathological narcissism were the two main dimensions of narcissism. Kohut and Kernberg, the two leading figures on narcissism theories, presented the grandiose type of narcissism (Kernberg1975, 2004) and vulnerable type of narcissism (Kohut, 1971,1977).

1.1.1. Normal Narcissism and Pathological Narcissism

Normal narcissism and *pathological narcissism* divergences were frequently discussed in the literature. There was a continuum from the clinical characteristics of narcissistic personality disorder to narcissistic personality features of healthy people (Levy-Warren, 1998; Lapsley & Aalsma, 2006; Ritter & Lammers, 2007). Normal narcissism and pathological narcissism have been said to emerge in the developmental process, based on parental behaviors and attitudes (Kohut,1977). Living in harmony with significant others and meeting the needs of self and others have been indicated to be the signs of healthy narcissism. Being approved and loved are said to be the narcissistic needs of every single person (Ronningstam, 2005). Developmentally, every person goes through normal narcissistic stages, according to Kohut (1971, 1977) and Kernberg (1975, 2004). Besides, self-worth, which is based on internal thoughts and feelings, rather than others' approval, helps the maintenance of self-esteem and normal narcissism (Kernberg, 1975; Kohut, 1977; Roche et al., 2013).

Self-esteem is important in the development of normal narcissism, lack of self-esteem, however, was associated with pathological narcissism (Horton et al., 2006). In psychological development, if parents meet self-object needs, if the child get acceptance, approval of his/her feelings, he/she would follow the normal narcissistic development. Later in adulthood, the outcomes of this normal development would be seen in various dimensions of human psychology such as humor, art, empathy, wisdom, self-acceptance, tolerance to failure, being proud with success, enjoyment of acts, aim-setting capacity belonging, reality testing

about limits, control of drives and affects, ambition, taking responsibility, regulation of negative affect (Kohut, 1977; Ronningstam, 2005).

Normal narcissism consisted of a real capacity to love, trust, and interdependence. Self and other representations were integrated, while feelings of emptiness and depletion do not exist. In some conditions normal narcissistic features could be even advantageous (Barry & Wallace, 2010; Ensink et al., 2017). Difficult developmental challenges seen in adolescence might be coped with successful and adaptive narcissistic features such as high self esteem, self- respect, self-love, ability to admire and be admired, set and pursue goals (Barry & Kauten, 2014; Kauten & Barry, 2016).The pathological narcissism, however, includes severe pathology in object relations, and observed with inflated self-esteem, grandiosity, exhibitionism, idealization, and devaluation of others, seeking for grandiose fantasy including power, appearance, and money, a need for approval, exploitations, envy, greed, oral rage attacks, the sensitivity of criticism, entitlement, harsh superego, sensitivity to rejection and abandonment (Kohut, 1971; Kernberg, 1975; Kohut; 1977; Kernberg, 2004).

1.1.2. Kernbergian and Kohutian Conceptualization of Narcissism

Kernberg (1984) consider narcissism as a libidinal investment of grandiose self rather than regression to an infantile state. According to him, the child was expected to integrate good and bad representations of self and objects around 3-5 years of age. However, in pathological narcissism, the child internalizes all good representations of the self, but there is no real integration. As a result, the grandiose self emerges (Kernberg, 2004). Kernberg (2004) considers guilt as an important feeling in the development of narcissism, that is responsible both in the rejection and admiration of parents. According to Kernberg, when parents of a child were cold and misbehaved, the child would need to repress bad partss of the self. Later, he/she projects bad parts to other people. Thus, the child would internalize

grandiose self, rather than developing integrated self-object representations. The ego and superego were not well differentiated due to pathological object relations. Thus, the superego will not function well as it is expected to be and will depend on externally suppressing the environment (Kernberg, 1975, 2004).

Kernberg suggests that narcissistic personality disorder includes a spectrum of personality organization, the neurotic, borderline, and psychotic level. The narcissistic individuals fall into either low or high level of borderline personality organization (1975, 1984, 2004). Borderline personality organization is characterized by splitting, denial, and other archaic defenses, mostly with appropriate reality testing, and identity diffusion. He also indicated that borderline personality disorder that was discussed in the DSM-IV (APA, 2013) is different than the borderline personality organization. The primary defenses were listed as immature, archaic defenses such as idealization, devaluation, omnipotent control, denial, splitting, projection (Kernberg, 1975, 1984, 2004). Antisocial personality or malignant narcissism were listed as severe forms of narcissism. Highly functional narcissistic individuals, however, might adapt some appropriate dimensions of social norms, even though they still experience boredom and emptiness. The main problems of narcissistic individuals mostly seen in social relationships, like deficits to invest others and seeking admiration from others. Kernberg chooses to classify from normal narcissism to pathological narcissism in three levels of psychopathology, high, middle, and low functioning. High-level narcissistic induvial might gain success to gratify his fantasies and might function successfully in life. In the middle group, they can have a grandiose sense of self and very little interest in real love and intimacy. The lowest functionality includes comorbid borderline personality, with identity diffusion and oscillation between grandiosity and suicide (Kernberg, 1975, 1984, 2004; Levy et al., 2011).

Self is the critical concept for understanding the narcissism in Kohut's *Self Psychology* (Kohut, 1971, 1977). Self, empathy, and self-object needs, including mirroring, idealizing and twinship, are the central concepts of self-psychology (Kohut, 1971, 1977). Kohut conceptualized self as the structure of the psyche,

which is growing steadily and including different and conflicting representations (Kohut, 1971). According to him, grandiose and inferior self could be both aspects of the self. Object libido and narcissistic libido develop synchronously and lead to the development of the self (Kohut, 1971).

Contrary to Freud (1914), narcissism was not related to the deficit of libidinal cathexis to object, but it was a normal development that was related to self and selfobjects relationship. Selfobjects were the primary caregivers who were experienced as a part and extension of the self. Infants who cannot regulate and soothe themselves needed to use the self-objects for healthy psychological development. The three primary needs that should be provided by self-objects are: mirroring, idealizing, and twinship needs (Kohut, 1971). Indifferent, cold, distant parenting, however, may lead to unmet self-object needs which may cause pathological narcissism (Kohut, 1971; Kohut & Wolf, 1978; Kohut, 1977). Thus, they may become individuals with narcissistic personality disorders with fragmentations or weakenings in the structure of the self.

There are two forms of idealizations: idealization of the archaic image of the parent and idealization of the oedipal parent (Kohut, 1966, 1971). They are both important for superego development. First, they are narcissistic in nature and should be neutralized through internalizations. However, some parts of these will retain being narcissistic features and will be part of the personality. According to Kohut (1968), children internalize the oedipal parent through optimal frustrations and thus superego develops through learning punishment and restrictions, moral values, and ideals like ambitions, creativity, and impulse control.

Idealized parental imago contributes to limit setting, soothing, and regulation of the child. If there is an ideal empathic environment, grandiose self-image will moderate and will be transformed into ambition, energy for joy, and self-esteem. In the same good enough environment, the idealized parent imago will transform into superego and ego ideals as a part of a cohesive self and personality. The child who encounter negligence, rejection, ignoring, nonacceptance, will not be able to consolidate a cohesive self and will be fixated in a “grandiose self” stage

(Kohut, 1971). Idealized parental imago, which includes the perfection of the father, could sometimes be pathological too (Kohut, 1968). The child who was disappointed with the father's behaviors and humiliated, he/she could not find someone to idealize and attribute omnipotence. In the future, this disappointment might lead to over idealization and dependency on other individuals or groups such as political parties, artists, religious groups (Kohut, 1977).

In the psychoanalytic literature, Kohut (1971, 1977) and Kernberg (1975, 2004) proposed different etiological reasons and treatment techniques for the narcissism. Kernbergian's (1975, 2004) conceptualization represents the grandiose subtype of narcissism, while Kohutian conceptualization (1971, 1977) represents the vulnerable type of narcissism. The following chapters will expand the theories and empirical research on grandiose and vulnerable subtypes of narcissism.

1.1.3. Subtypes of Narcissism

The two different subtypes of narcissism that have been largely discussed in the literature were the grandiose and vulnerable narcissism. The g*randiose* subtype includes "acclaim-seeking, arrogance, authoritativeness, distrust, entitlement, exhibitionism, exploitativeness, grandiose fantasies, indifference, lack of empathy, manipulativeness, thrill-seeking", and the *vulnerable* subtype includes "need for admiration, reactive anger, shame" (Glover et al., 2012: 502).

These two different narcissisms were also described in the literature as "the "*oblivious*" versus the "*hypervigilant*" type (Gabbard, 1989), the *overt* versus the *covert* or "*shy*" type (Akhtar, 2000); the *exhibitionistic* versus the "*closet*" type (Masterson, 1993)", "the "*thick-skinned*" versus the "*thin-skinned*" type (Rosenfeld, 1987)" (as cited in Mcwiliams, 2011, p.147).

The grandiose type of narcissism was first introduced by Ernest Jones (1913). Exhibitionist, being aloof, judgmental, remoteness, and emotional inaccessibility were defined as characteristics of the narcissistic "man". Kernberg

defined the contemporary grandiose type with explosiveness, being greedy, attention-demanding characteristics (Kernberg, 1975; Kernberg, 2004). The grandiose narcissists do not give attention to the negative feelings like envy, and devalue others while idealizing themselves (Rosenfeld, 1987). Self-regard was maintained by the idealization of the self, denial of the bad and vulnerable parts, and devaluation of others (Dickinson & Pincus, 2003). According to Kernberg, they may be highly functional in personal tasks and ordinary daily interactions because they need to maintain it for continuous admirations from other people. Limited enjoyment might derive from grandiose fantasies of being very successful and wealthy, which will bring them appreciation. They have reality testing, but this would be paralyzed in one of the fields of social relationships or work. Emptiness and boredom could be one of the dominant feelings. Capacity to love is severely impaired, and they cannot establish a real connection with others. Narcissistic individuals constantly idealize and devalue other people interchangeably (Kernberg, 1967, 1975, 1980, 2004). This might be due to their envious feelings, which are very threatening to tolerate. Kernberg (1967, 2004) explain the mechanisms of the grandiose fantasy and exploitative behaviors of narcissistic individuals as oral rage issues. According to him, oral rage, aggressiveness, and envy emerged against the rejecting, cold, careless, aggressive, sadistic parents. Thus, identification with the parent and traumatic frustrations causes envy. Besides grandiosity might be understood as a defense to re-rejection and abandonment (Kernberg, 1967, 1975, 1980, 2004). The projection of the all bad representations makes others very dangerous. So, the projection of rage creates paranoid situations. These individuals try to be self-sufficient; they do not want to be needy.

According to Kernberg (2004), there are three pathological traits of narcissistic individuals, pathological self-love, pathological object love, and pathological superego. Grandiose behaviors, exhibitionism, hard-driving, indifferent behaviors are signifiers of the self-love. In pathological object love, lack of real investment to others, lack of gratitude, and envy of others are the main manifestations. Finally, sensitivity to criticism and predisposition to depressive affective states indicates impaired superego development. If they experience a

narcissistic injury on the aim of grandiose ideals, they might easily be down to a depressive mood. The pathological superego can even go too far too malignant narcissism which includes antisocial behaviors, paranoid thoughts and sadism.

Kohut (1971, 1977) defined another type of narcissism and called it as '*vulnerable*' one. According to him, traits of *vulnerable narcissistic personality* include sensitivity to other people's attitudes and critics, vulnerability to rejection, timidity, "hypervigilance", sense of inferiority (Kohut, 1966; Gabbard, 1989).

Hypersensitive and touchy narcissistic person described by Kohut represents the vulnerable subtype (Kohut, 1971; Kohut, 1977). These people are very sensitive to criticism to maintain self-esteem because of traumatizing experiences at an early period (Rosenfeld, 1987). Gabbard's (1989) "hypervigilant" conceptualization includes shyness, regarding other's opinions and listening to others carefully with expecting criticism of others. While grandiose type and oblivious choose the be in the spotlight, vulnerable narcissist individuals do not like and even avoid being on the stage because of hypersensitivity (Cooper & Michels, 1988). Vulnerability is seen in feelings of shame, inferiority, and sensitivity to rejection and social withdrawal, dysphoria, and hypersensitivity (Rosenfeld, 1987). Avoiding threatening interpersonal relationships, needs for approval, extreme idealization of others, shame for grandiose fantasy, extreme criticism to self, fear of rejection and abandonment, insecurity, awareness of inner emptiness, sensitivity to the feeling of shame, dysphoric affective states and pessimism are the features that are related with vulnerable narcissism (Akhtar & Thomson, 1982; Gabbard, 1989, Cooper & Ronningstam, 1992; Akhtar, 2000).

When etiology, treatment formulations were compared, Kernberg and Kohut differed from each other. As Kernberg conceptualized grandiose narcissism with envy, Kohut, conceptualized vulnerable narcissism with inferiority feelings (Kohut, 1968, 1971; Kernberg, 1975, 2004).

Masterson (2000) also contributed to the different descriptions of narcissism and presented three different narcissistic subtypes; exhibitionistic, covert, and

devaluer. Grandiose and exhibitionistic narcissism traits emerge from investment to grandiose self, rather than omnipotent object, to cope with abandonment depression. So, exhibitionistic narcissism and grandiose, perfectionist behaviors are defenses, like avoiding objects and devaluation of an object are ways of escaping from depression. Covert narcissism includes investment to omnipotent object rather than grandiose self. Grandiosity is satisfied trough grandiosity and perfection of the idealized objects. Depression is more frequent in covert, vulnerable narcissism, due to a lack of active grandiose defenses. All narcissistic subtypes are defensive reactions against anxiety and abandonment depression (Masterson, 1993, 2000).

Empirical research showed various problems in the grandiose and vulnerable narcissism. Studies showed that vulnerable narcissism is related to low self-esteem, while grandiose narcissism is related to high self-esteem (Rose, 2002; Dickinson & Pincus, 2003; Rohmann et al, 2012). Reported self-esteem, however, may not show reality. One study measured high self-esteem scores in explicit measurements and reported that the lowest scores in implicit measurements were related to grandiose narcissism (Jordan et al., 2003). So, both subtypes are related to self-esteem problems while they have been reported and presented differently.

Research showed that narcissism was related to psychological health problems when it was mediated with self-esteem (Sedikides et al., 2004). Moreover, narcissistic rage emerged against the self-esteem threats and failure for both grandiose and vulnerable narcissism (Cain, et al., 2008). Self-esteem and expression of aggression were found to be related to narcissism. Grandiose narcissists express their aggression easily, vulnerable ones however experience it as covert hostility because of their hypersensitivity in interpersonal relationships (Smolewska & Dion, 2005).

Shame-prone people like vulnerable narcissists experience and express more anger than others like grandiose narcissists (Tangney et al., 2011).Shame was found to be positively correlated with vulnerable narcissism, and negatively correlated with grandiose narcissism (Rose, 2002; Hibbard, 1992; Tangney et al., 1992). Awareness of shame and shame regulation also might be a possible mediator

of psychopathology (Robins et al., 2001). This might be the reason why vulnerable narcissists experience more psychopathology than the grandiose narcissists. Vulnerable narcissism was found related with somatization, depression, anxiety, obsessive-compulsive disorder, paranoid thoughts, depressive and anxious temperament, negative affect, psychoticism and disinhibition, high level of stress and social avoidance internalizing symptoms, neuroticism (Hendin & Cheek, 1997; Dickinson & Pincus, 2003; Tritt et al., 2010; Miller & Maples, 2011; Miller et al., 2011; Miller et al., 2013; Miller et al., 2018).

Grandiose narcissism has some positive traits like low interpersonal stress (Dickinson & Pincus, 2003), extraversion (Miller et al., 2011), higher satisfaction of life (Rose, 2002), competitiveness, social potency, positive emotionality, assertiveness, and social self-esteem (Miller & Maples, 2011). Shame and emptiness were felt more by vulnerable narcissists (Rose, 2002). Grandiose narcissists are more detached from these negative feelings, and they have deficits in insight. Their high self-esteem and happiness serve as defense mechanisms to protect their psychic structure (Rose, 2002; Dickinson & Pincus, 2003). Thus, grandiose narcissistic pathology was found to be more related with mentalization impairments, but not with subjective distress (Bilotta et al., 2018).

Like grandiose and vulnerable narcissism subtypes, overt and covert subtypes were studied in the literature. Overt type (Akhtar & Thomson, 1982), like a grandiose narcissistic individual, has similar traits like attention-seeking, entitlement, arrogance, and lack of observable anxiety, indifference to other's needs, exploitativeness in relationships, envious of others, but also seeming socially charming (Levy et al., 2011). Covert type, like a vulnerable narcissistic, is inhibited in social relationships, stressed and visibly anxious, hypersensitive to others' thoughts, seemingly more modest. These two subtypes include common features as inordinately self-absorbed and having grandiose unrealistic expectancies of themselves. Overt and covert or grandiose and vulnerable subtypes differentiation empirically supported by various studies (Wink, 1991; Hibbard & Bunce, 1995; Rathvon, & Holmstrom, 1996; Hendin & Cheek, 1997; Rose, 2002; Dickinson &

Pincus, 2003; Levy et al., 2011; Pincus et al., 2014). There are, however, different discussions on these subtypes. Bateman (1998) proposed that two subtypes do not wholly exclude each other. According to him, vulnerable narcissists are not vulnerable as considered it is, and they carry a fit of covert severe anger, entitlement, and exploitation. Besides indifference of grandiose narcissists is a defense against helplessness, emptiness, and vulnerability to shame. Kernberg warns about this separation and suggests that they are just different clinical manifestations of the same disorder, and some traits might be overt, and some traits might be covert due to contradictory view of self and oscillations between grandiose and vulnerable feelings (Gabbard, 1989). So, he suggests considering the narcissistic organization as a continuum that begins with marginal polar hypersensitivity and intolerance to imperfections to another marginal polar of grandiosity and defensive work for a narcissistic injury. Marginal polar is the pathologic one while the middle is healthy relatively (Gabbard, 1989). For example, an overtly narcissistic person after a narcissistic injury might become inferior, depleted, and depressed and a covertly narcissistic person might manifest his grandiose and exhibitionistic fantasies.

In summary, vulnerable narcissistic with feelings of shame, awareness of low self-esteem, and symptoms like anxiety and depression would be more prone to somatization. On the other hand, being unaware of shame and low-esteem feelings, and lack of anxiety and depression in grandiose narcissists might be some of the protective factors in somatization. (Hendin & Cheek, 1997; Hibbard, 1992; Tangney et al., 1992; Robins et al., 2001; Rose, 2002; Dickinson & Pincus, 2003; Tritt et al., 2010; Miller & Maples, 2011; Miller et al., 2011). In this study, vulnerable narcissism and grandiose narcissism will be used as personality traits rather than a personality disorder.

1.2. MENTALIZATION

Mentalization refers to cognitive and affective understanding of the self and others' mental states. Parental mentalization contributes to the development of affect regulation, object representations, autonomy, and reflection capacity in infants (Fonagy et al., 1998). Mentalization capacity helps to see and reflect on the mental states of others' feelings, wishes, thoughts, intentions, goals, and attitudes (Fonagy, et al., 2002; Fonagy et al., 2007). This capacity makes behaviors and emotional experiences predictable and meaningful (Bateman & Fonagy, 2004).

Mentalization evolved from the studies on the theory of mind (Tom). Theory of mind refers to social cognitive skills in understanding other's minds, (Baron-Cohen, 1995). *Reflective function* (RF) is a very similar concept to mentalization and even used synonymously in the literature (Fonagy et al., 2016). Indeed, in neuroscience, attachment, and theory of mind (Baron-Cohen, 1995) studies, RF is the operationalization of attachment-based mentalization concepts by Fonagy and Target (1997, 2002).

Mentalization also differs from empathy, which is a feeling on how others feel, mentalization also includes self-reflection dimension. Furthermore, intentional self-reflection is controlled and learned while mentalization is an automatic process (Fonagy, et al., 2002). *Metacognition* which is the capacity to think about thinking and being *"mind-minded"* are other similar concepts (Holmes, 2006; Meins, et al., 1998). *Psychological mindedness* refers to an ability to cognitively understand behaviors and experiences with relationship to thoughts, feelings, actions to both self and others (Appelbaum, 1973). *Emotional intelligence*, however, refers to more emotional understanding, accessing, reflecting, and regulating concepts (Goleman, 1995). The mentalization concept includes some parts of various concepts and seems like being in the intersection of them all, emotional intelligence, empathy, mindfulness (Fonagy, 2006).

Mentalization deficits create problems on affect regulation and lead to psychopathology (Fonagy et al., 2002). The two types of mentalization deficits, hypermentalization and hypomentalization, (Fonagy et al. (2016) will be discussed in the next section.

1.2.1. Mentalization deficits: Hypermentalization and Hipomentalization

Two primary mentalization deficits, *hypomentalization* and *hypermentalization,* create problems in human relationships (Fonagy et al.,2016). *Hypomentalization* is associated with concrete thinking, and severe difficulty of understanding and predicting the mind of self or others (Fonagy, et al., 2016). Hypomentalization is related to borderline personality disorder (Fonagy & Luyten, 2016), eating disorders (Skårderud, 2007), and depression (Luyten & Fonagy, 2015). The problems in the self-report assessment of hypomentalization were also discussed in the literature (Fonagy et al., 2016; Sharp et al.,2011). Hypomentalization has been indicated to cause inaccurate responses on the self-report questionnaires. Even though hypomentalizers are more conscious of their limited reflective capacity, they can sometimes rate themselves with better scores.

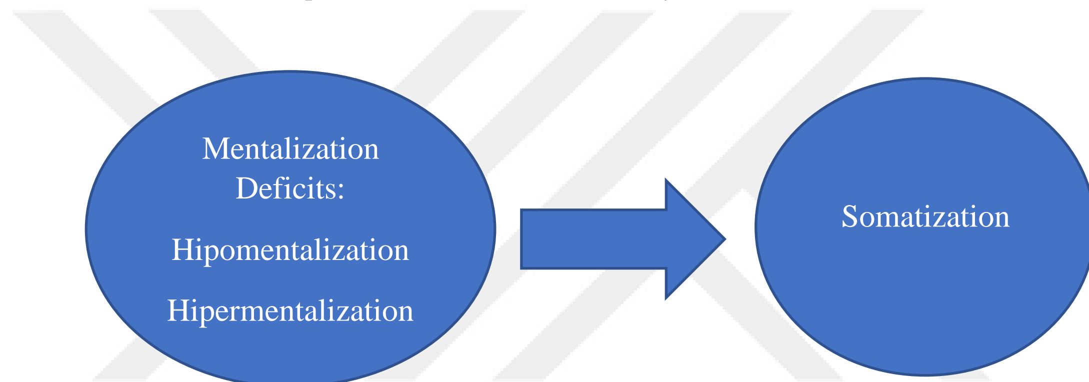
Hypermentalizing is also called pseudomentalizing or excessive mentalizing (Fonagy et al., 2016; Sharp et al.,2011). Hypermentalizers might have overly detailed and too precise reflections about self and others that may not match with objective and testable reality. Thus, they may score high on the RF questionnaires (Fonagy et al., 2016). Their high reflective functioning scores might be a defense mechanism to increase their self-esteem.

In psychopathology, borderline patients and vulnerable narcissistic patients, high-risk adolescents, people with alexithymia might show hypomentalization while in anorexia nervosa and grandiose narcissistic patients might show hypermentalization (Dimaggio et al., 2014; Fonagy et al., 2016; Duval, Ensink, Normandin & Sharp et al., 2018; Bilotta et al., 2018; Gagliardini & Colli, 2019; Badoud et al., 2015; Luyten et al., 2012). A*lexithymia* (Nemiah & Sifneos, 1970), the problem of recognizing and verbalizing feelings, creates proneness to somatization (Krystal, 1998; Bilotta et al., 2018; Ritzl et al., 2018). Alexithymia might be considered as a kind of mentalizing deficit since it includes impairments

in recognizing and expressing feelings. Both hypomentalization and hypermentalization, as mentalization deficits, were associated with somatization (Smadja, 2011; Aisenstein, 2006; Aisenstein & Smadja, 2010a; Aisenstein & de Aisemberg, 2010; Marty, 2012; Köksal, 2017; Kızılkaya, 2018; Ballespí et al., 2019) (See figure 1.1. below).

Figure 1.1.

Relationship between Mentalization Deficits and Somatization



Mentalization capacity reduces in narcissistic personality, due to affect dysregulation triggered by shame (Cherrier, 2013). Research shows that "pseudo-mentalizing" and specific mentalization deficits are associated with narcissism (Karterud & Kongerslev, 2019; Gagliardini & Colli, 2019). In a study done with adolescents, it was found that hypermentalizing correlated significantly with grandiose narcissism, while hipomentalizing, was associated with vulnerable narcissism (Duval, Ensink, Normandin, Sharp, & Fonagy, 2018; Gagliardini & Colli, 2019). Similarly, grandiose narcissism was found to be correlated with poor mentalization capacity (Dimaggio et al., 2014; Bilotta et al., 2018). Thus, in the literature, different mentalization deficits were associated with different psychopathologies (Fonagy et al., 2016).

1.2.2. Mentalization and Narcissism

Mentalization emerges in attachment with caregivers; therefore, researchers investigated early relationships and development of the narcissistic self (Fonagy et al., 2002). Insecure and especially avoidant attachment style in narcissistic personality disorder (NPD) decreases mentalization capacity, social life, and interpersonal relationships (APA, 2013; Simonsen & Euler, 2019). Grandiosity and arrogance are a strategy for bypassing helplessness and shame feelings (Lecours et al., 2013). The development of self in narcissistic people might derive from non-sustaining and neglecting attachment figures. Hence, envy, shame, inferiority, and anger become the main feelings of self of people with NPD (Bennett, 2006; Lorenzini, & Fonagy, 2013; Simonsen & Euler, 2019). If a baby experiences dependency needs insecure, he will not be able to regulate dependency needs when he is an adult and he will detach from others as a result of an insecure attachment system (Dimaggio et al., 2008). While the attachment style of grandiose narcissism is dismissive and avoidant, the attachment style of vulnerable narcissism may be avoidant or dominantly anxious due to negative self-image (Lorenzini & Fonagy, 2013; Vospernik, 2014; Simonsen & Euler, 2019).

There are different mentalization dimensions. First, in implicit- explicit dimension, a person with NPD will use automatic explicit mode with the activation of an insecure attachment system. The possibility of losing control in the interpersonal field, in which they will feel under threat, lead them to not attune to others' minds (Luyten & Fonagy 2015). So explicit mentalization will be the dominant model. In self and other dimensions, it was known that narcissistic people dominantly give attention to their own mental states (Simonsen & Euler, 2019). Besides, they try to control others' minds to feel safe internally (Bateman et al., 2013). People with NPD do not show problems in cognitive empathy dimensions while they show deficits in affective empathy (Ritter et al., 2011). In internal and external dimensions of mentalization, we see that their main focus is internal and about self-worth (Simonsen & Euler, 2019). However, on account of controlling

behaviors and intentions of the others, they may need to focus on the internal states of others (Dimaggio et al. 2008). Because a person with NPD has self-centeredness, he/she will initiate “nonmentalistic “stories” , commonly engaging in lengthy narratives, or lacking any critical distance from their narratives (psychic equivalence mode)” (Simonsen & Euler, 2019, 381). So, the narcissists use the mode of psychic equivalence when they encounter different opinions (Fonagy et al., 2014). They experience problems sympathizing with other people and their emotions (Dimaggio et al., 2008).

Self-psychology indicated similarities between narcissistic personality disorder and alexithymia, which has a predisposition for somatization (Rickles, 1986). Alexithymia, "without words for feelings” in Greek, was conceptualized as a personality feature and an inability to identify and describe emotions experienced by one's self or others. It is described to have impairements in emotional awareness, social attachment, and interpersonal relating (Nemiah & Sifneos, 1970; Sifneos, 1973). Alexithymic traits are similar and connected with impaired mentalization and reflective functioning capacity which is an affective understanding of self and other’ mental states including feelings, wishes, thoughts, intentions, goals, and attitudes under the behaviors (Fonagy, et al., 2002; Fonagy et al., 2007). Alexytimic people are, and emotionally stunted, nonempathic, and not psychologically minded (Rickles, 1986). Alexithymic features were also associated with somatization (Acklin & Alexander, 1988).

In summary, narcissistic individual overestimates their mentalizations, metacognition capacity (Ames & Kammrath, 2004: Ritter et al., 2011), and they have serious problems in understanding others’ minds.

1.3. SOMATIZATION

“*Somatization*” refers to the bodily manifestation of the psycho-social distress and emotional problem without an organic pathology (Lipowski, 1987a).

The psychosomatic word derives from the Greek words psyche and soma (Sadock & Sadock, 2015).

According to DSM-V (APA, 2013, p. 309) somatization problems classified as "somatic symptom and related disorders" and includes "diagnoses of somatic symptom disorder, illness anxiety disorder, conversion disorder (functional neurological symptom disorder), psychological factors affecting other medical conditions, factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder. DSM-V Diagnostic criteria were presented as follows:

> "A. A medical symptom or condition (other than a mental disorder) is present.
>
> B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:
>
> 1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
>
> 2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
>
> 3. The factors constitute additional well-established health risks for the individual.
>
> 4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.
>
> C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder)." (APA ,2013: p.322).

Psychosomatic problems can be classified based on affected specific systems including circularity system, respiratory system, dermatological system, endocrine system, urinary, and production system, muscular system (Sadock and Sadock, 2015; Karslı, 2008; Akbaba, 2012; Uncu, 2017). Thereby, there are sub-specialization of psychosomatic field such as psychodermatology, psychocardiology, psychoneuroendocrinology, psychoimmunology (Sadock & Sadock, 2015). Somatization or psychosomatic does not have an exact definition of diagnosis or clinical differentiation in literature. It has a wide and big clinical picture and sometimes refers to psychological factors that triggering and exacerbating the psychosomatic illnesses or hysterical conversions, defense mechanisms, and bodily manifestation of the psychic pain in depressive disorders (Debray et al., 2015; Öztürk & Uluşahin, 2014). Somatization and psychosomatic symptoms point similar problems while somatization is frequently used in medical & psychiatric literature and psychosomatic concept used in psychology and psychodynamic literature. In this study, the somatization concept will be based however, if the theoretician uses the psychosomatic word, it will be used.

1.3.1. Psychological Theories on Somatization

Hysteria word first used by Hippocrates, by deriving from the Greek word hysteron, and he suggested natural reasons for illness rather than supernatural explanations (Öztürk, & Uluşahin, 2014). Cartesian dualism, the duality of psyche and soma, and scientific positivism blocked the development of the psychosomatic understanding for centuries (Aisenstein, 2006; Aisenstein, 2008; Parman, 2005). The "Psychosomatic" concept was first used by German Psychiatrist "Heinroth" in the second half of the 19th century (Smadja, 2011). He used this term for "insomnia," and added psychological factors to its etiology. (As cited in Parman, 2005, Gökalp, 2018). Another revolutionary approach was brought by Sigmund Freud (1905) who suggested that instinctual drives roots from organic forces of the body and includes psychic representations and manifestations. Freud proposed 4

types of somatic symptoms; “conversion hysteria symptoms, the somatic symptoms of the actual neurosis, hypochondriac symptoms and organized organic ailments” (Aisenstein & Aisemberg, 2010, p. xv). Freud and Breuer (1893) showed that hysterical conversions included symbolic meanings of the unconscious conflicts and they exemplified these symbolic meanings in the treatment of hysterical paralysis of "Anna O." case. For them hysterical conversions emerge from internal conflicts, and somatization includes direct bodily expression and discharge of emotions and drives (Ac cited in Parman, 2005).

Hypochondria is another important concept for Freud. People with hypochondriac symptoms showed the insistence of bodily complaints while there was no organic pathology (Aisenstein & Smadja, 2010a). According to Freud, hypochondriac people have suppressed narcissistic libido, which was not processed by psyche (Smadja,2011). Freud also considered the defensive function of psychosomatic reactions as narcissistic regression. According to him, psychosomatic people might show magical disappearance of neurotic conflicts and manifestations. Freud thought that hypochondria and somatic complaints were similar due to libidinal regression to the body (As cited in Peykan, 2018). Hypochondria and hysteria could be differentiated by the reaction of the patient. In hysterical conversion patients do not seem to be aware of the seriousness of the situation, and show “la belle indifference” (Janet, 1907), in hypochondria, however,patients show exaggerated anxiety for sickness (As cited in Peykan, 2018).

Franz Alexander, a student of Ferenczi, approached the psychosomatic disorders both psychoanalytic and physiopathologic perspectives (Smadja, 2011). His approach has been named as *psychosomatic medicine* movement. He is the founder of the Chicago School of Psychosomatic Medicine in America (Aisenstein & Smadja, 2010a). He classified seven classic types of the psychosomatic disorder including “peptic ulcer, ulcerative colitis, bronchial asthma, neurodermatitis, rheumatoid arthritis, essential hypertension, and thyrotoxicosis” (as cited in Gubb, 2013, p.109, Alexander, 1950). For him, there are specific conflict types, which is

called also *as "the theory of specificity*", which every psychosomatic complaint has specific repressed emotions and drives (Aisenstein, 2008; Smadja, 2011). The transmission of repressed emotions to the autonomic nervous system leads to organic illness (Gubb, 2013).

French psychoanalysts, who were the followers of Freudian approach, founded "*The Paris School of Psychosomatics*". They called themselves "psychosomaticiens," and the main figures of this school were P. Marty, M. Fain, M. de M'Uzan and C. David (Aisenstein & Smadja, 2010a; Smadja 2011; Gubb 2013). These leading figures presented a modern Freudian approach to the psychosomatics theory. Libidinal economy and mentalization were the key concepts to differentiate transitory and nonfatal illnesses from serious and fatal illnesses. According to IPSO, everybody is psychosomatic but those who have high mentalization capacity have fewer problems and less fatal sicknesses than those with low mentalization capacity (Tunaboylu-İkiz, 2008; Marty, 2012). For them, if mentalization capacity is enough, somatization through regression might end up temporary "asthma crises, headache, and high blood pressure, and colitis", and when mentalization capacity is limited, it might lead to "progressive, serious, and fatal illnesses including cancer, auto-immune diseases" (Peykan, 2018: p. 31). They noticed that psychosomatic patients use "operational thinking". Even they are socially adjusted, they are isolated from affects, look desireless and lifeless, emotionally repressed. Factual, actual, and pragmatist thinking is dominant for these patients (Aisenstein, 2006; Marty, 2012; Cengiz, 2015).

"*Essential Depression*" was defined first by Marty in 1968 and in time replaced with *depression without an object* (Marty, 2012; Smadja, 2011). In essential depression, typical depressive symptoms do not reveal. These patients only express stress, tiredness, and reluctance without affective expressions and sadness about the object (Aisenstein & Aisemberg, 2010). Depressive emotions are not perceived, and these patients also do not complain about anything else than somatic reactions. An essential problem is the emptiness of these patients. Denial

of the mourning is an important manifestation. These patients do not have good internalized objects which are either lost or never has (Tunaboylu-İkiz, 2008).

Another important contribution to the psychosomatic field was done by Esther Bick (1968) who proposed that the skin is a primary container of body and personality. According to her, skin holds together noncoherent the parts of the self and helps to integrate and organization. The psychic skin of the baby is supported by maternal containment and if this is not good enough, or if the baby is severely deprived, maltreated, and neglected, then the baby would use 'second skin' defenses. French psychoanalyst Didier Anzieu (1974, 1989, 2008) developed the "skin-ego" concept based on Esther Bick' theories. He explained the body-mind relationships in his studies on dermatological psychosomatic reactions He pointed out the importance of early experiences with skin and the development of the ego. According to him, the skin-ego develops through physical experiences and tactuality with the primary caregivers (Anzieu, 2008). The fantasy of a common skin with the mother is required for developing skin-ego (Anzieu, 2018). The mother protects the baby from external stimuli and takes care of him. Later this function will be internalized by the baby. Skin-ego has 8 functions consisting of "holding, containing, shielding against stimuli, individuating, intersensorial, supporting sexual excitations, libidinal recharging, registering" (Anzieu, 2018: p.140-149).

Skin-ego concept is also critical in understanding narcissistic and borderline pathologies which include fear of revealing drives due to boundary deficiency, and fantasy of a common skin with the mother (Anzieu, 2016). Moreover, overstimulation, inadequate stimulation, intolerance to need for dependency, fear of abandonment, fear of penetration, the fantasy of common skin, the primary taboo of touch, weakness in skin-ego functions are the main concepts to understand the specific type of somatization which is skin reactions (Anzieu, 2018).

To sum up, there are various psychological theories for somatization and the quality of early dyadic relationships are critical in the development various somatic reactions.

1.4. ADOLESCENCE

Adolescence comprises rapid changes in biology and interpersonal relationships between childhood and adulthood. Transformations in cognitive, physical, biological, socioemotional fields create challenges and emotional instability in this period (Steinberg, 2007; Santrock, 2013; Santrock, 2015). There are changes in the sense of identity and self, self-regard, sexuality, morals and values, family, peer, and intimate relationships. Generally, researchers separate this period into three distinct stages as early, middle, and late adolescence. Early adolescence includes 10 to 13 years of age, middle adolescence starts around 14 years of age and finishes at 18 years, and late adolescence begins around 18 years and lasts until 24-26 years of age (Levy-Warren, 1998; Steinberg, 2007; Curtis, 2015; Sawyer et al., 2018).

Developmental and social psychology have various conceptualizations of the adolescence period. G. Stanley Hall's storm-and-stress view, Margaret Mead's sociocultural view of adolescence, the inventions view, cohort effects, millennium children, positive youth development are some of main theories and concepts for understanding adolescence (Rice & Dolgin, 2005; Steinberg, 2007; Santrock, 2013; Santrock, 2015). The storm-and-stress view presents adolescence with emotional turmoil and conflictual processes. For the socio-cultural perspective, however, adolescence period is less stressful and less conflictual in some cultures. The inventions view sees adolescence as a socio-cultural formation that was appeared with dependency and control, starting to work features of twenty century. Time perspective points to the importance of cohort or generation effect rather than chronological age in the formation of adolescence. Millennium children, who were

born after the ’80s, are characterized by ethnicity differences and dependency on technology. Finally, the positivist perspective emphasizes the negative and exaggerated stereotypes about youth, focuses on the strengths and positive development sides (Rice & Dolgin, 2005; Steinberg, 2007; Santrock, 2013; Santrock, 2015).

Psychodynamic theories conceptualized adolescence first with Freud’s (1905) psychosexual personality development. Psychosexual development includes the oral stage, anal stage, phallic (oedipal) stage, latency stage, and the genital stage (Freud, 1905). Freud proposed that the genital stage, which starts around 11-13 years old, has secondary importance in comparison to early childhood stages (the oral, the anal, and the oedipal). He described the genital stage with heightening sexual drives along with physiological maturation. Interest for the opposite sex, socialization, participation in groups, occupational choice, marriage desires are characteristics of this period. Fixation at this stage might lead to perversions according to Freud (1905). Freud's proposition of fixation in this stage, however, was not supported by his followers like Anna Freud and Peter Blos (Santrock, 1987, 2013). For them, regression in adolescence is not a defensive, but integrative, universal, typical, inescapable part of puberty. Sullivan (1953) examined adolescence within 3 periods: pre-adolescents, first adolescence, and second adolescence. He considers adolescence as a period that includes equal relationships between peers, taking and giving, close friendships, sexual and intimate relationships, social tasks. According to him, failure in this period might lead to deep loneliness, hopelessness, lack of sublimations, security problems, deficits in relating skills, and perversions.

Anna Freud (1958) supported Sigmund Freud’s emphasis on drives during adolescence (As cited in Parman, 1998). For her, heightening sexual drives impairs the equilibrium between id and ego, and thus disturbs the ego strength (As cited in Parman, 1998). Defense mechanisms would be stricter to cope with heightening sexual drives, and intellectualization and ascetism would be the main defenses in this period (Freud, 1936). In adolescence, youth suddenly withdraw their libido

from their parents, and this quick detachment from their primary love objects became painful (Holder, 2018). Therefore, they reverse the effects of this sudden change by acting the opposite, from love to hate, independence to dependence.

Erik Erikson (1968a, 1968b), in his psychosocial development theory, characterized adolescence period with various development tasks and crises of "identity versus role confusion." For him, the new late adolescence and emerging adulthood consist of intimacy versus isolation crises. The successful accomplishment of these crises will result in a positive sense of self and identity. However, failure will result in loneliness and isolation, and adolescents will experience role confusion (Erikson, 1968a, 1968b).

Blos (1966, p. 129) stresses that late adolescence as primarily a phase of consolidation in which there is an "elaboration of 1) a highly idiosyncratic and stable arrangement of ego functions and interests; 2) an extension of the conflict-free sphere of the ego (secondary autonomy); 3) an irreversible sexual position (identity constancy) 4) a relatively constant cathexis of object- and self-representations; and 5) the stabilization of mental apparatuses which automatically safeguard the integrity of the psychic organism". Adolescence is the second individuation process, a recapitulation of the oedipal period, time of conflicts of identity formation, personality consolidation, reawaking early internal conflicts, and affects (Blos, 1966, 1967, 1968, 1979). Thus, Blos sees late adolescence as a consolidation period of the previously emerged psychic apparatuses.

1.4.1. Late Adolescence

Late adolescence period has been extended in age and now it was described to be between 18-24 years of age. The recent neuroscience studies showed that the adolescents' brains continue to change after their twenties (Siegel, 2015; Patton et al., 2016; Jensen & Nutt, 2017; Arain et al., 2013; Casey et al., 2008; Spear, 2000; Patton et al., 2016; Sawyer et al., 2018). The late adolescence was discussed to

overlap with youth, emerging adulthood and young adulthood (Arnett, 2000; Patton et al., 2016; Sawyer et al., 2018). There are many confusions in the life of the late adolescents such as "delayed timing in role transitions, in completion of education, marriage, and parenthood," as well as in transition to employment and financial independence (Jaworska & MacQueen, 2015; Patton et al., 2016; Teipel, 2017; Sawyer et al., 2018, p. 1; McDonagh et al., 2018). Late adolescents pursue academic success, a good job and seek an intimate partner (Jaworska & MacQueen, 2015; Patton et al., 2016; Teipel, 2017; Sawyer et al., 2018; McDonagh et al., 2018). They however, experience a lack of financial independence, extended education periods, confused roles in the family relationships. Thus, late adolescence represents a feeling of in-betweenness because of unsatisfied wishes in which they are neither child nor adults.

Mature affect regulation, social relationships, executive functioning, and decision making continue to develop in the late adolescents (Siegel, 2015; Patton et al., 2016; Jensen & Nutt, 2017; Arain et al., 2013; Casey et al., 2008; Spear, 2000). Mentalization capacity was shown to play a critical role in adolescents' affect regulation, impulse control, and self-monitoring (Fonagy et al., 1998). The adolescents' mentalization capacity (reflective functioning skills), however, has also been observed to be lower than adults during this developmental period (Cropp, 2019). The research found that reflective functioning skills do not terminate in adolescence, but continue to improve through young adulthood because of developing brain (Sebastian et al., 2008; Fonagy & Luyten, 2009; Dumontheil et al., 2010; Keulers et al., 2010; Taubner & Hörz et al., 2013; Borelli et al., 2015; Borelli et al., 2018).

Adolescence deal with various other problems like self-esteem, body image, and narcissistic preoccupations. They may be very sensitive to their body changes and try to make a meaning about these changes (Güvenç & Aktaş, 2006; Steinberg, 2007; Oktan & Şahin, 2010; Bektaş, 2016). Generally, girls were found to have more problems with their body image in this period (Cicchetti & Cohen, 2006). The media messages for girls lead them to compare themselves with others, to be

unsatisfied with their bodies, and create anxiety about how they look (Oktan & Şahin, 2010). Body images affect adolescents' psychology (Güvenç & Aktaş, 2006; Bektaş, 2016) and a positive perception of the body increase self-esteem (Gander & Gardiner, 2010). Bodily preoccupation may lead to extreme psychopathologies like eating disorders or body dysmorphic disorder (Güvenç & Aktaş, 2006; Steinberg, 2007; Gander & Gardiner, 2010; Oktan & Şahin, 2010).

In light of the presented literature, late adolescence should be considered a unique development period which should be thoroughly investigated. In the following section, narcissistic traits, mentalization problems and somatization, problems of youth will be briefly examined.

1.4.2. Narcissism in Adolescence

Researchers indicated that narcissistic traits are increasing in adolescence, and was claimed to be the disorder of our age, even an epidemic of the contemporary era (Twenge & Foster, 2008; Twenge et al., 2008; Twenge & Campbell, 2009; Twenge & Foster, 2010; Twenge et al., 2014, Twenge & Campbell, 2015). According to Blos (1966), adolescence was characterized by increasing sexual and aggressive drives. These drives increase the burden and anxiety of adolescents who also struggle with the conflicts of the previous developmental stages (Blos, 1966). All these conflicts and twinge of identity formation solved through narcissistic defenses. They use old grandiose defenses because of early parental rejections in the past (Sheikh et al., 1993). Adolescence is the second individuation process in which there are various dynamics like the recapitulation of the oedipal period and reawaking early internal conflicts, (Blos, 1966, 1967, 1968, 1979). If an adolescent has narcissistic injuries from the past due to envy, shame, and loss, his development of self will be impaired (Klein, 1957; Kohut, 1971). When there are fixations in the development stages, the adolescence period would be challenging, and narcissistic issues would reveal again.

Narcissism rises in adolescence as a normal developmental step and narcissistic vulnerability increases in this period due to inherent self-esteem problems. Shame and narcissism work as adaptive functions against the loss of childhood identification in the service of individuated self (Bleiberg, 1994; Lapsley & Aalsma, 2006; Roberts et al., 2010; Hill & Lapsley, 2011; Uji et al., 2012).

According to the Diagnostic and Statistical Manual of Mental Disorders-V (2013, p. 671) "narcissistic traits may be particularly common in adolescents and do not necessarily indicate that the individual will go on to have narcissistic personality disorder". So, heighten narcissistic traits might be a transitory phenomenon rather than the development of psychopathology. Self-esteem problems, shame, a revival of childhood conflicts, preoccupations on the body and heightening sexual and aggressive drives make challenging adolescence period and narcissistic issues become adolescents' major issues (Bleiberg, 1994; Levy-Warren, 1998; Lapsley & Aalsma, 2006; Roberts et al., 2010; Hill & Lapsley, 2011; Uji et al., 2012).

Different psychopathologies were related to different narcissistic subtypes in the late adolescence period. Grandiose narcissism was related to "emotional and cognitive reactivity (Thomaes et al., 2011), physical, verbal and relational aggression, as well as to conduct problems (e.g. Golmaryami & Barry 2009; Ha et al. 2008; Lau et al., 2011; Thomaes et al. 2009), proactive and reactive aggression (Fossati et al., 2010), cyberbullying (Ang, Tan, & Talib Mansor, 2011), depression, anxiety and social stress (Barry & Kauten, 2014), and low peer preference (Barry et al. 2008)" in child and adolescents (As cited in, Ensink et al., 2017, p. 3). In the vulnerable narcissism, both internalizing and externalizing problems, especially depression (Fossati et al., 2010), were frequently seen (Ensink et al., 2017).

Normal and pathological narcissisms in adolescence have different traits. Maladjustment, including aggression, low self-esteem, internalizing problems, and poor perceived interpersonal relationships in adolescence was found to be related to pathological narcissism, as self-esteem and aggression were related to non-

pathological narcissism (Barry & Kauten, 2014). Besides, non-pathological narcissism was negatively correlated with internalizing problems.

There is evidence of the overt and covert, the grandiose and vulnerable subtypes of narcissism in adolescence. However, there are also healthy narcissisms, which include low levels of anxiety, relationship problems, depression, self-esteem, and family problems (Lapsley & Aalsma, 2006). In one study, non-pathological narcissism was found to be related to prosocial behaviors reported by parents. Grandiose narcissism was positively associated with both self and parent-reported prosocial behavior. Vulnerable narcissism, however, did not show any association with prosocial behavior (Kauten & Barry, 2016).

In adolescence, vulnerable and grandiose narcissisms were related to mentalizing difficulties, including hipermentalizing and hipomentalizing (Duval, Ensink, Normandin, Fonagy, et al., 2018). In a study, with females, vulnerable and grandiose narcissisms in adolescence were found to be related to maltreatment and partially mediated the relationship between abuse and neglect and internalizing and externalizing difficulties (Ensink et al., 2017). Besides, narcissism increased with age in males and decreased in females. Narcissism was also related to alexithymia, which is a similar concept to mentalization impairment (Bilotta et al., 208). So, in the adolescence, narcissism was associated with mentalization problems and gender in the literature. A study in Turkey examined university students in the late adolescence. Their results showed that rejection sensitivity was related to vulnerable narcissism and the self-sufficiency dimension of grandiose narcissism (Özdemir, 2017).

In sum, heighten narcissistic features and narcissistic vulnerability in adolescence might lead to various psychopathology. In this study, the relationship between narcissism and somatization will be explored for further understanding of late adolescence.

1.4.3. Mentalization and Psychopathology in Adolescence

The development of reflective functioning skills "does not terminate in adolescence but continues to improve through young adulthood. This may be explained by the course of brain development (Sebastian et al., 2008; Fonagy & Luyten, 2009; Dumontheil et al., 2010; Keulers et al., 2010; Taubner & Hörz et al et al., 2013; Borelli, et al., 2015; Borelli et al., 2018)" (As cited in, Cropp, 2019, p. 2). Thus, the adolescence period is characterized by developing reflective functioning capacity. Besides, adolescents are hypersensitive to both self and others' mental states (Lingiardi & McWiliams, 2017). In addition to this, the integration of mental state knowledge and language might be impaired in this period due to the inherent demands of this period.

Reflective functioning capacity is critical for affect regulation, impulse control, and self-monitoring in adolescence (Fonagy et al., 1998). So mentalization deficits in youth were associated with psychopathology (Sharp & Venta, 2013; Duval, Ensink, Normandin & Sharp et al., 2018). Parental deficiency in seeing a child as a psychological agent, and parental poor mentalization capacity and insecure attachment might be responsible for mentalization deficits in adolescence and consequently psychopathology (Fonagy & Target, 1997; Sharp, 2006; Sharp & Fonagy, 2008; Meins et al., 2013; Ensink et al., 2016)

Mentalizing impairments were associated with different psychopathology in adolescence period including borderline personality disorder (Sharp et al., 2011; Ha et al., 2013; Sharp & Venta, 2013; Fossati et al., 2014; Sharp, 2014; Bo et al., 2015; Bo et al., 2017) , self-harm (Rossouw & Fonagy, 2012), *narcissistic personality disorder* (Duval, Ensink, Normandin, Sharp, & Fonagy, 2018; Bilotta et al., 2018; Karterud & Kongerslev, 2019; Gagliardini & Colli, 2019), conduct disorder, (Sharp & Venta, 2013; Taubner & Curth, 2013; Taubner & White et al., 2013; Möller et al., 2014), eating disorders (Jewell et al., 2016; Rothschild-Yakar et al., 2010), anxiety disorders (Banerjee, 2008, Banerjee, & Watling, 2004; Banerjee, & Watling, 2010), depressive disorders (Taubner et al., 2011; Fischer-

Kern et al., 2013), internalizing and externalizing disorders(Chow et al., 2017; Fonagy & Luyten, 2018; Cropp, 2019), and *somatization* (Bizzi et al., 2019).

Hypermentalizing was found to be positively correlated with *grandiose narcissism,* while hipomentalizing was found strongly associated with psychological problems, including *vulnerable narcissism* and, to a lesser extend, with grandiose narcissism (Duval, Ensink, Normandin & Sharp et al., 2018). Besides, lack of interest and curiosity on mental states characterizes grandiose narcissism in adolescence. In another study, vulnerable and grandiose narcissism in adolescence was found significant with mentalizing difficulties including hipermentalizing and hipomentalizing (Duval, Ensink, Normandin & Fonagy, 2018). The narcissistic personality disorder was found related to mindreading impairments, but this incapacity did not directly associate with subjective distress in adolescence (Bilotta et al., 2018). In one study that investigates narcissism, internalizing problems predicted by hipomentalization while externalizing problems predicted by both hipomentalization and less interest and curiosity about mental states in the adolescence period (Ensink et al, 2017). Grandiose narcissism predicted by both hipermentalizing and hipomentalizing. While hypermentalizng predicted vulnerable narcissism. In this study, vulnerable narcissism and borderline personality traits predicted by the same variables. (Ensink et al, 2017). Therefore, on a mentalization perspective, they have some overlaps.

In sum, in the light of presented the literature, , mentalization deficits were found to be related with narcissism and somatization, and high reflective functioning capacity should be considered as a protector factor in adolescence.

1.4.4. Somatization in Adolescence

Children and adolescents have similar and different manifestations of somatization then adults. Common symptoms in child and adolescents can be aligned as "abdominal pain, headaches, chest pain, fatigue, limb pain, back pain,

worry about health and difficulty breathing" and "gastrointestinal problems" (Campo, & Fritz, 2001; Brill et al., 2001, p. 597; Janssens et al., 2009). Child and adolescents symptom ratios vary remarkably, e.g., for dizziness (2.4–41.5%), tiredness (9.3–40%), aches and pains (12–31.5%), headaches (8.6–47%), nausea (.9–29.7%), stomach-aches (5.3– 45%), and vomiting (.9–11.6%)" (Steinhausen & Winkler Metzke, p. 508). Until adolescence, the prevalence rate is similar for girls and boys, in adolescence, however, girls have been found to show more psychosomatic complaints then boys (Schulte & Petermann, 2011; Yavuz et al., 2018). Girls have been indicated to score high on all five somatic clusters, including pain-musculoskeletal, pseudoneurological, gastrointestinal, cardiovascular-respiratory, dermatological symptoms (Vulić-Prtorić, 2016). Anxiety, depression, self-worth, and self-competence, general health was also found to be related to somatization in children and adolescence (Litcher et al., 2001).

The prevalence rate of somatization in adolescence was found to be between 1-10% in Turkey (Sapmaz et al., 2017). In a research done in Turkish schools, somatic complaints were found to be the second highest reason to seek medical attention (Gür et al., 2008). In the two school semesters, it was reported that 39% of students saw the school nurse for pain, 38% for stomachache, and 31% for headache (Kadıoğlu et al., 2011).

There are various risk factors in the somatization problems of adolescence.. Malas et al. (2017) listed these risk factors as follows: low socio-economic level, childhood medical and psychiatric illnesses, cognitive and learning disabilities, parental psychiatric history, alexithymia, dysfunctional family, parental attitudes, cultural factors, societal and family perspective on illness, difficulties in life such as peer relations and academic problems, family conflicts, parental lost, physical, emotional and sexual trauma, low coping mechanisms, biological and genetic factors. In a study done in Turkey, the results revealed that somatization was associated with being female, the existence of chronic medical or psychic illness history in the family, lack of emotional support from parents and parental intrusiveness, and anger (Eray et al., 2015). Another study done in Germany found

that the predictors of somatization in adolescence were female, low social class, the experience of any substance use, anxiety, and affective disorder as well as the experience of traumatic sexual and physical events (Lieb et al., 2002, p. 321).

In the etiology of somatization, personality traits, mentalization, and stress have been found to play major roles in somatic problems (Garralda, 1999; Rangel et al., 2000; Stumpf et al., 2018). Anxiety disorders, depression, and post-traumatic stress disorder were also found to be associated with somatization (Dhossche et al., 2001; Ginsburg et al., 2006; Janssens et al., 2010). There were correlations between somatization, impaired mentalization and emotional awareness (Zunhammer et al., 2015). Alexithymia created psychosomatic complaints in adolescence (Ebeling, 2001; Burba et al., 2006; Allen et al., 2011). Alexithymia and somatic expression were found to be associated in childhood and adolescence (Garralda, 1996; Ebeling, 2001). Similarly, in a research done in Turkey, somatization was related to alexithymia and theory of mind skills(Yavuz et al., 2018).

Parental factors, especially *parental somatization or somatic complaints of the parents*, anxiety, and depression, and Alexithymic traits and somatization of parents were also related to adolescents' somatization (Garber et al., 1990; Ebeling, 2001). In a study done with Turkish adults, both maternal and paternal somatic complaints were found to be significantly correlated with somatization. Moreover, maternal complaints were more effective than paternal complaints (Köksal, 2017). Similarly, in another study, maternal somatic complaints were indicated to be an important predictor of somatization (Özden, 2015).

Finally, adolescents' somatizations were related with various deficits in the mentalization, alexithymia and emotional awareness. Therefore, in next section, the relationship between somatization and mentalization will be discussed.

1.5. SOMATIZATION AND MENTALIZATION

Attachment-based mentalization theory is one of the latest psychodynamic approaches for the treatment of somatization problems. Katz (2010) is one of the leading figures of attachment-based mentalization perspective on somatization. He refers to reflective function capacity to describe mentalization which helps the person to understand his own affects and thoughts. He emphasizes the preventive role of mentalization against somatization. For Katz, the child learns to understand his/her mental states and develop self and object representations with the help of the caregiver. If mentalization capacity is limited, a person would need a container who will digest the projections or acting outs or body becomes the last way of discharging overwhelming affects. Griffies (2010) also states that somatizers might have pain processing difficulties due to their attachment problems. Chronic pain could be a manifestation of the abnormalities of the neural circuits which were founded by attachment relationship. Poor mentalization capacity was rooted in the separation issues with mother in the insecurely attached individuals (Griffies, 2010).

The attachment-based mentalization approach defines medical sicknesses as psychosomatic if it is related to unexpressed, inaccessible, or disavowed emotions (Gubb, 2013). Attachment theoreticians on somatization originally do not give exact etiology, but suggest treatment as in the classical psychodynamic method. IPSO members were relating to "unbinding or regression" mechanisms so propose different specific illnesses and different treatment methods. Clients of attachment psychotherapist come directly to psychotherapy, not for medical sickness, but other emotional problems. These patients could not relate to the association between medical illness and their psychological problems (Sloate, 2010). Attachment-based mentalization theory propose a concrete thinking for psychosomatic reactions (Gubb, 2013). If a person thinks concretely, he cannot reflect the experience, sensations, and affects. He/she cannot tolerate uncertainty but only can describe and see as an external event. Symbolization capacity is deteriorated for concrete thinkers. Kohutis (2010) mentions a client with irritable bowel syndrome who knows the negative affects cognitively, but cannot feel affectively so isolated. As it seems he can label and understand the affects. However, if the affect is not

experienced, the body expresses the emotional parts of the affect. Kohutis also suggested that when he was able to integrate talk about affects, he left to acting out as criticism, control or diarrhea. Kohutis (2008) also mention about alexithymic people who are concrete thinker with gastrointestinal and gynecological. He explored that these people have limited capacity to recognize and express emotions and fantasy life and symbolic reflection. As it is expected, they cannot make sense of their dreams or cannot dream. It seems Kohutis integrates the operational thinking concept of IPSO and concrete thinking (Gubb, 2013). People with failure of speaking symbols will speak and communicate via the body.

Children and adolescents with somatic symptom disorder have lower RF (Bizzi et al., 2019). Furthermore, RF regarding self was significantly lower than RF regarding others. Reseachers suggest that mentalization deficits might be a result rather than the reason for functional somatic disorder.Thus, the treatment of mentalization capacity became an effective intervention (Luyten et al., 2012; Luyten et al., 2013). Moreover, structured short-term psychodynamic psychotherapies found also effective in functional somatic patients. (Abbass et al., 2009).

In short, mentalization is important in the understanding of somatization problems. Furthermore, the attachment-based mentalization approach and psychodynamic psychotherapy have been found to be effective in the treatment of somatization problems.

1.6. SOMATIZATION AND NARCISSISM

In literature, somatization and narcissistic personality disorder have been stated to have significant associations with each other (Noyes et al., 2001; Bornstein & Gold, 2008). There is no certain answer, however, whether narcissistic personality leads to somatization problems or not.

Self-psychology conceptualizes somatization as an experiential expression of a disturbance in the cohesion of the self, and defense against the affect which treats self-esteem regulation and fear or fragmentation (Rodin, 1991). Somatization is the disposition to experiencing self in physical terms and states of bodily preoccupations. Consolidation of the boundaries and structure of the self and early infant and caregiver interaction formulates the self-psychology aspect of the somatization. Somatic patients are more conscious about the physical rather than psychological aspects of their emotional states. Affective arousal brings disorganization possibility so perceived as a threat. So, affects are warded off by patients and these affects might be acceptable only through somatic manifestations and in intellectualized ruminations.

McDougall (1980) considers somatization as a reaction to narcissistic injury and roots in foreclosure or neglect during a critical developmental phase. Krystal (1997) sees both self-pathology and alexithymia as an emotion regulation problem. For Krystal, they derive from premature rupture in infantile omnipotence. Similarly, Kohut (1971) describes a lack of fantasy and deficiency in self-soothing and psychic stabilizing functions of the self-representation on narcissism. “The narcissistic state of consciousness detailed by Bach (1977) poignantly describes the difficulties found in alexithymia, including defects in (1) perception of self, including body self; (2) language and organization as expressive of thought; (3) personal sense of agency. intentionality; (4) regulation of mood; and (5) perception of time' space, and causality” (Rickles, 1986, pp. 220-221). By integrating the association between three concepts, Rickles (1986) proposes the role of narcissism, and alexithymia in somatization which is overshadowing the more subtle pathology of the self.

According to Greenspan (1981) the capacity for somatopsychic differentiation which is separating somatic from psychic experience depends on parental differentiation of somatic and psychic states. According to him, if parents fails in their parenting, a child might learn to answer this with somatic reactions. Psyche and soma split emerge in psychosomatic disorders (Winnicot, 1966). This

creates disposition to somatization in adults who are "disaffected" (McDougall, 1984), with a lack of mentalization capacity (Marty, 2012), and alexithymia (Nemiah & Sifneos, 1970). Supporting this mention mechanisms, according to Rodin, (1991) somatization is associated with disturbed self, lack of emotional awareness due to affect regulation, and primitive defense mechanisms that wards off affects from experiences

In the therapy process, there are various issues in their relationships with the therapists. Narcissistic transference, resistance to transference, the self-object transference were frequently observed in the sessions (Kohut,1977). This complex dynamic of transferences make the therapy process even more challenging (Lefebvre, 1980; Krystal, 1998; Marty, 2010; Aisenstein & Smadja, 2010b; Yasky et al., 2013). Especially Lefebvre (1980) and Marty (2010) emphasize working with narcissistic transference and narcissistic traits in the treatment of psychosomatic patients. Narcissism is related to somatization, and in therapy, when narcissistic traits decreases somatization also decreases, and the quality of life and positive mood increases (Daig et al., 2009). In short, narcissism, which is related to psychosomatic complaints should be carefully elaborated in the treatment of somatization.

1.7. NARCISSISM, MENTALIZATION, AND SOMATIZATION

Reflective functioning impairments and psychopathology in adolescence and young adulthood period was investigated in different studies (Duval, Ensink, Normandin & Sharp et al., 2018). The results showed that hypermentalizing was positively correlated with grandiose narcissism. Interest and curiosity on mental states, however, were negatively correlated with psychopathology and grandiose narcissism. Hipomentalizing, was found strongly correlated with psychological problems, including vulnerable narcissism and borderline personality disorder

(Duval, Ensink, Normandin & Sharp et al., 2018). The studies indicated that while both subtypes of narcissism are related to mentalization deficits, especially grandiose narcissist have hypermentalizing problems while vulnerable narcissists have hypomentalizing problems (Duval, Ensink, Normandin, Fonagy, et al., 2018; Duval, Ensink, Normandin & Sharp et al., 2018; Gagliardini & Colli, 2019).).

In another study, psychiatric outpatients, somatization, and grandiose and vulnerable narcissistic phenotypes examined on the base of gender (Kealy et al., 2016). This study showed that both types are positively correlated with somatic symptoms. So, in contrast to the previous study, the grandiose type was also related to somatization. However, gender was an important variable to determine the narcissistic type in this study. Somatic symptoms were positively correlated with vulnerable narcissism in women and grandiose narcissism in men (Kealy et al., 2016). Besides, women report more somatic complaints than men in the same study.

In Turkey, somatization was found related to vulnerable narcissism while it was not associated with grandiose narcissism (Ekinci, 2018). Moreover, vulnerable narcissism was found related to more psychopathology in comparison with grandiose narcissism in this study.

There are limited research on the relations between grandiose narcissism, vulnerable narcissism and somatization (Kealy, 2016). Grandiose narcissistic individuals deny weakness and impotency and this defensive process might protect them from subjective distress and psychopathology rather than vulnerable narcissistic individuals. Vulnerable ones might exacerbate the physical experience of depletion and fragmentation (Kohut 1971; Kealy, 2016). From this perspective, vulnerable narcissistic people are prone to somatization.

The link between somatization and mentalization has been explored by various researchers in Turkey. Aydoğan (2018) found that somatic problems were correlated with poor mentalization capacity and early traumatic experiences in Turkish adolescents. This study also revealed that parents of these adolescents have poor mentalization capacity, early traumas, and psychosomatic complaints.

Furthermore, higher-order awareness, comprehension, clarity reduce somatic symptoms in adolescents.

One of the psychosomatic illness, alopecia areata was examined in patients in Turkey (Yaya,2016). It is found that lack of mentalization capacity which refers to difficulties in symbolization, phantasy, operational thinking, and depression without an object were associated with a psychosomatic sickness alopecia areata. Problems on early period object relations considered as the reason for the factors which affect the psychosomatic illness (Yaya,2016). Psychosomatic thinking was found associated with drug use in Turkey. Psychosomatic thinking style of patients and poverty in their cognitive functioning, monotony in their affective processes, the difficulty in object relations and symbolization were revealed in Rorschach Test analysis (Duman, 2009). Hence, these concepts are closely related to each other and somatization.

In Turkey, in a university sample that includes late adolescents, somatization level was investigated (Özden,2015). Maternal somatic problems, an individual's medical history, gender, and maternal education level was found as predictors of psychosomatic symptoms. Besides associations between somatization and alexithymia, and emotion dysregulation were found to be significant.

Two studies examined the role of specific mentalization deficits on somatization. Skin related reactions are one of the frequent examples of psychosomatic complaints. Hypermentalizing was found to be related to the number of skin-related disorders (Kızılkaya, 2018). Besides separation-individuation problems, being female, the existence of a history of trauma, age, being in a relationship was positively correlated with higher skin disturbance scores (Kızılkaya, 2018).

Köksal (2017) indicated that insecure attachment styles, both anxious and avoidant, were positively related to somatization. In this study, hipomentalization was found positively correlated with somatization while the link between hypermentalization and somatization was negative. Attachment anxiety, health

status, health complaints rate of the mother, educational attainment, hypermentalization and gender were found to be significant predictors of the somatization (Köksal, 2017).

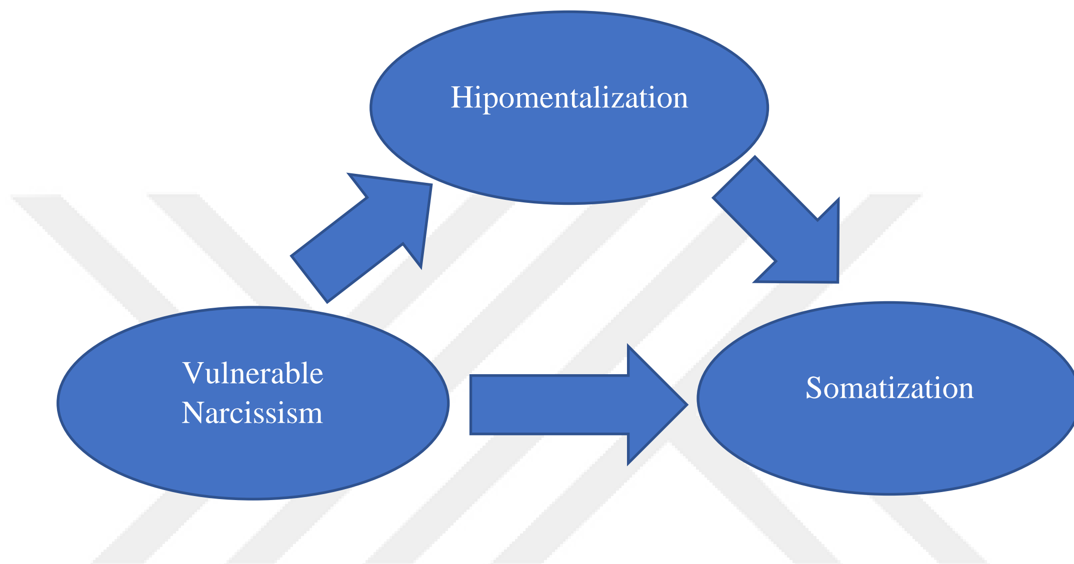
There various research on the relationships between narcissism and somatization, mentalization and somatization, and narcissism and mentalization. The associations between all three, narcissism, mentalization deficits and somatization, however, have not been examined especially in the late adolescence period.

1.8. CURRENT STUDY

The relationships between narcissism and somatization, mentalization and somatization, and narcissism and mentalization were summarized in the above literature. There is very limited research, however, on the relationship between narcissism subtypes and mentalization deficit subtypes, even they are associated with different psychosomatic symptoms. Main research questions of this study are as follows (1) what are the association between narcissistic personality traits (vulnerable and grandiose) and somatization (2) what are the association between mentalization deficits (hypermentalization and hypomentalizaiton) and somatization (3) what are the associations between narcissism, mentalization deficits, and somatization? Hence, the current study aims (1) to find a positive association between vulnerable narcissistic traits, and a negative association between grandiose narcissistic traits, and somatization in the late adolescence period; (2) to find a positive association between mentalization deficits, hipomentalization and hipermentalization and somatization in the late adolescence period; (3) to examine the possible role of mentalization deficits, specifically hipomentalization, on the link between vulnerable narcissistic traits and psychosomatic complaints in the late adolescence period (See figure 1.2. below).

Figure 1.2.

The main aim of the study was to examine the mediational role of hipomentalization on the link between vulnerable narcissism, and somatization in the late adolescence period



CHAPTER 2

METHOD

2.1. DESIGN

A quantitative method, predictive correlational survey model was conducted in this study to understand associations between narcissistic traits, mentalization deficits and psychosomatic complaints in late adolescence. This model explored both the direct and indirect associations, types of and degrees of associations between independent and dependent variables (Büyüköztürk et al., 2014).

2.2. UNIVERSE, SAMPLING AND PARTICIPANTS CHARACTERISTICS

The universe of the current study was late adolescents who were between 18-24 years old, living in Turkey. A convenient sampling method was used in this study. Convenient sampling is a method of selection through which it was easier to reach and apply questionnaires. This method was chosen because of time and financial limitations.

The required number of participants was determined by using an online sample size calculator (https://www.surveymonkey.com/mp/sample-size-calculator/). The analysis offered 385 participants with a 95% confidence level and 5% margin error. A total number of 923 individuals responded to the online survey. Due to non-completion of all the measures of interest, 428 cases removed. After eliminating uncompleted data, the final sample was reduced to 495 participants.

Regarding gender, 81.2% of the participants were female, while 18.4% were male. Late adolescents who participated in the Survey were between 18 and 24 years old. The sample was consisting of 50 (10.1%) people who is 18, 41 (8.6%)

people who are 19, 51 (10.8)% people who is 20, 52 (11%) people who is 21, 69 (14.5%) people who is 22, 71(15%) people who is 23 and 140(29.5%) people who is 24. Regarding socioeconomic status, the participants who defined their status as Middle were in the majority (51.1%). The participants who fall into the High-Middle category were 23.6%, the Low-Middle were 16.2%, Low were 5.7%, and High were 3.4%. (For detailed information regarding perceived socio-economic status, perceived trauma history, please see Table 2.1.).

Table 2.1.

Demographic Characteristics of Participants

Variables	N	%
Gender		
Female	385	81.2
Male	87	18.4
Other	2	0.4
Age		
18	50	10.5
19	41	8.6
20	51	10.8
21	52	11
22	69	14.6
23	71	15
24	140	29.5
Socio-Economic Status		
Low	27	5.7
Low-middle	77	16.2
Middle	242	51.1
Middle-high	112	23.6
High	16	3.4

Perceived Trauma History		
Yes	288	60.8
No	186	39.2

In this study, the demographic characteristics of the participants' parents were important including age, level of education, physical complaints of the parents. These variables used at both the hierarchical regression analysis and path analysis. (For detailed information about demographic characteristics of parents please see Table 2.2.).

Table 2.2.

Demographic Characteristics of Parents

Variables	N(M)	%M	N(F)	%F	*Mean*	*SD*
Level of Education						
Primary school	119	27.1	75	17.4		
Secondary school	45	10.3	49	11.4		
High school	127	28.9	133	30.9		
Associate degree	32	7.3	22	5.1		
Undergraduate	85	18.4	121	28.1		
Graduate	22	5.0	17	4.0		
Doctorate	1	0.2	9	2.1		
Other	8	1.8	4	0.9		
Age of Mothers	422				49.5	5.17
Age of Fathers	414				54.6	22.6
Parental Physical Complaints	N(M)	%M	N(F)	%F		
1 (Never)	96	22.1	166	38.4		
2	94	21.7	117	27.1		
3	55	12.7	59	13.7		

4	64	14.7	37	8.6
5	63	14.5	30	6.9
6	35	8.1	10	2.3
7 (Always)	27	6.2	13	3.0

Note: M= Mother, F= Father

2.3. INSTRUMENTS

The measures of this study consisted of two main sections. The first section included the Demographic Information Form in which the information about participants' age, gender, socioeconomic status, perceived trauma history, socio-economic status, past and current psychological health and age, level of education, physical complaints of the parents were gathered (see Appendix A for the Demographic Information Form). In the second section, self-report instruments were given to the participants, including the Somatization Scale (SS), the Short Form of the Five-Factor Narcissism Inventory (FFNI-SF), and the Reflective Functioning Questionnaire (RFQ-54) respectively.

2.3.1. The Demographic Information Form

The Demographic Information Form (See Appendix B) included three sets of questions regarding the participant himself/herself, his/her mother, and his/her father. The questions gathered informations regarding age, gender, perceived socioeconomic status, perceived trauma history, socioeconomic status, age, level of education, somatic complaints of the parents.

2.3.2. The Somatization Scale (SS)

The Minnesota Multiple Personality Scale (MMPI) has a somatization subscale (SS) which consists of 33 “yes” or “no” questions (Hathaway & McKinley, 1951). These questions measure psychosomatic complaints level and include questions about somatization like headache, stomachache, sweating, tiredness, pain, and lethargy. Scale might be used with people who are 18 years and older.

Dülgerler (2000) adapted the scale to the Turkish population and found a test-retest reliability score as 0.96 and Kuder-Richardson-20 internal consistency coefficient as 0.83 (See Appendix C). The validity of the Turkish version with SCL-90 was found as 0.80 (Dülgerler, 2000). In this sample, the reliability alpha coefficient was found as .85 which was higher than the Turkish version (See table 5).

2.3.3. The Short Form of the Five-Factor Narcissism Inventory (FFNI-SF)

The FFNI-SF (see Appendix D) is developed by Sherman et al. (2015) as a self-report instrument to measure vulnerable and grandiose narcissism dimensions of narcissism as well as various personality characteristics based on the Five-Factor Narcissism Inventory (FFNI) that was developed by Glover et al. (2012). FFNI-SF has 60 items rated on a five-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*) and. It permits to calculate both vulnerable and grandiose narcissism subscale scores and 15 narcissistic traits which are “acclaim-seeking, arrogance, authoritativeness, distrust, entitlement, exhibitionism, exploitativeness, grandiose fantasies, indifference, lack of empathy, manipulativeness, need for admiration, reactive anger, shame, and thrill-seeking” (Glover et al., 2012, 502).

The Turkish adaptation of this scale was conducted with a sample of 428 university students whose ages range from 18 to 32. The Cronbach’s alpha of the Turkish version was reported as .87 for the overall scale (Ekşi, 2016). The Cronbach’s alphas for the subscales ranged between 0.57 and 0.79. The validity of the scale was supported by its positive correlation (.65) with the Narcissistic

Personality Inventory. In this sample, the reliability alpha coefficient of the grandiose narcissism subscale was found as .88 and the vulnerable narcissism subscale was found as .78 which were higher than the Turkish version (See table 2.3.).

2.3.4. The Reflective Functioning Questionnaire (RFQ-54)

The RFQ-54 (See Appendix E) is a self-report questionnaire developed to measure mentalization capacity which refers to one's understanding of self and other's feelings, wishes, goals, desires, attitudes, and so on (Ghinai et al., 2008). It has 54 items evaluated on a 7-point Likert type measurement. RFQ-54 has a satisfactory internal consistency of .82 (Fonagy et al., 2016). This scale developed with college students and staffs so it might be used with people who are 18 and older (Fonagy et al., 2016). Fonagy et al. (2016) suggested a re-scoring of 26 of the items to generate independent scores for two sub-dimensions: RFQ Certainty (Hypermentalization) and RFQ Uncertainty (Hypomentalization). RFQ higher certainty scores refer to being too certain about mental states about self and others while RFQ higher Uncertainty scores refer to being too uncertain about these mental processes. Both hypermentalization and hypomentalization reflect impairment in reflective function capacity (Fonagy et al., 2016). In this study, the Cronbach's an of RFQ Uncertainty was .77 for the clinical sample and .63 for the non-clinical sample. Internal consistency scores of RFQ Certainty were .65 the clinical and .67 for non-clinical samples (Fonagy et al., 2016).

The Turkish version of the scale was used in previous studies by Köksal (2017) and Kızılkaya (2018) with sample who are older than 18. Köksal (2017) found the Cronbach alpha coefficients for the Turkish version as .90 for the Certainty / Hypermentalization sub-dimension and as .81 for the Uncertainty / Hypomentalization sub-dimension. Köksal(2017) also found a significant positive correlation between Uncertainty and Somatization, $r = .189$, $p < .001$. Uncertainty was found to be positively correlated with Attachment Avoidance, r

= .246, p <.001 and Attachment Anxiety, r = .261, p < .001. Additionally, negative correlation was found between Certainty and Uncertainty, r = -.493, p < .001. Kızılkaya (2018) found Cronbach's alpha for the Certainty as .90, as Cronbach's alpha for the Uncertainty was .87. In this study, the Cronbach's alpha coefficients for both dimensions calculated to check the internal consistency of the scale. In this sample, the reliability alpha coefficient of the Certainty subscale was found to be .88, and the Uncertainty subscale was found as .85 (See table 2.3.).

Table 2.3.

Reliability Coefficients (Cronbach's a) of the Scales

Scale and Subscales	Cronbach's *a*
The Somatization Scale	0.85
The Short Form of the Five-Factor Narcissism Inventory (FFNI-SF)	
Vulnerable Narcissism	0.78
Grandiose Narcissism	0.88
The Reflective Functioning Questionnaire (RFQ-54)	
RFQ Certainty (Hipermentalization)	0.88
RFQ Uncertainty (Hipomentalization)	0.85

2.4. PROCEDURE

Before data collection, the ethics approval of the current study was obtained from Istanbul Bilgi University Ethics Committee. The application of the current study was approved by the committee on the 20th of February with project number 2020-20024-46. All data was collected via an online survey tool, 'SurveyMonkey' (www.surveymonkey.com). The online survey link was shared via e-mails to mail groups and as social media posts.

Participants initially received an informed consent form (see Appendix A) to ask for their voluntary participation. They were informed about the purpose of the study, their right to quit, and communicate with the researcher in case they have any questions or concerns about the study. At any point, they were encouraged to communicate with the investigator if they had any questions or concerns about their participation. When they agreed, the instruments listed above were presented in the following order; the Somatization Scale (SS), the Short Form of the Five-Factor Narcissism Inventory (FFNI-SF), and the Reflective Functioning Questionnaire (RFQ-54), and the Demographic Information Form. It took approximately 13-17 minutes to fill in all the instruments. Identifying information was not asked at any stage of the study.

2.5. DATA ANALYSIS AND INTERPRETATION

In this study there were two main independent variables : (1) grandiose narcissism and (2) vulnerable narcissism scores measured by the Short Form of the Five-Factor Narcissism Inventory (FFNI-SF) and two main possible mediating variables: (1) certainty and 2) uncertainty scores measured by the Reflective Functioning Questionnaire (RFQ-54).

The Pearson Correlation Analysis, the Spearman Rho Correlation Analysis, Independent T-Test Analysis, and the Hierarchical Regression Analysis were

measured by means of Statistical Package for Social Sciences (SPSS), version 21 for Windows. The Pearson correlation analysis and the Spearman rho correlation Analysis were conducted to check correlations between the study variables. Correlations between continuous variables were calculated with the Pearson Correlation analysis such as vulnerable narcissism, grandiose narcissism, somatization, certainty and uncertainty scores and age while Spearman rho correlational analysis applied for nominal or ordinal variables such as gender, socio-economic status, somatic complaints of parents, perceived trauma history. After preliminary analysis, for following test analysis assumptions such as homogeneity of variances with Levene's test and Kolmogrov- Smirnov normality test applied before the independent-samples t-test, Hierarchical regression analysis and the mediation analysis.

The results of the assumption test was mentioned in the result section under related analysis. Since there were outliers in the study variables, and data violates the normal distribution, R^2 logarithmic normalization method applied to ensure normal distribution condition for parametric analyses. All study variables normalized with this method. The independent-samples t-test was conducted to compare the level of somatization in females and males. The hierarchical regression analysis conducted to explore the predictors of somatization with the dependent variable somatization and predictor variables of vulnerable narcissism, grandiose narcissism, hipermentalization, hipomentalization, age, gender, socio-economic status, perceived trauma history, and age, education, and somatic complaints of parents. Finally, the path analysis for mediation was conducted by PROCESS macro for SPSS (Hayes, 2013, 2017). This analysis conducted to explore associations between vulnerable narcissism, mentalization deficits and somatization. Perceived trauma history, somatic complaints of the mother, which are the significant predictors of somatization in the hierarchical regression analysis, were used as control variables in this analysis.

CHAPTER 3

RESULTS

The findings of the current study will be presented in four sections. First, the results of preliminary analysis; descriptive statistics for the study variables, and the scales will be given. Second, the correlational analyses (the Pearson and the Spearman RHO) will be presented to demonstrate the relationships between study and demographic variables. Third, the results of the hierarchical regression analyses will be presented, showing the degree to which independent variables, and controlling variables predict the level of somatization, respectively. Fourth, the independent sample t-tests will be presented to understand the effect of gender on somatization and narcissistic subtypes. Finally, a mediation analysis (the Path Analysis) that examined the role of mentalization deficits on the link between vulnerable narcissism and somatization will be presented.

3.1. DESCRIPTIVE STATISTICS

Before evaluating the current study's hypotheses, it is important to examine the relationships among the focal measures. Before the analyses, the scale scores were computed, and descriptive statistics were investigated. Since there were outliers in the study variables, and data violates the normal distribution, R^2 normalization method applied to ensure normal distribution condition for parametric analyses. All study variables normalized with this method. The minimum, maximum, mean, and standard deviations for the scales and the sub-scales scores of the study variables are shown in Table 3.1.

Table 3.1.

Descriptive Statistics of the Scale Scores of Study Variables

	Min	Max	*M*	*SD*
Somatization	1	5.74	3.44	.90
Vulnerable Narcissism	4.47	7.62	6.34	.56
Grandiose Narcissism	9.38	14.04	11.62	.86
Hipermentalization	0	8.60	4.87	1.43
Hipomentalization	0	8.49	6.34	1.33

Furthermore, based on the literature, participants' socioeconomic status, age and gender, perceived trauma history, and parents' age, level of education, physical complaints were also included in the analyses as covariates.

3.2. ASSOCIATIONS OF STUDY VARIABLES

This study aims to find predictors of somatizations and possible mediating factors. Before examining the study's hypotheses, in this section, associations of independent study variables with somatization will be presented.

To figure out the variables associated with somatization, the Pearson Correlation, and the Spearman Rho Correlation tests were applied. Firstly, it was found that somatization was positively correlated with vulnerable narcissism $r = .30$, $p < .001$, hipomentalization $r = .23$, $p < .001$, perceived trauma history $r = .24$, $p < .001$, and somatic complaints of the mother $r = .25$, $p < .001$, somatic complaints of the father $r = .12$, $p < .05$, and negatively correlated with hipermentalization $r = -.17$, $p < .001$, socio-economic status $r = -.14$, $p < .01$, and age $r = -.14$, $p < .01$, (See table 3.2. and 3.3. for correlations between variables in detail). As it was expected, these results suggest that vulnerable narcissistic traits, hipomentalization, hypermentalization, existence of trauma history, somatic complaints of the mother,

and somatic complaints of the father, the younger age, and socioeconomic status are risk factors for somatization. On the other hand, gender, age of the mother, and the father, education level of the mother, and father were not related to somatization as it was expected.

Vulnerable narcissism was positively correlated with hipomentalization $r= .32$, $p < .001$, perceived trauma history $r= .09$, $p < .05$, age of the father $r= .09$, $p < .05$, and negatively correlated with hipermentalization $r= -.26$, $p < .001$, gender $r= -.14$, $p < .01$. (See table 3.2. and 3.3. for correlations between variables in detail) These results suggest that both mentalization deficits as hipomentalization and hipermentalization, the existence of trauma history, higher age of the father, being female is a risk factor for vulnerable narcissism.

Grandiose Narcissism was positively correlated with hipermentalization $r= .17$, $p < .001$, gender $r= .19$, $p < .001$, socioeconomic status $r= .15$, $p < .01$, and negatively correlated with age $r= -.18$, $p < .001$, and age of the mother $r= -.18$, $p < .01$ age of the father $r= -.13$, $p < .05$. (See table 3.2. and 3.3. for correlations between variables in detail). These results suggest that hipermentalization, the younger age, the younger age of the mother and the father are the risk factors for grandiose narcissism.

Hipomentalization was positively correlated with somatic complaints of the mother $r= .14$, $p < .01$, and perceived trauma history $r= .09$, $p < .05$ and negatively correlated with hipermentalization $r= -.38$, $p < .001$, socioeconomic status $r= -.15$, $p < .01$. (See table 3.2. and 3.3. for correlations between variables in detail). These results suggest that somatic complaints of the mother, trauma history, lower socioeconomic status are risk factors for hipomentalization while higher hipermentalization is negatively associated with hipomentalization.

Hipermentalization was positively correlated socioeconomic status $r= .20$, $p < .001$ and negatively correlated with somatic complaints of the mother $r= -.12$,

$p < .05$. (See table 3.2. and 3.3. in the next page, for correlations between variables in detail). These results suggest that higher socioeconomic status and somatic complaints of the mother are risk factors for hipermentalization.

Table 3.2.

Correlations between the Study Measures and Participant's Measures

Variables	1	2	3	4	5	6	7	8	9
1.Som.	-	.30***	-.01	.23***	-.17***	-.14**	-.05	-.14**	.24***
2. Vu. N.		-	.02	.32***	-.26***	-.01	-.14**	-.03	.09*
3. Gr. N.			-	-.05	.17***	-.18***	.19***	.15**	.04
4. Hipom				-	-.38***	-.06	-.03	-.15***	.09*
5. Hiperm					-	.07	-.01	.20***	.01
6. Age						-	-.05	.03	.02
7. Gen.							-	-.07	-.11*
8. SES								-	-.02
9. Trauma									-

*Note: *p < .05, **p* < .01., ****p* < .001

Som. = Somatization Vu. N. = Vulnerable Narcissism, Gr. N.= Grandiose Narcissism, Hipom = Hipomentalization, Hiperm = Hipermentalization, Gen. = Gender, SES = Socio-Economic Status, Trauma= Perceived Trauma History,

Table 3.3.

Correlations between the Study Measures and Parental Measures

Variables	1	2	3	4	5	6	7	8	9	10	11
1.Som.	-	.30***	-.01	.23***	-.17***	-.08	.01	.25**	.05	-.05	.12*
2. Vu. N.		-	.02	.32***	-.26***	-.01	-.01	-.02	.09*	.06	-.09
3. Gr. N.			-	-.05	.17***	-.18***	.05	.16***	-.13**	-05.	.04
4. Hipom				-	-.38***	-.06	-.01	.14**	.07	.01	-.11
5. Hiperm					-	.07	.00	-.12*	.03	-.06	.11
6. A. M.						-	.11**	-.08	.16**	.11*	-.11**
7. E. M							-	-.04	.07	.55***	.02
8. S. M								-	-.06	-.05	.25***
9. A. F									-	.19***	-.07
10. E. F.										-	.06
11. S. F											-

Note: $*p < .05$, $**p < .01.$, $***p < .001$

Som. = Somatization Vu. N. = Vulnerable Narcissism, Gr. N.= Grandiose Narcissism, Hipom = Hipomentalization, Hiperm = Hipermentalization, A. M.= Age of Mother, E. M.= Education Level of Mother, S. M.= Somatic Complaints of Mother, A. F.= Age of Father, E. F.= Education Level of Father, S. F.= Somatic Complaints of Father.

3.3. FINDINGS RELATED TO INDEPENDENT T-TEST FOR GENDER

An independent-samples t-test was conducted to compare the level of somatization in females and males. After normal distribution and equality of variances assumptions supported, the independent-samples t-test was conducted. To check the equality of the variances the Levene's test for equality of variances conducted and there were no significant differences between variances (p=.285). There was not a significant difference in the scores for females (M=3.46, SD= .91) and males (M=3.36, SD=.86) in the level of somatization (t=.91, p = .363). (See table 3.4. for details) These results suggest that gender does not influence the level of somatization.

Table 3.4.

Results of the independent-samples t-test for genders

Groups	N	Mean	*sd*	*df*	*T*	*p*
Female	385	3.46	.11	470	.91	.36
Male	87	3.36	.10			

3.4. FINDINGS RELATED TO INDEPENDENT T-TEST FOR NARCISSISM

Since gender was found significant in both grandiose and vulnerable narcissism in correlational analysis, additional independent sample t-test analyses conducted to understand the difference deeply.

3.4.1. Vulnerable Narcissism and Gender

The independent-samples t-test was conducted to compare the level of vulnerable narcissistic traits in females and males. After normal distribution and

equality of variances assumptions supported, the independent-samples t-test was conducted. To check the equality of the variances the Levene's test for equality of variances conducted and there were no significant differences between variances (*p*=.892). There was a significant difference in the scores for females (*M*=6.38, *SD*= .55) and males (*M*=6.19, *SD*=.55) in the vulnerable narcissistic traits (*t*=2.88, *p* = .004). (See table 3.5. for details) These results suggest that gender influences the vulnerable narcissistic traits and females have more vulnerable narcissistic traits than males.

Table 3.5.

Results of the independent-samples t-test for genders in vulnerable narcissism

Groups	N	Mean	*Sd*	df	*T*	*p*
Female	385	6.38	.55	470	2.88	.004
Male	87	6.19	.55			

3.4.2. Grandiose Narcissism and Gender

The independent-samples t-test was conducted to compare the level of grandiose narcissistic traits in females and males. After normal distribution and equality of variances assumptions supported, the independent-samples t-test was conducted. To check the equality of the variances, the Levene's test for equality of variances conducted and there were no significant differences between variances (*p*=.261). There was a significant difference in the scores for females (*M*=11.54, *SD*= .84) and males (*M*=12.07, *SD*=.77) in the vulnerable narcissistic traits (*t*=.-5.46 *p* = .000). (See table 3.6. for details) These results suggest that gender influences the grandiose narcissistic traits and males have more grandiose narcissistic traits than males.

Table 3.6.

Results of the independent-samples t-test for genders in grandiose narcissism

Groups	N	Mean	*Sd*	df	*T*	*p*
Female	385	11.54	.84	470	-5.46	.000
Male	87	12.07	.77			

3.5. FACTORS THAT PREDICT SOMATIZATION

3.5.1. Findings Related to the Hierarchical Regression Analysis

The following aims and hypotheses are advanced to account for the expected predictors:

Aim 1: To examine the association between narcissistic personality
traits (vulnerable and grandiose) and somatization

Hypothesis1: Vulnerable narcissism will predict the level of somatization

Hypothesis2: Grandiose narcissism will not predict the level of somatization.

Aim 2: To examine the association between mentalization deficits
(hipermentalization and hipomentalization) and somatization

Hypothesis3: Hypomentalization will predict the level of somatization.

Hypothesis4: Hypermentalization will predict the level of somatization.

The first hypothesis expects that vulnerable narcissism will predict the level of somatization and grandiose narcissism will not. The second hypothesis expects that both hipomentalization and hipermentalization will predict the level of somatization. Hierarchical regression analyses were conducted to investigate the contribution of the mentalization deficits (hipermentalization and hipomentalization), and narcissistic traits (Grandiose narcissism and vulnerable narcissism), on the somatization scores when the participants' factors (age, sex,

socioeconomic status, perceived trauma history) and parental factors (age, education, and somatic complaints of the parents) were taken into account. Before the test conducted normal distribution assumptions for variables were supported with the Kolmogorov-Smirnov test of normality. The hierarchical regression analysis resulted in four steps. Step four was the most comprehensive one while being significant and explaining 20% of the variance on somatization ($F_{(7.97)}$=13.05, p<001). The findings showed that the strongest predictor of the somatization was vulnerable narcissism (β=.25, p<.001). The other predictors of somatization were perceived trauma history (β=.18, p<.001), somatic complaints of the mother (β=.18, p<.001), age (β=-.12, p<.05), and hipomentalization (β=.10, p<.05), respectively (For details of each step, see table 3.7.). The results indicate that late adolescents who have vulnerable narcissistic traits, perceived trauma history, somatic complaints of the mother, specific mentalizing deficits hypomentalization (uncertainty), and the younger age, they will have increased somatic complaints. Thus, the first hypothesis supported that vulnerable narcissism is a significant predictor of somatization while grandiose narcissism is not a significant predictor of somatization. The second hypothesis partially supported that hypomentalization is a significant predictor of somatization while hypermentalization did not predict somatization.

Table 3.7.

Summary of Hierarchical Regression Analysis for Variables Predicting Somatization (*N*= 391)

		Step 1			Step 2			Step 3			Step 4	
Variables	B	B SE	*β*	B	B SE	*B*	B	B SE	*β*	B	B SE	*β*
SES	-.84	.35	-.12*	-.83	.36	-.12*	-.63	.36	-.09	-.57	.36	-.08
Gender	-.05	.78	-.03	-.32	.77	-.02	-35	.75	.02	.35	.78	.2
Age	-.04	.15	-.14**	-.43	.16	-14**	-.37	.15	-.12*	-.36	.15	-.12*
Per. Trauma His.	3.01	.61	.24***	2.62	.61	.21***	2.52	.60	.20***	2.23	.58	.18***
Age of Mother				-.00	.06	-.00	-.01	.06	-.01	-.04	.06	-.03
Education of M.				.08	.43	.01	.13	.43	.02	.23	.42	.03
Som. Com. M.				.65	.17	.20***	.58	.16	.18***	.56	.16	.18***
Age of Father				.02	.01	-.00	.02	.01	.07	.02	.01	.06
Education of F.				.05	.22	.01	-.02	.22	-.01	-.10	.22	-.03
Som. Com. F.				.18	.20	.05	.10	.19	.03	.05	.19	.01

Certainty							-.03	.02	-.06	-.00	.02	-.01
Uncertainty							.10	.03	.16**	.06	.03	.10*
Gran. Nar.										-.02	.02	-.05
Vul. Nar.										.22	.04	.25***
R^2 (Adjusted)	.10(.09)			.14(.12)			.18(.15)			.23(.20)		
F for change in R^2	10.11***			3.57**			7.35***			13.05***		

*Note: *p < .05, **p* < .01., ****p* < .001

SES= Socioeconomic status, Per. Trauma His.= Perceived Trauma History, Education of M.= Education of Mother, Som. Com. M.= Somatic Complaints of Mother, Education of F.= Education of Father, Som. Com. F.= Somatic Complaints of Father, Gran. Nar.= Grandiose Narcissism, Vul. Nar.= Vulnerable Narcissism.

3.6. PATH ANALYSIS

The following aim and hypothesis are advanced to account for the expected predictors:

Aim 3: To examine the possible role of mentalization deficits, specifically hipomentalization, on the link between vulnerable narcissistic traits and psychosomatic complaints in the late adolescence period

Hypothesis5: The impact of vulnerable narcissistic traits on the level of psychosomatic complaints mediated by hypomentalization in the late adolescence period.

To test whether there is a mediating role of mentalization deficit hypomentalization on the link between vulnerable narcissism and somatization path analysis was conducted by PROCESS macro procedure for SPSS (Hayes, 2013, 2017). The independent variable was vulnerable narcissism while the dependent variable was somatization. Perceived level of trauma and maternal somatic complaints used as covariates since they were effective predictors somatization in the hierarchical regression model. Before the test conducted normal distribution assumptions for variables were supported with the Kolmogorov-Smirnov test of normality. Mediation pathway for hipomentalization tested. Bias-corrected 95% confidence intervals of total effects, direct effects, and indirect effects were provided using bootstrap estimation with 5000 samples. An estimation method considered to provide reliable results. Ranges of confidence intervals must not include zero value to reach significant mediation (Hayes, 2013, 2017). In this section, the findings of these analyses will be presented.

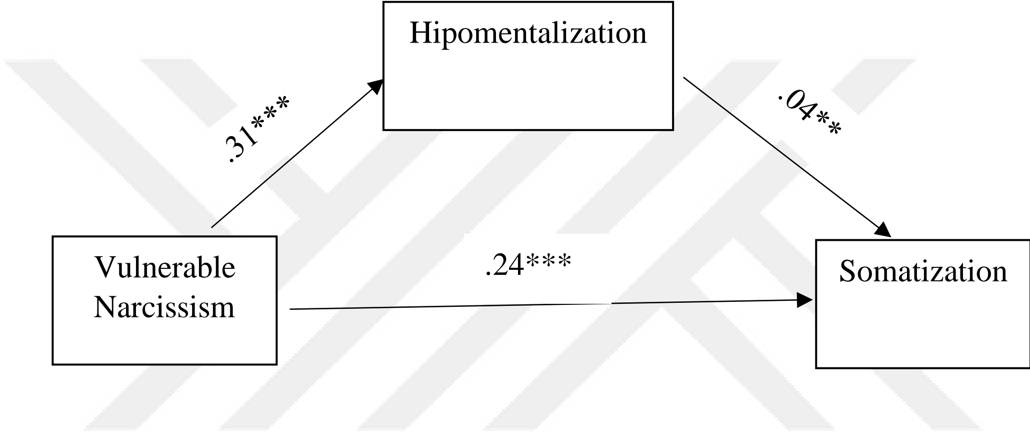
3.6.1 Mediator Role of Hipomentalization on the Link between Vulnerable Narcissism and Somatization

The Path analysis was conducted to test the impact of vulnerable narcissistic traits on the level of psychosomatic complaints mediated by hypomentalization. Perceived level of trauma and socioeconomic status was used as control variables. A bootstrap confidence interval for the indirect effect based on 5.000 bootstrap samples was entirely above zero (0.0140 to 0.702). The total direct effect of vulnerable narcissism on somatization was significant (β =.25, *p*=.000, *SE*=.04). The direct effect of vulnerable narcissism on somatization was significant (β =.24, *p*=.000, *SE*=.04). The direct effect of vulnerable narcissism on hipomentalization was significant (β =.31, *p*=.000, *SE*=.07). The direct effect of hipomentalization on somatization was significant (β =.13, *p*=.005, SE=.03). According to the mediational model, the effect on the mediating variable demonstrated that vulnerable narcissism had a significant indirect effect on somatization through hipomentalization (*B*=.04, SE=.01, 95% CI[.01,.07]).

The results demonstrated a significant partial mediation and the mediation hypothesis supported (R^2=.18, *P*=.000, $F_{(3.000)}$=30.56). (for the results of the model, please see figure 3.1.).

Figure 3.1.

Path Analysis Model: Association between vulnerable narcissism and somatization and hipomentalization



Note: $^{**}p < .01$, $^{***}p < .001$

CHAPTER 4

DISCUSSION

The first goal of the study was to examine the associations between narcissism, mentalization deficits, and somatization. Secondly, it was aimed to investigate the relationship between narcissistic personality traits (vulnerable narcissism, and grandiose narcissism) and somatization. Third, the relationship between mentalization deficits (hipermentalization, hipomentalization) and somatization was explored. This study has generated four main important findings. 1) Vulnerable narcissism is predictive for somatization while grandiose narcissism is not. 2) Hipomentalization is predictive for somatization while hipermentalization is not. 3) Somatic complaints of the mother, perceived trauma history, younger age are also important predictors of somatization. 4) Hipomentalization partially mediated the link between vulnerable narcissistic traits and somatization in the late adolescence period. Findings of the main and additional analyses were discussed in this section.

4.1. THE HIERARCHICAL REGRESSION ANALYSIS

4.1.1. Narcissism and Somatization

The first hypothesis of this study was that vulnerable narcissism will predict the level of psychosomatic complaints. Hierarchical regression analysis conducted to test the hypothesis. The results showed that *vulnerable narcissism* was a significant predictor of somatization in the late adolescence. Besides, it was the strongest predictor of the hierarchical regression analysis.

In the literature, similar to our results, somatization was found to be related with vulnerable narcissism, but not with grandiose narcissism (Rathvon & Holmstrom, 1996; Daig et al., 2009; Miller & Maples, 2011; Miller et al., 2011; Ekinci, 2018; Miller et al., 2018). Miller et al. (2011) in their study, with undergraduate students who are around 19 years of age, indicated that somatization was associated with vulnerable narcissism, but it was not related to grandiose narcissism. More specifically, they found that vulnerable narcissism was positively correlated with neuroticism, negative emotionality depression, vulnerability, anxiety, and impulsiveness, and negatively correlated with agreeableness, self-discipline, assertiveness, positive emotions, and extraversion. Additionally, these traits such as neuroticism, negative emotionality, depression, vulnerability, anxiety, and impulsiveness were mostly addressed as the features of the somatic patients in the literature (Lipowski, 1988; Lieb et al., 2007; Schmaling & Fales, 2018; Stumpf et al., 2018). Thus, negative emotionality and neuroticism were found to be related to symptoms of all forms of psychopathology (Johnson, 2003). So, even it is not possible to establish cause and effect relationships, vulnerable narcissistic traits were closely related to anxiety, depression, and somatization.

These results could be found due to the characteristics of vulnerable narcissistic. Avoiding threatening interpersonal relationships, social withdrawal, needs for approval, extreme idealization of others, shame for grandiose fantasy, extreme criticism to self, fear of rejection and abandonment, insecurity, awareness of inner emptiness, sensitivity to the feeling of shame, dysphoric affective states and pessimism are the features that are related with vulnerable narcissism (Akhtar & Thomson, 1982 Rosenfeld, 1987 Gabbard, 1989, Cooper & Ronningstam, 1992; Akhtar, 2000). Because of their early years of trauma and deficits in the selfobject (mirroring, idealization, twinship), they have been stated to experience problems on the sense of self and affect regulation (Kohut, 1971, 1977). These traits might make them more prone to stress, anxiety, and depression.

The second hypothesis which claimed that grandiose narcissism would not predict the level of psychosomatic complaints was supported. Grandiose narcissistic individuals deny weakness and impotency, and this defensive process might protect them from subjective distress and psychopathology rather than vulnerable narcissistic individuals. Vulnerable ones might exacerbate the physical experience of depletion and fragmentation (Kohut 1971; Kealy, 2016).

Grandiose narcissism was found to be positively correlated with extraversion, openness, assertiveness, activity, excitement seeking, achievement striving, competence, and negatively correlated with neuroticism, compliance, vulnerability, depression, and anxiety (Miller et al., 2011).Therefore, grandiose narcissists might have more protective factors against stress and somatizations.

The results of this study were in line with the Kernbergian grandiose narcissistic phenotype (1975, 2004) that is not related to somatization, and with Kohutian vulnerable narcissistic phenotype (1971, 1977) that was found to be related to somatization. Moreover, following the Kohutian self-psychology tradition and vulnerable narcissistic phenotype, Rickles (1986), Rodin, (1991), and Krystal (1998) theoretically explained the self-disturbance in narcissistic personality and somatization disorder. The current results indicate that self-psychology would be more helpful for understanding the etiology and treatment of narcissistic individuals.

In the literature, somatization and narcissistic personality disorder were found significantly related (Rathvon & Holmstrom, 1996; Noyes et al., 2001; Bornstein & Gold 2008; Daig et al., 2009; Kealy et al., 2016). However, cited research found significant relationships between somatization and the one-dimensional model of narcissistic personality disorder like DSM-V (APA, 2013) rather than grandiose and vulnerable subtypes. Besides, some studies suggest the possible relationship between narcissistic traits and transference in somatic patients in the therapy

process (Lefebvre 1980; Marty, 2010). Even these studies do not directly claim that narcissistic personality leads to somatization problems, they indicate that narcissistic personality is very frequently seen in the therapy of psychosomatic patients. It is called as a narcissistic impasse, narcissistic resistance, selfobject transference, narcissistic transference (Kohut,1977; Lefebvre, 1980, Krystal, 1998; Marty, 2010; Aisenstein & Smadja, 2010b; Yasky et al., 2013). In short, narcissism is related to psychosomatic complaints or makes it challenging for the treatment.

The findings of the current study supported the existing literature and contributed to the association between vulnerable narcissism and somatization in the late adolescence period.

4.1.2. Mentalization Deficits and Somatization

Various research examined the relationship between mentalization and somatization; however, a limited study investigated the association between somatization and different mentalization deficits. Therefore, the second aim of this study was to examine the association between mentalization deficits (hipermentalization, hipomentalization) and somatization in late adolescents. The third and the fourth hypotheses claimed that hypomentalization and hypermentalization will predict the level of somatization, respectively.

The findings showed that *hipomentalization* was a significant predictor of somatization in late adolescence. The Paris Psychosomatic School (Smadja, 2011; Marty, 2012; Gubb, 2013) and mentalization-attachment based theories (Fonagy et al., 2002; Griffies, 2010; Kohutis, 2010; Sloate, 2010; Luyten et al., 2012) explained and demonstrated strong correlations between mentalization and somatization. Researchers found that low mentalization capacity was strongly associated with high level of psychosomatic complaints (Aisenstein, 2006; Kohutis,

2010; Griffies, 2010; Aisenstein & Aisemberg, 2010; Subic-Wrana, 2010; Smadja, 2011; Luyten et al., 2012; Marty, 2012; Cengiz, 2015; Köksal, 2017; Kızılkaya, 2018; Aydoğan, 2018; Ballespí et al., 2019; Bizzi et al., 2019). Similarly, in the adolescence, high mentalization capacity was found to be positively correlated with low somatization. And, the low mentalization capacity was found associated with high somatic complaints (Aydoğan, 2018; Ballespí et al., 2019; Bizzi et al., 2019). In the light of the presented literature, unreflective and concrete thinking, limited capacity to recognize and express emotions of self and others, fantasy life and symbolic reflection, limited curiosity and interest in mental states might be the predisposing, precipitating, and perpetuating factors of somatizations.

The fourth hypothesis that predicted the role of hypermentalizing in somatization was not supported. H*ipermentalization* was not found to be a significant predictor of somatization in the late adolescents. There are, however, various findings on the link between the two. In a study done in Turkey, with a sample aged 18-63, hipermentalization was found negatively correlated with somatization (Köksal, 2017). In another study, mentalization deficit, hypermentalizaiton (pseudomentalizers) was found to be positively correlated with somatic skin reactions (Kızılkaya, 2018).

Hypermentalization might be a possible developmental stage in the late adolescence period that is not directly related to psychopathology. As it was discussed that normal narcissism, self-focus and body-preoccupation are parts of normal adolescent development, as a part of adolescence, they might be hypermentalizers. Although hypermentalization is considered as a reflective functioning deficit, it was found to be positively correlated with anger control (Fonagy, 2016). In the empirical studies that examined hypermentalization in psychosomatic patients, they were observed to have sophisticated narratives without affective component and hypermentalizing was used as a denial of internal worlds (Luyten et al., 2013; Köksal, 2017). Thus, hypermentalizing might not be

an impairment in emotional awareness. However, it might refer to a problem of recognizing the relationship between bodily sensations and emotional states (Subic-Wrana et al., 2010). Badoud et al. (2015) in their research on alexithymia also found positive correlations between mentalization and hipomentalization, and negatively correlations with mentalization and hipermentalization. In this study, hipermentalization was positively correlated with mindfulness and empathy, and negatively correlated with externalizing and internalizing problems. In Turkey, in a university sample, in the late adolescence period, alexithymia and somatization were also found to be positively associated. These results fit with other studies in alexithymia and adolescent psychosomatics (Garralda, 1996; Ebeling, 2001; Burba et al., 2006; Subic-Wrana, 2010; Allen et al., 2011).

Since, hipomentalization and hypermentalization concepts are new in the literature, there is very limited research which will explain mechanisms of why hipomentalization is related to somatization and hipermentalization is not. In sum, the results of study highlighted the importance of focusing on the mentalization skills, especially, on hipomentalization when working with somatization problems in late adolescents living in Turkey.

4.1.3. Significant Predictors of Somatization

The significant predictors of somatization found in the hierarchical regression analysis were perceived trauma history, somatic complaints of the mother and age. They were in line with the existing literature. The gender, maternal education level, and socioeconomic status, however, were not compatible with previous studies.

Perceived Trauma History and Somatization

Although measuring the effect of trauma was not one of the main aims of the current study, the results revealed that perceived trauma history was associated with somatization. Similar to existing trauma and somatization literature, significant associations were found between the two. According to Levine (2014), traumatic experiences impair the emotional homeostasis and capacity to represent experience. Consequently, an individual might not mentalize the experience, and thus somatization might become the only discharging medium. Childhood or adulthood traumas have been stated to play a role on the somatization problems (Lieb et al., 2002; Imbierowicz & Egle, 2003; Spitzer et al., 2008; Katon et al., 2011; Annemiek van et al., 2011; Gupta et al., 2017). In a study, Vietnam veterans with post-traumatic stress disorder reported that 45.5% of them had somatic complaints (Wolf et al., 1998). Childhood traumas such as physical, emotional, sexual abuse, and neglect, and living in a traumatic family environment with emotionally distant, non-supportive parental attitudes, maltreatments, and attachment problems were all found to be associated with somatization problems (Noyes, 2002; Waldinger, 2006; Güleç et al., 2013; Brown et al, 2015;). Traumatized children who lived with parents with mentalization deficits were found to have difficulties in linking emotions with symbolization (Krystal, 1997). Fonagy et al. (2002), Kohut (1971, 1972) and Kernberg (1975, 2004) pointed out the role of childhood traumas on the self-disturbances such as narcissism and mentalization and affect regulation problems. According to Gubb (2013), the body takes the role of the mind for handling overwhelming affects (Gubb, 2013). Therefore, early trauma histories would be important to examine for further understanding of somatization in late adolescents.

Parental Somatic Complaints and Somatization in late Adolescents

Somatic complaints of the mother was another important predictor of somatization in this study. They were significant correlations between fathers' and adolescents' somatic complaints, but paternal somatization problems were not a

significant predictor of somatization. Somatic complaints of the parents are related to children and adolescents' somatization as literature suggested (Garber et al., 1990; Ebeling, 2001).

The difference between maternal somatic complaints and paternal somatic complaints might root in the primary caregiver function of mothers in Turkey. In research done with adults, both maternal and paternal somatic complaints were found significant. However, in this study, maternal complaints were more effective than paternal complaints (Köksal, 2017). Another study also supported that maternal somatic complaints were the most important predictor of somatization (Özden, 2015). According to researchers, this is the result of modeling and social learning (Bass & Murphy, 1995). So, in this sample, modeling might be a possible mechanism. A child who sees his/her mother complaining about somatic problems might model her and complain about somatic problems too. Caregivers might create a perception that complaining about somatic problems is a method of receiving care and intimacy (Stuart & Noyes 1999).

Secondary gains of somatic complaints are also discussed in the literature (Craig et al., 1993). So, in this sample, late adolescents might use psychosomatic symptoms as a way of receiving care and intimacy or gaining other kinds of secondary gains. Even it has not been investigated in this study; genetics might be an important factor for parent-child somatization problems. This should be investigated in further studies. Problems of the affect regulation of the mothers might lead to impairments in mentalizing the child's needs (Köksal, 2017). If a parent cannot regulate her affect, she will not be able to regulate her child too. So, the child will have affect regulation difficulties too. Mentalization is an important factor to protect from somatization problems; deficits in mentalization might lead to reflective functioning problems and somatization disorders in children. So, in this sample, deficits in parental reflective functioning capacity might be a possible transmission of emotion dysregulation and thus somatization. In short, modeling,

affect regulation, mentalization, and attachment might play important roles in the transmission of somatic complaints from mothers to children.

Bialas and Craig (2007) also found different types of interaction between child and psychosomatic mothers than non-psychosomatic mothers. An unknown mediator might be affecting the psychosomatic mother and child relationship. Trauma history, anxiety and depression might be possible mediator which further study may explore.

Socioeconomic Status and Somatization

In this study, adolescents' somatic complaints decreased when their socioeconomic status (SES) increased. In the literature, socioeconomic status was found as an important factor in somatization. Low socioeconomic status has been stated to be a risk factor for somatization in both adults and adolescents (Huuerre et al., 2004; Schreier & Chen, 2013; Malas et al., 2017). In the regression analysis, for the first and second steps, SES protected its importance, but it lost its significance in the third step. So, although the association between SES and somatization existed, the predictor role of the SES was not found in this study. Similarly, in a study done with college students, socioeconomic status was not found as an important predictor of the somatization (Özden, 2015). The education level of the parents was not a predictor of somatization, although it might be relevant to the SES of late adolescents.

These SES results might explain the difference in the expression of somatization complaints and emotions based on the income of the families. Since, high intellectual capacity and education have been stated to lead to expression of emotions verbally rather than somatization (Köksal, 2017). Besides, different socio-economic classes might have different emotional expression strategies, and low socioeconomic status might result in more authoritarian family and limited chance to talk about emotions freely. Limited expression by symbolic language will

result in somatic manifestations. Financial problems in low SES might lead to emotional distress, which makes prone to somatization.

Age and Somatization

The participants of this study were similar in their developmental stages; the range of age between them was not significant. For this reason, the effect of age was not expected. In contrary to expectation, although not very strong one, the age has been found to be one of the predictors of somatization. With the increase of age, the somatization level decreased significantly in late adolescents. Late adolescence is an important transition from early and middle adolescence, in which major changes occur, when teenagers get older, they might be less preoccupied with their body. So, in younger adolescents, increased self-awareness and attentiveness to changes create serious intrapsychic symptoms (Vulić-Prtorić, 2016). Thus, younger adolescents' somatic symptoms might be affected by their emotional and physical maturation process. Increasing age might be associated with increasing language and word capacity. Expression by symbols, metaphors is a protective factor against somatization (Marty, 2012; Gubb, 2013). So, increasing language capacity would be a potential mediator.

4.2. THE ANALYSES FOR GENDER

Gender was found as an important factor in somatization literature. Somatization prevalence was found to be 0.2% to 2 % for females and 0.2% for males (APA, 2000). The results of the independent T-tests revealed that *gender* was not associated with somatization. Some studies on adults showed that females have more somatic symptoms than males (Sağduyu et al., 1997; Tamada, 2005; Karslı, 2008). Besides, in adolescence, females have found to have more somatic symptoms than males (Vulić-Prtorić, 2016; Eray et al., 2015; Lieb et al., 2002). It

is important to add that even gender was not associated with somatization in the current study, the mean of the female scores was bigger than males, but the difference was not significant. For this, problems with the homogeneity of the sample might play an important role. Future studies should have equal representations of gender in their samples.

Some studies imply additional knowledge for the different stages of the adolescence periods. Until adolescence, the prevalence rate is almost similar between girls and boys, but following years in adolescence, with puberty girls show more psychosomatic complaints (Schulte & Petermann, 2011; Yavuz et al., 2018). Females have more problems with their body image and somatic preoccupations (Güvenç & Aktaş, 2006; Steinberg, 2007; Oktan & Şahin, 2010). In adolescence, attention is directed to the body, and female adolescents are busy with how they are looked. They are more sensitive to bodily signals at this period and try to make a meaning about bodily changes. This might lead to more somatic symptoms in adolescence. Insignificant differences between genders on the level of somatization might be explained by reversing the trend of puberty, decreasing the somatization level of girls, in the late adolescence period in Turkey. In addition to this, in Turkish culture, expressing anger is acceptable for males but not for females. Expression of sadness, weakness, or a way of discharging, which is crying, is not accepted. So, males also might have a problem expressing their emotions freely and thus in a somatic way.

In the time of transition from adolescence to adulthood, problems of reaching to a good university, finding a job and a new partner, gaining money and other inherent factors might lead to somatization late adolescent males more than females since still Turkey as a patriarchal society, and males are expected to gain money as breadwinners (Parman, 2005; Engin & Pals, 2018). Families might have more expectations from males for economic gains. This situation might create specific stress for males. Besides, insufficient emotion regulation strategies might increase

the prevalence of males in the late adolescence period. Males use sadness inhibition as an emotion regulation strategy, and this makes them prone to somatic symptoms (Özden, 2015). In traditional societies, females generally 112 cannot decide about their bodies, and their autonomy is limited (Gökalp, 2003). On the other hand, traditional gender roles, gender inequality, and social stressors are changing in Turkey, and even there is still a gap between genders, there is an increasing trend on the way of gender equality including education (Aktaş et al., 2019). In addition to this, in this sample, most of the individuals are university students (75%), and most of them were females (76%), so there are no significant differences in education, social status, and facilities. This might decrease the somatization level of females. In the literature, the dynamic behind gender equality on the level of somatization was not well found before, so it is difficult to indicate possible dynamics.

4.2.1. GENDER AND NARCISSISM

Based on the existing literature, additional analyses for the effect of gender on *narcissism subtypes* were carried, and significant results were found. According to Levy et al. (2007), the *Grandiose* phenotype represents stereotypical male narcissist, while the *vulnerable* phenotype represents a stereotypical female narcissist. According to DSM-V (APA, 2013) 50%-75% of the patients are male, and as it was discussed, DSM-V represents grandiose narcissism of Kernberg (1975, 2004). In this study, the prevalence of grandiose narcissistic traits was higher for males. Various studies supported the findings that grandiose narcissism is more common in males than females (Otway & Vignoles, 2006; Grijalva et al., 2015). Similarly, supporting the findings of the current study, a vulnerable phenotype is commonly seen in women (Mechanic & Barry, 2015; Peker & Aydın, 2016). In the adolescence period, females might be more prone to vulnerable narcissistic traits,

because they may have more problems with their body image that might lead to self-esteem problems and shame (Güvenç & Aktaş, 2006; Steinberg, 2007; Oktan & Şahin, 2010). As it was shown in the literature, aggression is related to grandiose subtype (Smolewska & Dion, 2005; Tangney et al., 2011). Grandiose narcissism has been stated to derive from investment to grandiose self rather than omnipotent object, and vulnerable narcissism derives from investment to omnipotent object rather than grandiose self (Grijalva et al., 2015). Therefore, in males, grandiosity might be satisfied through "the grandiosity of the self" and for females through "the perfection of the idealized objects" (Masterson, 1993, 2000).

Societal factors might be affecting the presentations of the gender phenotype. In patriarchal societies such as Turkey, independent, aggressive, exploitative, entitlement, arrogance, authoritativeness, manipulativeness are the stereotypical traits of men and "need for admiration from others, reactive anger and shame are stereotypical traits of women (Wink, 1991; Kernberg, 2004; Glover et al., 2012; Giddens, 2012). Besides, man needs to be stronger in patriarchal societies like Turkey. In addition to this, aggression is acceptable for males, but not for females. Females were more criticized due to aggressive reactions and repressed in male-dominant cultures, like Turkey. Thus, the findings of the current study supported the importance of societal pressures on gender that might change the presentations of narcissism in different cultures.

4.3. MEDIATION ANALYSIS

The third aim of this study was to examine the possible role of hipomentalization on the link between vulnerable narcissistic traits and somatization in late adolescents. The impact of vulnerable narcissistic traits on the

level of psychosomatic complaints would be mediated by hypomentalization was proposed as the 5th Hypothesis.

The results indicated a partial mediational role of hipomentalization on the link between vulnerable narcissistic traits and somatization in late adolescence. These findings are compatible with the existing theoretical literature. Rodin (1991) considers somatization as an expression of the disturbances in the cohesion of the self and as a defense for self-esteem dysregulation and fear of fragmentation. Bodily preoccupations are the appearance of the fragmentation and disintegration threat. These results were supported by the theoretical background of self-psychology, Kohutian vulnerable narcissistic self, and somatization emergence (Kohut, 1971, 1977). In addition to narcissism and somatization relationships, mentalization is related to somatization. Mentalization is a protective factor and used in the treatment of psychosomatic symptoms (Smadja, 2011; Aisenstein & de Aisemberg, 2010; Marty; Aydoğan, 2018; Ballespí et al., 2019). Mental representations of the affects, linking affects to words, and symbols create a way of mental discharge rather than somatic discharge and expression (Gubb, 2013). Concrete thinking and operational thinking as a form of hypomentalizing, are also responsible for psychosomatic disorders. Hypomentalizing is associated with inadequacy and severe difficulty of understanding and predicting the mind of self or others (Fonagy, et al.,2016). Rickles (1986) proposed the role of narcissism and alexithymia in somatization. He suggested that alexithymia and narcissism, both have a common etiology, a disturbance of self and causes somatization. Besides, for Krystal (1998) narcissism leads to somatization by interfering with mentalization and emotion regulation mechanisms. In other words, rather than the direct effect of the narcissism, somatization is mediated by mentalization impairments on narcissistic individuals. So, if a late adolescent has vulnerable narcissistic traits and hypomentalization, s/he probably will have more psychosomatic complaints.

In summary, this is a unique study that investigated the associations of three constructs, metallization, narcissism, and somatization. The results provided a preliminary basis and contributed to the understanding of somatization problems in Turkish adolescents.

4.4. CLINICAL IMPLICATIONS

The outcome of the present study supported the Kohutian vulnerable narcissistic phenotype is a predictor of somatization (Kohut, 1971, 1977; Rickles, 1986; Rodin, 1991; Krystal, 1998). The Kernbergian grandiose narcissistic phenotype (Kernberg, 1975, 20049, however, was not found to be a predictor of somatization in this study. In addition to this, vulnerable narcissism was found to be the strongest predictor of somatization.

Kohut and Kernberg's proposed different psychotherapy techniques for narcissism treatment. Kernberg suggested that confrontation of the grandiosity and interpretation of the defenses against envy will be necessary for the treatment of these patients (Kernberg, 1975). Kohut, however, indicated that the acceptance of selfobject needs of the narcissistic client and being emphatic with their subjective experiences, by accepting both idealization and devaluation, will be helpful in the treatment process (Kohut, 1971, 1977). Therefore, when psychotherapists work with somatic patients, they should be aware of possible underlying personality dynamics, self-disturbance, and signs of vulnerable narcissism. Self-psychology encourages therapists for being empathic, responsive, and supportive of the sense of self of their clients. For this reason, it would be important for clinicians to be open to the subjective experiences of their clients. The self-object experience will contribute to the capacity for autonomous self-regulation and the integration of affective experiences. According to Krystal (1979), psychodynamic psychotherapy

should begin with increasing the mentalization capacity of the clients, through verbalizing and affect regulation rather than unconscious exploration. New studies on somatization and mentalization also supported the suggestions of Krystal (Skårderud, 2007). The therapist should be empathic to mirroring, idealizing, and twinship self-object needs of the clients and help to maintain the ruptured development due to unmet needs from parents. So, the therapists should not interpret the deep unconscious materials and defenses but should be more understanding and mirroring the "perfectness" of the client. Idealizing transference might not be interpreted until the client does not need it (Kohut, 1971, 1977). Thus, if clients have vulnerable narcissistic traits, clinicians might benefit better from the Kohutian approach (Kohut, 1971, 1977).

It was demonstrated that when narcissistic trait decreases, somatization also decreases, and quality of life and positive mood increases (Daig et al., 2009). In therapy with psychosomatic patients, narcissistic resistance is frequently seen in thin-skin narcissism (Yasky et al., 2013). Narcissistic transference, resistance to transference, or the self-object transference (Kohut, 1977) frequently appear and make the psychotherapy process even more difficult (Lefebvre, 1980; Krystal, 1998; Marty, 2010; Aisenstein & Smadja, 2010b; Yasky et al., 2013). Especially Lefebvre (1980) and Marty (2010) emphasize the importance of working with narcissistic transference and narcissistic traits to treat psychosomatic patients. In short, the therapists should give attention to transference and countertransference to understand their clients and find appropriate treatment strategies.

The results showed that hipomentalization is an important mediator between vulnerable narcissism and somatization. Therefore, the therapist first should aim to increase the mentalization capacity to reduce their clients' somatic symptoms and to benefit from therapy (Skårderud, 2007). Mentalization-Based Treatment for Adolescence (MBT-A) is suggested to be helpful for somatic clients with vulnerable narcissistic features, (Rossouw & Fonagy, 2012; Bleiberg & Rossouw,

2012; Bleiberg, 2013; Fonagy et al., 2014; Beck at et., 2016). The mentalization-based treatment aims to develop mentalization capacity in their clients by helping them to create self and object representations. A mentalizing therapist helps his/her client to take a reflective stance. As a result, the client became curious about their mental states, mind, and body associations, reflecting of experience and affects rather than using the body as a way of expressing (Gubb, 2013). When reflective functioning and putting into words trough symbolization increases, somatic expression of clients decreases (Gubb, 2013; Kohutis, 2010).

Mentalization deficits might be a result rather than the reason for functional somatic disorder in lots of patients or exacerbated. Therefore, the treatment of mentalization capacity is an effective intervention (Luyten et al., 2012; Luyten et al., 2013). Even more structured short-term psychodynamic psychotherapies found effective on functional somatic patients (Abbass et al., 2009). Therefore, these treatment modalities might be promising on psychotherapy of late adolescence with psychosomatic complaints.

4.5. THE LIMITATIONS AND FUTURE RESEARCH

The results of this study provided evidence for the associations of somatization with vulnerable narcissism and hipomentalization, however, there were some inherent limitations. One of the major drawbacks of the present study was the gender representations of the sample. There was an important difference between adolescents regarding gender; 81.2% of the participants were female, while 18.4% were male. In the convenient sampling and online survey used in this study, late adolescent females participated more than the males. In future research, it would be better to balance the representations of both genders.

The late adolescence period has a new specific age range, as it was discussed in the literature (Jaworska & MacQueen, 2015; Sawyer et al., 2018; McDonagh et al., 2018). Since there were no scales that had Turkish norms for adolescents between 18-24 ages, this study used adult scales. New scales for late Turkish adolescence should be developed and used in further studies.

The cross-sectional design of this study is chosen due to pragmatic reasons. However, it is also considered as a limitation. In the future, longitudinal studies might help to cause-effect attributions in the associations between measures. Longitudinal studies might also allow the examination of the developmental trajectory in somatization, mentalization, as well as narcissism. The adolescence period brings some inherent narcissistic preoccupations; however, there is no measure to control the influence of adolescence on narcissistic scores. In addition, there is not enough research on how these narcissistic preoccupations changed with age. Future researchers might try to examine the effect of developmental changes on narcissism. Mentalization and somatization were measured at one point in time, but these are not static constructs. Somatization might be increased, when emotional crises experienced, and level of stress increased. This study, however, was not able to control the fluctuations in the mentalization and somatization scores within different time frames. It is therefore, possible to miss some of the somatizers, while some people in crises might have exacerbated scores on somatization. The results also needed to be replicated within clinical samples since this study sample was non-clinical late adolescents.

Somatic complaints of the mothers were found as a significant predictor of somatization. In a study on undergraduate students and somatization, it was indicated that somatic complaints of the mothers were more important than insufficient emotion regulation strategies (Özden, 2015). The results show the importance of examining parents, especially maternal somatic complaints in future studies. The intergenerational transmission of somatic complaints of Turkish

adolescents should also be investigated by researchers. A possible link between genetic transmission of somatization from parents to children should be examined in future studies.

Non-verbal expressions are very important in human psychology. In the future, non-verbal implicit methods might be used for both reflective functioning and narcissistic personality subtypes. Since narcissistic people do not report some feelings such as shame (Jordan et al., 2003), the use of non-verbal measures might help researchers for a better understanding of psychological problems.

The current study found that vulnerable narcissism, hipomentalization, perceived trauma history, somatic complaints of the mother, and age are important predictors of somatization. However, the hierarchical regression model only explained 20% of somatization scores. Thus, a large number of variance left unexplored. New studies might add some possible variables such as anxiety, depression, state and trait stress, trauma to explore more variances on somatization. Psychotherapy experience (short and long term) and psychiatric treatment experience might be controlled in future studies.

The use of mixed methods, quantitative and qualitative, might be better to understand the nature of the somatization and its predictors. Perceived trauma history was one of the strongest predictors of somatization. Therefore, in future research, perceived trauma history could be examined in-depth.

The findings of the current study supported the importance of societal pressures on gender that might change the presentations of narcissism in different cultures. Future research might research presentations of narcissism and cultural effects with a different sample. Besides, the reasons for these findings might be studied to comprehend in-depth.

To design treatment models, mental health workers might use scales and projective tests to better understand somatization, mentalization, and narcissism

problems in late adolescents. Although self-report scales contribute to reaching a larger number of individuals, it fails to understand various aspects of human psychology like the unconscious. Mentalization is generally occurred as an automatic response, unaware rather than conscious (Fonagy et al., 2016). Mentalization deficits, therefore, might be measured with projective tests to understand the symbolic internal world, operational thinking, dreams, and metaphors. Thus, an examination of the relationship between trauma and somatization is needed with reliable and valid scales. Both early and current traumas and other traumas should be measured with reliable and valid scales. Early periods of traumas might not be revealed in objective self-report scales, so projective tests such as the Rorschach (Exner, 1991) with Turkish adolescents' norms (İkiz, 2007) might be given in future studies.

CONCLUSION

The current research is the first study that investigated the association between vulnerable narcissistic traits and somatization and mediating effects of the mentalization deficits on this relationship in Turkish late adolescents. This study demonstrated that vulnerable narcissism and hypomentalization were important in the understanding of somatic complaints in late adolescence. Moreover, somatic complaints of the mother, perceived trauma history, and lower age were found to be risk factors for somatization. The findings of this study provided preliminary findings for clinicians who are working with Turkish adolescents with somatization problems. Recommendations for future research will contribute researchers who are aiming to understand the etiology and treatment of psychosomatic complaints.

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APPENDICES

APPENDIX A: Informed Consent Form

Bilgilendirilmiş Onam Formu

Sayın Katılımcı,

Bu araştırma İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı Çocuk-Ergen Alt Dalı öğrencisi Yasin Gürkan tarafından Dr. Öğr. Üyesi Elif Akdağ Göçek danışmanlığında "Kendimiz ve Başkalarıyla İlgili Düşünme Biçimlerinin, Gençlik Döneminde Kişilik Özellikleri ile Somatizasyon İlişkisindeki Rolü" 'nün incelenmesi amacıyla, yüksek lisans tez çalışması kapsamında yürütülmektedir. Araştırmaya 18-24 yaş arası bireyler katılabilmektedir ve araştırmaya katılım tamamen gönüllülük esasına dayanmaktadır. Araştırmanın herhangi bir noktasında hiçbir gerekçe belirtmeden anketi doldurmayı bırakabilirsiniz. Soruları yanıtlamanın katılımcı üzerinde herhangi bir olumsuz etkisi olması beklenmemektedir. Bu çalışmanın hiçbir aşamasında kimlik bilgileriniz sorulmayacaktır. Sorulara vereceğiniz yanıtlar araştırmacılar dışında kimseyle paylaşılmayacaktır. Veriler toplu halde değerlendirilerek yalnızca bilimsel yayın amacıyla kullanılacaktır. Çalışmanın amacına ulaşması için sizden beklenen, tüm soruları eksiksiz ve içtenlikle cevaplamanızdır. Soruları tamamlamanız yaklaşık 15-20 dakika sürmektedir.Araştırmaya yönelik herhangi bir sorunuz olması halinde Yasin Gürkan (yasin.gurkan@bilgiedu.net) ile e-mail aracılığıyla iletişime geçebilirsiniz.

☐ Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesebileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

APPENDIX B: Somatization Scale (SS)

Somatizasyon Ölçeği

Bu formda sıra ile numaralandırmış bazı sorular bulacaksınız. Her soruyu okuyarak kendi durumunuza göre **DOĞRU** ya da **YANLIŞ** olup olmadığına karar verin. Bu soruları sadece kendinizi düşünerek yanıtlayın.

Bu sorular birbirinin aynısı ya da tam tersi gibi gelebilir. Mümkünse bütün soruları cevaplandırmaya çalışın.

1. Çoğu zaman boğazım tıkanır gibi olur.	Doğru	Yanlış
2. İştahım iyidir.	Doğru	Yanlış
3. Başım pek az ağrır.	Doğru	Yanlış
4. Ayda bir iki defa ishal olurum.	Doğru	Yanlış
5. Midemden oldukça rahatsızım.	Doğru	Yanlış
6. Çoğu kez midem ekşir.	Doğru	Yanlış
7. Bazen utanınca çok terlerim.	Doğru	Yanlış
8. Sağlığım beni pek kaygılandırmaz.	Doğru	Yanlış
9. Hemen hemen hiçbir ağrım ve sızım yoktur.	Doğru	Yanlış
10. Bazen başımda sızı hissederim.	Doğru	Yanlış
11. Çoğu zaman başımın her tarafı ağrır.	Doğru	Yanlış
12. Sağlığım birçok arkadaşımınki kadar iyidir.	Doğru	Yanlış
13. Pek seyrek kabız olurum.	Doğru	Yanlış
14. Ensemde nadiren ağrı hissederim	Doğru	Yanlış
15. Vücudumda pek az seğirme ve kasılma olur.	Doğru	Yanlış
16. Çabucak yorulmam.	Doğru	Yanlış
17. Pek az başım döner ya da hiç dönmez.	Doğru	Yanlış
18. Yürürken dengemi hemen hemen hiç kaybetmem.	Doğru	Yanlış

19. Soğuk günlerde bile kolayca terlerim.	Doğru	Yanlış
20. Çoğu zaman yorgunluk hissederim.	Doğru	Yanlış
21. Hemen her gün mide ağrılarından rahatsız olurum.	Doğru	Yanlış
22. Tekrarlanan mide bulantısı ve kusmalar bana rahatsızlık verir.	Doğru	Yanlış
23. Çoğu zaman bütün vücudumda bir halsizlik duyarım.	Doğru	Yanlış
24. Son birkaç yıl içinde sağlığım çoğu zaman iyiydi.	Doğru	Yanlış
25. Çoğu defa sabahları dinç ve dinlemiş uyanırım.	Doğru	Yanlış
26. Çoğu zaman bana kafam şişmiş ya da burnum tıkanmış gibi gelir.	Doğru	Yanlış
27. Çoğu zaman balım sıkı bir çember içindeymiş gibi hissederim.	Doğru	Yanlış
28. Kalp ve göğüs ağrılarından hemen hemen hiç şikayetim yoktur.	Doğru	Yanlış
29.Hayatımda hiçbir zaman kendimi şimdiki kadar İyi hissetmedim.	Doğru	Yanlış
30. Kalbimin hızlı çarptığını hemen hemen hiç hissetmem ve çok seyrek nefesim tıkanır.	Doğru	Yanlış
31. Hiç felç geçirmedim ya da kaslarımda olağanüstü bir halsizlik duymadım.	Doğru	Yanlış
32. Ortada hiçbir neden yokken haftada bir ya da daha sık birdenbire her yanımı ateş basar.	Doğru	Yanlış
33. Vücudumun bazı yerlerinde çok defa yanma, gıdıklanma, karıncalanma ve uyuşukluk hissederim.	Doğru	Yanlış

APPENDIX C: Five Factor Narcissism Scale- Short Form (FFNI-SF)

Beş Faktör Narsisizm Ölçeği-Kısa Form

Değerli Katılımcı,

Bu ölçek 60 maddeden oluşmaktadır. Her bir madde 1 ile 5 arası puanlanmaktadır. Lütfen her bir maddeyi dikkatlice okuyunuz ve sizi en iyi tanımlayan seçeneği işaretleyiniz. Doğru ya da yanlış cevap yoktur. Sizden beklenen içtenlikle cevap vererek bilimsel bir çalışmaya yardımcı olmanız. Lütfen bütün sorularla ilgili görüşlerinizi ifade ediniz.

	Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum
1. Aşırı hırslı biriyimdir.	①	②	③	④	⑤
2. Başkaları çok övündüğümü söylerler ama söylediğim her şey doğrudur.	①	②	③	④	⑤
3. Liderlik yapmak benim için kolaydır.	①	②	③	④	⑤
4. Birileri bana iyilik yaptığında, acaba benden ne istiyorlar diye merak ederim.	①	②	③	④	⑤
5. Özel muamele görmeyi hak ediyorum.	①	②	③	④	⑤
6. Başkalarını eğlendirmekten büyük zevk alırım.	①	②	③	④	⑤
7. İlerlemek için insanlardan yararlanmak iyi bir şeydir.	①	②	③	④	⑤
8. Sıklıkla ünlü olmak ile ilgili hayaller kurarım.	①	②	③	④	⑤
9. İnsanlar beni yargıladığında, bunu hiç umursamam.	①	②	③	④	⑤
10. Başkalarının ihtiyaçlarını konusunda kaygılanmam	①	②	③	④	⑤
11. İnsanları manipüle etmede /kullanmada oldukça iyiyimdir.	①	②	③	④	⑤

12. Kendimden emin olmak için sık sık başkalarının iltifatlarına ihtiyacın varmış gibi hissederim.	①	②	③	④	⑤
13. Eleştirilmekten, o kadar nefret ederim ki, olduğunda öfkemi kontrol edemem.	①	②	③	④	⑤
14. Bir şeyde başarısız olduğumu fark ettiğimde kendimi küçük düşmüş hissederim.	①	②	③	④	⑤
15. Heyecan duymak için neredeyse her şeyi deneyebilirim.	①	②	③	④	⑤
16. Başarılı olmak için inanılmaz bir motivasyonuna sahibim.	①	②	③	④	⑤
17. Sadece kendi ayarımdaki insanlarla ilişki kurarım.	①	②	③	④	⑤
18. Otorite pozisyonu alma konusunda kendimi rahat hissederim.	①	②	③	④	⑤
19. Diğer insanların bana karşı dürüst olacaklarına inanırım.	①	②	③	④	⑤
20. Kuralların başkaları için geçerli olduğu kadar benim için geçerli olduğunu düşünmüyorum.	①	②	③	④	⑤
21. Başkaları tarafından fark edilmekten hoşlanırım.	①	②	③	④	⑤
22. Kendi ilerlemem için insanları birer araç olarak kullanırım.	①	②	③	④	⑤
23. Sık sık çok başarılı ve güçlü olacağıma dair hayaller kurarım.	①	②	③	④	⑤
24. Başkalarının benim hakkımda ne düşündüğü gerçekten umursamam.	①	②	③	④	⑤
25. Başkalarının dertlerini genelde fazla ilgi göstermem.	①	②	③	④	⑤
26. İnsanları bir şeyler yaptırmak için yönlendirebilirim.	①	②	③	④	⑤
27. Benlik duygum istikrarlıdır.	①	②	③	④	⑤
28. Doğru muamele görmediğimde aşırı öfkelendiğim zamanlar olmuştur.	①	②	③	④	⑤
29. Başkalarının önünde küçük düşürüldüğümde berbat hissederim.	①	②	③	④	⑤
30. Gözü pek biriyimdir.	①	②	③	④	⑤

31. Büyük biri olmayı arzularım. ① ② ③ ④ ⑤

32. Benden daha aşağı kişilerle takılarak zamanımı boşa harcamam. ① ② ③ ④ ⑤

33. İnsanlar genellikle benim liderliğimi ve otoritemi takip ederler. ① ② ③ ④ ⑤

34. İnsanlara güvenme konusunda temkinliyimdir ① ② ③ ④ ⑤

35. Adaletsiz gibi gözükebilir ancak ihtimam, imtiyaz ve ödül gibi ayrıcalıkları hak ediyorum. ① ② ③ ④ ⑤

36. Bir parti ya da toplantıda en popüler kişi olmaktan hoşlanırım. ① ② ③ ④ ⑤

37. Başarıya ulaşmak için bazen diğer insanları kullanmanız gerekir. ① ② ③ ④ ⑤

38. Başarısıyla tanınmış biri olmayı nadiren hayal ederim. ① ② ③ ④ ⑤

39. Başkalarının eleştirilerine karşı oldukça kayıtsızımdır. ① ② ③ ④ ⑤

40. Sempati duygum zayıftır ① ② ③ ④ ⑤

41. Eninde sonunda benim dediğim olur. ① ② ③ ④ ⑤

42. Hayatta yeterince başarıya ulaşıp ulaşamayacağım hakkında kendimi oldukça güvensiz hissederim. ① ② ③ ④ ⑤

43. Hak ettiğim şeyi alamamak beni gerçekten çok öfkelendirir. ① ② ③ ④ ⑤

44. İnsanlar beni yargıladığında utanırım. ① ② ③ ④ ⑤

45. Heyecan verici bir şey yapmak için yaralanmayı göze alabilirim. ① ② ③ ④ ⑤

46. Başarılı olmaya motiveyimdir. ① ② ③ ④ ⑤

47. Üstün bir insanım. ① ② ③ ④ ⑤

48. Çoğu durumda sorumluluk almaya eğilimliyimdir. ① ② ③ ④ ⑤

49. Sık sık diğerlerinin bana gerçeğin tamamını söylemediğini düşünürüm. ① ② ③ ④ ⑤

50. Özel muamele görmeyi hak ettiğime inanırım. ① ② ③ ④ ⑤

51. İnsanları eğlendirmeye bayılırım.	①	②	③	④	⑤
52. Kendi hedeflerime ulaşmada diğerlerini kullanmaya istekliyimdir	①	②	③	④	⑤
53. Bir gün benim adımı insanların çoğunun bileceğine inanıyorum.	①	②	③	④	⑤
54. Başkalarının benim hakkımdaki görüşlerini çok az umurumdadır	①	②	③	④	⑤
55. Başkalarının acıları beni üzmez.	①	②	③	④	⑤
56. İnsanlara istediklerimi yaptırmam kolaydır.	①	②	③	④	⑤
57. Keşke başkalarının benim hakkımdaki düşüncelerini bu kadar umurumda olmasaydı	①	②	③	④	⑤
58. İnsanlar bana saygısızlık ettiğinde tepem atar.	①	②	③	④	⑤
59. Başkalarının önünde bir hata yaparsam kendimi aptal gibi hissederim.	①	②	③	④	⑤
60. Riskli ya da tehlikeli şeyler yapmaktan hoşlanırım.	①	②	③	④	⑤

APPENDIX D: Reflective Functioning Scale-54 (RFQ-54)

REFLECTIVE FUNCTIONING (YANSITICI İŞLEYİŞ) ÖLÇEĞİ

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

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

Kesinlikle Katılmıyorum	1	2	3	4	5	6	7	Kesinlikle 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 zihnimdeki 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 etkileyebilir.

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 hissederim.

40. ___Eğer güvensiz hissedersem, 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 E: Demographic Information Form

Demografik Bilgi Formu

A. Kişisel Bilgiler

1. Yaş

18	19	20	21	22	23	24

2. Cinsiyet

Erkek	Kadın	Diğer

3. Öğrenciliğiniz devam ediyor mu?

Evet	Hayır

3.1. Eğer varsa halen devam ettiğiniz üniversite ve sınıfınız?

Önlisans
Lisans
Yüksek Lisans
Doktora

3.2.Okuduğunuz bölüm?

4. Kendinizi aşağıdaki gelir seviyelerinden hangisinde değerlendirirsiniz?

Alt
Alt-Orta
Orta
Orta-Üst

Üst

5. Şimdiye kadar hiç sizi derinden etkilediğini düşündüğünüz bir travmatik bir olay yaşadınız mı? (Örneğin; Tanık olunan veya maruz kalınan doğal afetler, kazalar, taciz/tecavüz, işkence, sevilen/yakın olunan birinin kaybı, ait hissedilen bir yerin kaybı, aile içi/dışı şiddete maruz kalma ya da maruz kalma, savaş, terör, vb.)

Evet	Hayır

6. Tanı almış herhangi bir sağlık probleminiz var mı? Varsa açıklayınız.

Evet (Açıklayınız):	Hayır

6.a. Bu sağlık problemiyle ilgili tedavi alıyor musunuz?

Evet	Hayır

6.b. Bu sağlık probleminiz günlük hayatınızı ne kadar şiddette etkiliyor?

Hiç Tamamen

1	2	3	4	5	6	7

7. Psikolojik/psikiyatrik bir hastalığınız/şikayetiniz var mı veya daha önce geçirdiniz mi?

Evet	Hayır

7.a. Evet ise, lütfen belirtin?

7.b. Evet ise, bu psikolojik/psikiyatrik bir hastalığınız/şikayetinizin hayatınızı ne oranda etkilediğini aşağıdaki tabloya göre değerlendiriniz.

Hiç Tamamen

1	**2**	**3**	**4**	**5**	**6**	**7**

7.c. Evet ise, bu konuda psikolojik/psikiyatrik bir yardım alıyor musunuz/ aldınız mı?

Evet	Hayır

8. Gündelik hayatınızda 1 stressiz ve 7 çok stresli olmak üzere stres düzeyinizi hangi seviyede değerlendirirsiniz?

Stressiz Çok Stresli

1	2	3	4	5	6	7

9. Gündelik hayatınızda 1 depresif durumun olmadığı ve 7 çok depresif olunduğu durumu tanımlamak üzere depresyon düzeyinizi hangi seviyede değerlendirirsiniz?

Hiç Depresif Değil Çok Depresif

1	2	3	4	5	6	7

10. Gündelik hayatınızda 1 anksiyetesiz (kaygısız) ve 7 çok anksiyeteli (kaygılı) olmak üzere genel anksiyete (kaygı) düzeyinizi hangi seviyede değerlendirirsiniz?

Kaygısız Çok Kaygılı

1	2	3	4	5	6	7

B. Aile Bilgileri

1. Anneniz sağ mı?

Evet	Hayır

1.1. Evet ise annenizin yaşı:

1.2. Evet ise annenizin eğitim durumu:

İlkokul	Ortaokul	Lise	Önlisans	Lisans	Yüksek Lisans	Doktora	Diğer

1.3. Evet ise annenizin bilinen bir sağlık sorunu var mı?

Evet	Hayır

1.4.Anneniz siz çocukluk ve gençlik yıllarındayken fiziksel sorunlardan (baş ağrısı, mide ağrısı, halsizlik, kalp çarpıntısı, uyuşma gibi) ne düzeyde şikayet ederdi? 1 hiç ve 7 sürekli olmak üzere derecelendirin.

Hiç Sürekli

1	2	3	4	5	6	7

2. Babanız sağ mı?

Evet	Hayır

2.1. Evet ise babanızın yaşı:

2.2. Evet ise babanızın eğitim durumu:

İlkokul	Ortaokul	Lise	Önlisans	Lisans	Yüksek Lisans	Doktora	Diğer

2.3. Evet ise babanızın bilinen bir sağlık sorunu var mı?

Evet	Hayır

2.4.Babanız siz çocukluk ve gençlik yıllarındayken fiziksel sorunlardan (baş ağrısı, mide ağrısı, halsizlik, kalp çarpıntısı, uyuşma gibi) ne düzeyde şikayet ederdi? 1 hiç ve 7 sürekli olmak üzere derecelendirin.

Hiç Sürekli

1	2	3	4	5	6	7

ETİK KURUL DEĞERLENDİRME SONUCU/RESULT OF EVALUATION BY THE ETHICS COMMITTEE

(Bu bölüm İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurul tarafından doldurulacaktır /This section to be completed by the Committee on Ethics in research on Humans)

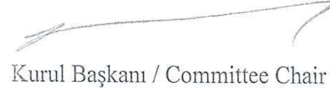
Başvuru Sahibi / Applicant: Yasin Gürkan

Proje Başlığı / Project Title: The Exploration of the Role of Mentalization on the Relationship between Narcissistic Traits and Psychosomatic Complaints in Late Adolescence

Proje No. / Project Number: 2020- 20024-46

1.	Herhangi bir değişikliğe gerek yoktur / There is no need for revision	XX
2.	Ret/ Application Rejected Reddin gerekçesi / Reason for Rejection	

Değerlendirme Tarihi / Date of Evaluation: 20 Şubat 2020



Kurul Başkanı / Committee Chair

Doç. Dr. Itır Erhart

Üye / Committee Member

Prof. Dr. Aslı Tunç (izinli)

Üye / Committee Member

Prof. Dr. Turgut Tarhanlı

Üye / Committee Member

Prof. Dr. Hale Bolak Boratav

Üye / Committee Member

Prof. Dr. Koray Akay