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THE RELATIONSHIP OF PSYCHOSOMATIC SKIN REACTIONS WITH SEPARATION-INDIVIDUATION AND MENTALIZATION

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Psikosomatik Deri Reaksiyonlarının Ayrışma- Bireyleşme ve Mentalizasyon ile İlişkisi

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Abstract

The overall purpose of the study is to predict psychosomatic skin reactions. In addition, the relationship of psychosomatic skin reactions with separation-individuation, mentalization capacity, gender and traumatic experience is investigated.

The research was carried out with a survey package presented through an online survey link. Through snowball sampling, a total of 672 participants were included in the study. In the survey package, the Informed Consent Form, the Demographic Information Form, the Separation-Individuation Inventory (SII), the Reflective Functioning Questionnaire (RFQ-54) were used respectively.

It has been hypothesized that individuals who have more separation-individuation related issues are expected to have more psychosomatic skin reactions. Moreover, it was also expected that the level of psychosomatic skin reactions would be positively associated with the two dimensions of the impaired mentalization capacity; Hypermentalization (being too certain about the mental states of self and others) and Hypomentalization (being too uncertain about the mental states of self and others). The study also hypothesized that women and individuals with trauma history would have higher levels of psychosomatic skin reactions.

In order to measure psychosomatic skin reactions, three variables as skin related symptom number, intensity of these symptoms and skin related diagnosis were used. A composite score was generated by multiplying the number of skin related symptoms with the intensity of the symptoms in order to effectively establish the overall skin related disturbance level that participants experience.

The results of the study showed that individuals who had more difficulties in separation-individuation had higher scores of composite skin disturbance. Further, Hypermentalization, as an indicator of impaired mentalization capacity, was found to be positively correlated with the number of skin related diagnoses. It was also observed that women showed a higher level of psychosomatic skin reactions in terms of both the composite skin disturbance level and number of skin

diagnoses as compared to men. Individuals with a history of trauma were also observed to have a higher level of psychosomatic skin reactions in terms of both the composite skin disturbance level and number of skin diagnoses, as compared to individuals with no trauma history.

In terms of predicting psychosomatic skin reactions, traumatic experience, being a female, difficulties in separation-individuation, being in a relationship and age were found to predict the composite skin disturbance respectively. In terms of the number of skin related diagnoses, age, being a female, trauma history, being in a relationship, Hypermentalization and difficulties in separation-individuation were observed to be the predictors respectively.

Keywords: Psychosomatic skin reactions, composite skin disturbance, number of skin diagnoses, separation-individuation, hypermentalization, hypomentalization

Özet

Bu çalışmanın temel amacı psikosomatik deri reaksiyonlarının yordanmasıdır. Ayrıca, çalışmada psikosomatik deri reaksiyonlarının ayrışma-bireyleşme, zihinselleştirme kapasitesi, cinsiyet ve travma yaşantısı ile ilişkisi incelenmektedir.

Kartopu örneklemiyle ulaşılan 672 katılımcı internet üzerinden yaygınlaştırılan anket paketini doldurarak araştırmaya dahil olmuşlardır. Anket paketi sırasıyla, Bilgilendirilmiş Onam Formu, Demografik Bilgi Formu, Ayrışma-Bireyleşme Envanteri (SII), Yansıtıcı İşleyiş Ölçeği (RFQ-54)'nden oluşmaktadır.

Ayrışma-bireyleşme açısından daha fazla zorluk yaşayan bireylerin daha yüksek düzeyde psikosomatik deri reaksiyonları olacağı hipotezi ileri sürülmüştür. Bununla beraber, psikosomatik deri reaksiyonlarının, zihinselleştirme kapasitesindeki yetersizlikleri işaret eden iki alt boyut olarak 'kesinlik' (hipermentalizasyon) ve 'belirsizlik' (hypomentalizasyon) ile pozitif yönlü bir ilişkide olacağı beklenmiştir. Çalışmada ayrıca, kadınların ve travma yaşantısı olanların psikosomatik deri reaksiyonu düzeylerinin daha yüksek olacağı öngörülmüştür.

Bireylerin deri ile ilgili yakınmaları Demografik Bilgi Formunda araştırılmıştır. Psikosomatik deri reaksiyonları, deri ile ilişkili semptomların sayısı, bu semptomların şiddeti ve deri ile ilişkili tanı sayısı olarak üç değişkenle ölçülmüştür. Bireylerin ne düzeyde deri ile ilgili problem yaşadıklarını daha kapsamlı ele alabilmek adına, semptom sayısı ve şiddetinin çarpımından oluşan bileşik deri rahatsızlığı skoru elde edilmiştir.

Çalışmanın bulguları daha yüksek bileşik deri rahatsızlığı skoru alan bireylerin ayrışma bireyleşmede daha fazla sorun yaşadıklarını ortaya koymuştur. Ayrıca, zihinselleştirmedeki zayıflığın göstergesi olan Hipermentalizasyonun, deri ile ilişkili tanı sayısı ile pozitif bir ilişkide olduğu bulunmuştur. Bunlarla beraber, kadınların erkeklere kıyasla hem bileşik deri rahatsızlığı hem de deri ile ilişkili tanı sayısı açısından daha yüksek psikosomatik deri reaksiyon düzeyi gösterdikleri görülmüştür. Ayrıca, travma yaşantısı olan bireylerin olmayanlara kıyasla hem

bileşik deri rahatsızlığı hem de deri ile ilişkili tanı sayısı açısından daha yüksek psikosomatik deri reaksiyon düzeyleri olduğu bulunmuştur.

Psikosomatik deri reaksiyonlarının yordanması açısından bakıldığında ise, bileşik deri rahatsızlığı skorunu sırasıyla travmatik yaşantı, kadın olmak, ayrışma-bireyleşme zorluğu, romantik ilişki ve yaşın yordadığı gözlemlenmiştir. Deri ile ilişkili tanı sayısı açısından ise, yordayıcı faktörler olarak sırasıyla, yaş, kadın olmak, travma yaşantısı, romantik ilişki, Hipermentalizasyon ve ayrışma-bireyleşme zorluğu ortaya çıkmıştır.

Anahtar kelimeler: Psikosomatik deri reaksiyonları, bileşik deri rahatsızlığı, deri ile ilişkili tanı sayısı, ayrışma-bireyleşme, zihinselleştime kapasitesi, hipermentalizaston, hipomentalizasyon

INTRODUCTION

Psychosomatic factors are suggested to play an important role in skin related disturbances (Gupta & Gupta, 1996). However, the interrelation of the skin and psyche has long been underestimated (Jafferany, 2006). Although there are many studies on the psychiatric comorbidities such as depression and anxiety of specific skin diseases and the relationship between stressful life events and skin diseases, research on the underlying psychic mechanisms that could be in relation to the disturbances of the skin is scarce. Thus, this study aims to emphasize the integrality of the skin and psyche; and investigate the possible disturbances of the psyche that could be related to the skin disturbances from a psychoanalytic perspective.

Many theoreticians contributed to the psychosomatic meaning of the skin and skin reactions within the psychoanalytic literature. Although diverse opinions exist, it is generally agreed that skin has a central importance in the developing psyche of the infant on the basis of interactions with the primary caregiver (Anzieu, 1989; Bick,1968; Freud, 1905; Marty, 1958; Schur, 1955; Spitz 1951). In terms of skin reactions, skin may serve as a site for communication of the non-verbalized and unresolved affect on the basis of early disturbances in the mother-infant dyad (Pines, 1980). Thus, in relation with the early predicaments between the mother and infant, "*the skin may itch, the skin may weep, and the skin may rage"* (Pines, 1980, p. 315). While the skin encompasses the body, it plays a fundamental role in the development of the ego (Anzieu-Premmereur, 2015). To emphasize the possible link between the psyche and skin diseases, Anzieu (1989) proposes that there could be such an equivalence that the more disruption any of the functions of the ego suffers, the more severe the skin disease would be.

With regards to skin reactions, psychoanalytic theory often refers to disturbances in the ego functioning by means of adhesive identification, confusions about the subjective identity and boundaries between the self and other, inability to differentiate oneself from the outside and construct an independent identity and the difficulties in the formation of a representation and symbolization capacity.

On the basis of the psychoanalytic literature, the current study thus conceptualizes the early mother-infant relationship on the basis of Separation-Individuation Theory. By separation-individuation process, Margaret S. Mahler et al. (1989) refer to the infant's gradual process of differentiation from the symbiotic relationship with the mother and achievement of a sense of separateness and distinct identity via experiences with the primary love object, who is the mother in most cases, and of his/her own body.

Furthermore, as the psychoanalytic literature often refer to the link between skin and the disruptions in the functions of the ego, which comprises also the capacity to symbolize and reflect, the current study will focus on the notion of mentalization. The concept of mentalization refers to the capacity to reflect on both our own and other's mental states in terms of attitudes, wishes, feelings, goals and needs (Fonagy et al., 2016). Mentalization capacity is achieved on the basis of the attachment system between the mother and the infant (Fonagy & Target, 1997). Although not directly with regard to skin reactions, the relationship between the capacity to mentalize and somatization has often been emphasized (Gubb, 2013).

Thus, the current study aims to examine the relationship of psychosomatic skin reactions with the disruptions of the psyche within the developmental trajectory in terms of separation-individuation and mentalization. The study focuses on these two variables; separation-individuation and mentalization as independent from each other. Further, the study is not bound to a specific skin disease and encompasses skin reactions in general, since it constructs its main aim as exploring general deteriorations of the skin and its relation to difficulties in separation-individuation and mentalization.

Since there are no studies found in the review of literature that looks into the associations of psychosomatic skin reactions with these two variables as separation-individuation and mentalization, the results of the study could be considered as providing a preliminary basis for further studies.

1.1. SKIN AND PSYCHE

The skin is distinguished as the largest organ in our body (Koblenzer, 1997; Urpe, Pallanti & Lotti, 2005). It is also the earliest to develop in the embryo and based on biological law, the earlier an organ is formed, it is more likely to be of central importance (Anzieu, 1989).

Both the skin and the central nervous system stem from the same embryonic ectoderm (Anzieu, 1989; Koblenzer 1997; Osman, 2014, Piccardi et al., 2006). In other words, the skin and the nervous system are derived from the same tissues (Baruch, 2007). The fact that they both have the same embryogenic point of origin can be interpreted as a metaphor and serves as a thought-provoking meaning regarding the interconnectedness of the skin and psyche (Osman, 2014).

Regarding the central role of the skin in human existence, skin-to-skin contact is responsible for the regulation of the physiological functions of the totally helpless infant such as blood pressure, heart rate and respiratory functions until homeostatic organization is achieved (Koblenzer, 1997). It also regulates growth hormone secretion (Koblenzer, 1997). In fact, infants who experience tactile contact, gain weight and reach behavioral maturity much faster than those who do not experience consistent skin-to-skin contact (White & Labarba, 1976). When the infant is placed on the mother's body at birth, through the skin contact, the nervous and agitated infant calms down (Levine & Stanton, 1984; Pines, 1994). Through the satisfaction gained from being held, sensations of smell, touch, taste and warmth are passed through between the mother and her infant. Thus, the skin becomes a means of preverbal communication and as early as at birth; it is through the skin that emotions of a non-verbal kind are somatically experienced (Weiss, 1999; Pines 1994). Accordingly, through this contact, the mother may communicate diverse emotions including love, acceptance, and pride on the one hand, and non-acceptance, disgust and even rage on the other (Koblenzer, 1997). Accordingly, the skin serves as an interface between the mother and infant in terms of the constitution of the human being in a binary corporeality, both biologically and psychically (Baruch, 2007). In the same vein, the main argument of Didier Anzieu (1989) and Esther Bick (1968) is that the formation of the psychic apparatus depends on and

takes its support from the skin's functions and the early tactile experiences of pre-verbal kind within the mother-infant system. In other words, tactile experiences of the somatic plane are gradually moved into a mental plane consisting of representations that encompasses the ego and its functions (Anzieu, 1989). Therefore, adequate mothering for the infant, which constitutes the satisfaction of the infant's physical needs in combination with providing a tactile care, serves as a regulator not only of biological functions but also of the emotional and behavioral development as well as a susceptibility to a disease regarding the skin (Hofer, 1978). In this sense, the infant can gradually achieve a sense of integrity, the ability to separate oneself from the others and to distinguish his/her emotions from the physical sensations (Koblenzer, 1990). The disturbances in maternal care can have emotional and physical effects immediately as seen in infantile skin diseases. However, maternal disturbances can also exert their influence in later adult life as in emotional difficulties and particularly, in disturbances regarding the skin as if the skin cannot provide the proper holding (Howlett, 1999).

As well as the skin being the site of early communication of inner emotions within the mother-infant dyad, the expressiveness of the inner emotions and states through skin reactions is further taken up by psychoanalytic theory. Conor (2004) states that the skin can express the emotions and inner states in a way that the person does not have much control over it, as if he/she is overtaken. It can be observed in cases where a person starts to blush when he/she is in an embarrassing state. However, psychoanalytic theory moves further suggesting that while the skin uncontrollably expresses conscious emotions and states, it is also capable of expressing the emotions and states that the person is unconscious of. Thus, the outbursts of skin diseases can be expressions of unconscious inner states (Conor, 2004). Along the same line, Ulnik and Linder (2016) introduce the skin as a *"thinking entity capable of symbolizing and elaborating concepts, thus producing symptoms as a function of language, thought, and mental abstractions"* (p. 22).

According to Conor (2004), the skin can reflect a direct picture of one's mental world; and the expressiveness of the skin can be seen as an image or allegory

of those mental states. In connection with this, Conor (2004) gives an example of a woman who had a skin disease -eczema- on the same part of her body where her mother had the tattoo of a concentration camp. This example shows how the skin can serve as a paper on which one writes down or leaves marks in order to express oneself. The case further suggests that the mind's influence on the skin can also be related to images and enactments of specific events (Conor, 2004). Koblenzer (1983) further suggests that for some cases, the localization of the skin lesion depends on the symbolic meaning that it has for the subject.

The psychoanalytic contributions regarding the expressiveness of the skin will be discussed in detail in the next sections of the study. In general, psychoanalytic theory approaches skin reactions in terms of the predicaments that occur within the early mother-infant interactions. Koblenzer (1983) states that psychoanalytic theory agrees on the crucial role of tactile experiences in early development and the early disruptions in the mother-infant dyad may result in the communication of frustrations through skin reactions in infancy. However, more importantly, a fixation at this stage during emotional development may occur which is expected to have an intervening role in the development of some skin-related diseases later in life (Koblenzer, 1983). Psychoanalytic theory often associates skin diseases with psychic regression to a point of earlier fixation; the disorganization of the psyche due to conscious or unconscious stress, the disturbances in a symbiotic relationship in combination with problems in early identification processes with the mother, an insufficient or a prolonged symbiosis, a poor symbolization capacity, difficulties in separation-individuation and the establishment of subjective identity, conflicts around being too close or too distant in relationships (Ulnik, 2013). As also stated above, all these psychoanalytic interpretations refer to the early mother-infant dyad. However, it has not yet come to an agreement whether the maladjustment in focus within the mother-infant relationship is in relation with the over-protection / over-stimulation or lack of protection / insufficient stimulation (Anzieu, 1989; Stone, 1953).

Howlett (1999) emphasizes that in dealing with skin reactions, it is not possible to draw simple causal associations since the aetiology constitutes a

complex, multifactorial and interactive system. Taylor (1985) introduces a biopsychosocial model, stating that the emotional states and the conditions of the skin can influence each other in a reciprocal manner on the basis of interactions between the mother and the infant being the essence of both the psychical and emotional development of the child. There may also be differences in genetic predisposition to a skin disease among children. Further, both the mother and the child can affect the states of each other reciprocally in terms of responses that they both produce.

Ulnik and Linder (2016) thought that although one cannot make precise scientific interpretations, the life history of individuals with skin diseases can give clues of associations. These associations between the skin and the life of the patients propose considering that for these patients, expressing themselves does not happen only through a verbal level but also through the impairments on their skin. On the same line, Koblenzer (1983), mentions observing various children with skin diseases who express their frustrations and unhappiness through their skin rather than handling those emotions more effectively on a verbal level. Koblenzer (1986, 1995) further presents case reports stating that the dermatological patients who could not benefit from traditional dermatological treatments improve after they verbalize and become aware of their emotions such as rage, guilt and abandonment in a safe and an empathic therapeutic setting.

Ulnik and Linder (2016) state that the symptoms on the skin can be interpreted as symbols for which it *"does not (and must not) imply a causal attribution, because the meaning of cause and effect is probably beyond our grasp and the ultimate origin of things is still a mystery"* (p. 24). Thus, in understanding the integrality of the skin and psyche, the scope should be on the associations and symbolization aspects between the two rather than hypothesizing a deterministic relationship. This perspective forms the framework of this study.

1.1.1. Psychodermatology

Psychodermatology is a collaboration of the fields of Psychiatry and Dermatology which aims to understand the interactions between mind and skin (Mercan & Altunay, 2006). According to Gupta and Gupta (1996), psychosomatic factors are in play in at least one third of the patients with dermatological reactions. Moreover, a placebo effect is found to be more than %30 for some skin reactions suggesting the importance of psychosomatic aspects of dermatological diseases. Thus, one must consider the possible association of emotional factors with the skin reactions for an effective management (Gupta & Gupta, 1996).

While stress appears to be a factor in the emergence of skin diseases, it can also exacerbate the symptoms in many skin diseases such as eczema, acne and psoriasis (Mercan & Altunay, 2006). A range of 50% to 100% of dermatological patients report that they experience emotional triggers associated with the onset and/or exacerbation of the skin reactions (Jafferany, 2007). Further, Gupta (2006) states that up to approximately 70% of the patients of psoriasis, atopic dermatitis, urticaria and acne report that psychological stress exacerbates their symptoms.

Psychodermatology approaches the skin diseases as consisting of a complex interplay of biological, social and psychological mechanisms. Understanding the psychological impact necessitates considering various factors such as genetic predisposition, the course of the disease, personality structure, personal history, demographic factors, what the disease means for the patient's family and for the society that the patient is subjected to and current life situations (Koblenzer, 1983; Jafferany, 2007). Furthermore, the results from various studies demonstrated a positive correlation between a change in the person's life situation and the onset and intensity of skin diseases (Koblenzer, 1983). Koblenzer (1983) proposes that the symptoms often develop when the patient has a hard time coping with the period of psychological disturbance. This is usually characterized by hopelessness, helplessness, relationship problems, loss of enjoyment, break down in the sense of continuity, reactivation of past feelings. According to Koblenzer (1983), the disruption in coping mechanisms *"may then activate emergency, neuronally transmitted measures that, altering the biological equilibrium, may interfere with*

the individual's ability to deal with concurrent pathological processes. Thus, disease is permitted to develop" (p. 504). Although detailed discussion of the physiological mechanisms involved in skin diseases is beyond this study's grasp, it is worthy to note that that there is an ongoing interaction between the neuroendocrine system and the immune system in terms of the onset of the skin disease which is called the "neuro-immuno-cutaneous system" (Jafferany, 2007). Briefly, it involves the psychological stress triggering the neuroendocrine system in a way that inflammation of the skin occurs as a result of disruptions in the regulation of the immune system response in the skin (Jafferany, 2007). Selye (1949) puts forth that the skin reactions occur in the period of the body's adjustment to stress.

Stress is not only associated with the onset of skin-related symptoms, but also observed as an outcome of them. Emotional difficulties such as shame, poor self-image, low self-esteem, and decreased quality of life due to their skin diseases are observed in dermatology patients (Jafferany, 2007).

In addition to the stress and emotional difficulties that trigger and also result from skin conditions, dermatology patients have also been often associated with a vulnerability to stress (Brufau, Berná, Redondo & Ulnik, 2012). A study conducted by Jobling (1976) showed that 84% of the psoriasis patients expressed having difficulties in establishing relationships because of their diagnosis and this is the most difficult part of having the disease. However, among these patients, few of the participants expressed having experiences of rejection or exclusion. Thus, the problem seems to lie within the anticipation of being rejected. Richards, Fortune, Griffiths, & Main (2001), based on their study, also agree that psoriasis patients may have personality variables which makes them more fearful of getting rejected and that the disease may not be the cause of these feelings. Hence, non-adaptive coping styles with stress could make individuals more vulnerable to stress, disrupting the underlying physiological mechanisms (Brufau, Berná, Redondo & Ulnik, 2012). Furthermore, from a biological standpoint, it has been argued that childhood anxiety is associated with biological changes that have long lasting effects for adult life, leaving the individual more vulnerable to stress and prone to

psychosomatic reactions (Fava & Sonino, 2005; McCauley et al., 1997; Romans, Belaise, Martin, Morris, & Raffi, 2002; Weiss, Longhurst, & Mazure, 1999).

The prevalence of psychiatric disorders in dermatological patients in general ranges from 21% to 43% (Picardi et al., 2006). The most frequently encountered psychiatric disorders in dermatology patients are depression, anxiety disorders such as obsessive-compulsive disorder (OCD), social phobia and general anxiety due to the disease and post traumatic disorder (PTSD) (Gupta, 2006). The severity of pruritus (itching) was found to be directly related to the severity of depressive symptoms in atopic dermatitis, urticaria and psoriasis (Gupta, Gupta, Schork & Ellis, 1994). Moreover, higher depression and anxiety levels in terms of state and trait anxiety in both atopic dermatitis (White, Horne & Varigos, 1990; Vargas et al. 2006) and psoriasis (Gupta & Gupta, 1996) were observed. In addition to this, psoriasis patients were observed to show high levels of obsessionality and difficulty with expressing their emotions verbally. Atopic dermatitis and urticaria patients were also observed to show difficulties in expressing and handling anger effectively (White, Horne & Varigos, 1990; Ginsburg, Prystowsky & Kornfeld et al., 1993; Juhlin, 1981; cited in Gupta & Gupta, 1996).

Moreover, traumatic experience has been associated with skin reactions (Gupta, Gupta & Jarosz, 2017). A study conducted by Wolf, Alavi, Mosnaim and Pain (1988) with 22 Vietnam veterans, who have post-traumatic stress disorder (PTSD), reported that 45.5% of the participants had various skin related symptoms, most commonly pruritus (itching). Another study by Boscarino (2004) with a large sample of 2460 Vietnam veterans, showed that participants with PTSD had a high prevalence of 5.6% for psoriasis. Shoemaker (1963) conducted a study with 40 urticaria patients and showed the association between trauma and neglect in early childhood with urticaria. The study concluded that these patients suffered a disturbed childhood and still find themselves in equally disturbed life situations as adults; and their urticaria seemed to occur within the context of the earlier traumatic setting. As a case study, Gupta and Gupta (2012) presented five cases with both urticaria and post-traumatic stress disorder (PTSD) and demonstrated that working through the underlying traumatic experience lead to the total resolution of their

urticaria. In discussing these patients, Gupta and Gupta (2012) further noted that these patients with recurrent flares of urticaria had shown PTSD symptoms with delayed onset as revealed by detailed histories of the patients. These case histories included reports of traumatic experiences that took place even almost a decade before the onset of the PSTD symptoms. The authors suggested that the events associated with the unresolved issues related to their trauma and that trigger the symptoms may be very idiosyncratic and can sometimes only be assessed during the course of therapy (Gupta & Gupta, 2012).

Furthermore, women in general are observed to show higher prevalence in terms of psychiatric comorbidity in dermatology (Jafferany, 2007). Women dermatology patients show elevated problems in body-image, higher levels of anxiety, depression, obsessive-compulsive behavior associated with a wide range of dermatological diseases (Koblenzer, 1997). Koblenzer (1997) further puts forth that women have higher prevalence rate than men in terms of many dermatological diseases such as dermatitis, acne, chronic urticaria, pruritus, psoriasis, trichotillomania. Koblenzer (1997) proposes that the differences in gender may stem from the familial structure and gender-based upbringing style; girls are seen as more fragile and vulnerable and are further expected to be more "*docile*" and "*biddable*" in order to gain parental love and the role of 'daddy's little girl' in return (p. 130). Modulation of affect cannot be learned while emotions, particularly anger, cannot be expressed freely. Thus, the affective discharge remains to be channeled onto the body just like in early infancy. On the other hand, boys are expected to be tougher, stronger and more aggressive. They express their anger and frustrations more freely allowing the mastery of intense affective states. In line with this perspective, Koblenzer (1997) states that in psychotherapy, an unconscious anger is often found to be related to depressive symptoms and the associated skin disease. Despite the recent efforts to change these gender-based attitudes and perceptions, the legacy that does not allow for the free expression of negative emotions, especially aggression, for women is still prevailing. Thus, skin-related symptoms that are associated with unconscious and/or unverbalized affect might be more prevalent in women.

Lastly, as also evident in the brief accounts above, Aydın (2013) states that the review of the psychodermatology literature regarding the relationship between the skin and mind reveals that the studies often focus on the psychological and/or psychiatric comorbidities with the skin diseases, the stress which is associated with the precipitation and exacerbation of the disease or the emotional problems as a result of having the disease rather than focusing on the underlying functioning of the psychic apparatus of the individuals who develop skin diseases which psychoanalytic theory often refers to.

1.2. PSYCHOANALYTIC PERSPECTIVES ON SKIN

1.2.1. Skin in the work of Freud

Freud (1905) refers to the skin as the *"erotogenic zone par excellence"*– excellent erotogenic zone- (p. 169). Further, Freud (1923) mentions the crucial role of the skin in terms of the psyche in a footnote from the 'The ego and the id' as follows:

> The ego is first and foremost a bodily ego; it is not merely a surface entity, but itself the projection of a surface (p. 26). I.e. the ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body (the skin). It may thus be regarded as a mental projection of the surface of the body, besides … representing the superficies of the mental apparatus (p. 26, n. added in 1927).

According to Freud, touching on a hysterogenic spot such as the skin or a thought of this contact, can provoke the awakening of a traumatic memory and a series of ideas. The skin is the site where old memories, feelings of excitement, and fantasies are revived. It is also the source of both the discharge of energy and receiving it (cited in Ulnik, 2008).

Although Freud himself did not theorize about the unconscious dynamics of dermatology patients, his emphasis on the crucial role of the skin both as the direct receiver of stimulation and as the building block of the ego that serves to "contain"

paved the way for further conceptualizations of skin as well as skin-related symptoms.

1.2.2 Didier Anzieu's Concept of The Skin-Ego

The concept of the "Skin-Ego" by Didier Anzieu (1989), a psychoanalyst who worked extensively with dermatological patients for many years, has vital importance for this study particularly in terms of emphasizing the importance of the communicative function of the skin, how the early skin experiences link with the formation of the ego, and the possible link between the structure of the psyche and dermatology.

The Skin-Ego concept leans upon the assumptions that the psychic apparatus begins to form on the basis of physical experiences; and the tactile sense is the starting point (Ulnik, 2008). By his concept of the Skin-Ego, Anzieu (1989) refers to *"a mental image of which the Ego of the child makes use during the early phases of its development to represent itself as an Ego containing psychical contents, on the basis of its experience of the surface of the body"* (p. 61). In order to point out the important role of the skin in terms of the physical experiences and its contribution in the progression of the ego, Anzieu-Premmereur (2015) states that *"the ego encloses the psychic apparatus as the skin encloses the body"* (p. 659).

The skin, with its reflexive capacity, serves an exchange of communication within the maternal relationship, slowly giving rise to the reflexivity of thought (Anzieu- Premmereur, 2015). Through contact with possibly the mother, both external and internal physical experiences and repetitive signification of these experiences, in which skin has a central role, later on will provide the psyche with the achievement of symbolic capacity; and these experiences will be reproduced such as symbols, fantasies and thoughts which comprise the ego (Ulnik, 2008).

Touch is the first sense to appear in the ectoderm, activating respiratory and digestive functions in the event of birth; and the skin has a precedence over all other senses, serving as the overarching control over other neurological subsystems (Anzieu, 1989). In the first few months of life, since the ego of the infant is not yet adapted to reality and the thought capacity is not yet formed, the only way that the

infant makes sense of the world is through its body and many of the body's functions are *"played out on and through the skin"* (Lafrance, 2013, p. 23). Through physical stimuli, the skin, as being the reference point for all other senses (Anzieu-Premmereur, 2015), provides the psyche with the representations and by this way, the infant constructs a sense of self which is called the 'Skin-Ego' (Ulnik, 2008). According to Anzieu (1989), the Skin- Ego refers to the time in which the infant is neither just a bodily Ego anymore nor has it developed an Ego yet. In other words, the psychogenesis of the Skin-Ego represents the point at which psychical Ego and bodily Ego are differentiated at the functional level, whereas they remain confused at the representational/symbolic level (Anzieu, 1989). The Skin- Ego, is the starting point of the progression of the thinking-Ego which has *"the capacity for reception, perception, protection, cohesion, support, integration of sensations, identity and energy"* (Ulnik, 2008, p.44). Therefore, it can be seen that the skin of the infant serves as a framework regarding how the fully developed ego will be built. (Lafrance, 2013). The disturbances of the Skin- Ego and the thinking- Ego, demonstrate how the Ego takes in the bodily perceptions including skin perceptions and uses them for the sake of communicating with the outside world as well as attempting to protect itself from the dangers coming both from the inside and outside (Ulnik, 2008).

1.2.2.1. Psychogenesis of the Skin-Ego

Within the scope of the mother-infant interaction, the skin ego develops through leaning on the functions of the skin and the fantasy of a common skin with the mother (Anzieu, 1989).

Regarding the functions of the skin, Anzieu (1989) states that "*every psychical activity is anaclitically dependent upon a biological function"* (p. 40). Taking this view as the basis for his metaphorical concept of the Skin-Ego, Anzieu lists the functions of the skin as follows: The primary function *"is as the sac which contains and retains inside it the goodness and fullness accumulating there through feeding, care and the bathing in words"* (p. 40). The second function is to serve as an interface / a boundary which separates the outside from the inside. By this way,

it protects against the invasion of the aggression and greed either from the object of interest or other people. Finally, the third function is to serve as the primary communication site with others and to create relations with the outside while being an inscription site for the messages that others leave (Anzieu, 1989).

In the pre-ego phase, the skin with its functions of containment, protection and inscription performs as a surrogate ego, preparing the infant to move towards its independence (Lafrance, 2013).

Regarding the fantasy of a common skin, the mother has a function of surrounding the infant with an external envelope in which she is expected to emit signals and interpret the signals emitted by the infant along with providing all kinds of maternal care (food, warmth, affection, caress etc.). While the maternal environment serves as an external envelope, the surface of the infant's body serves as an inner envelope and a double feedback system is formed in between (Ulnik, 2008).

According to Anzieu (1989), it is very important that the external layer adjusts itself flexibly and leaves some free space between itself and the inner envelope. Sticking too closely to the infant's body would result in the suffocation of the Ego and mean an invasion of one of the Egos in the environment; whereas too much looseness of the external layer would result in the Ego lacking consistency because the messages that the infant sends out would not be received and held by the external layer. The Ego of oneself signifies that the one has its own uniqueness and that one feels as having the capacity to send out messages and gets confirmed that they are received. Thus, this appropriated external envelope is to be expected to aid the infant's individuation process by recognizing and confirming its individuality.

The double feedback between the external and inner envelope eventually leads to the formation of an interface which is fantasized as a skin common to the mother and the child (Anzieu, 1989). The fantasy of a common skin is the necessary building block of the Skin-Ego and must be formed (Ulnik, 2008).

According to Anzieu (1989), the next step demands the suppression of this common skin fantasy and the acknowledgement that each has his/her own skin, thus

his/her own ego. This process inevitably encompasses pain and resistance. It is at this point that fantasies of the flayed, bruised, hurt or murderous skin may force their impact. However, if the separation process is experienced as abrupt, the extreme dependence on the mother becomes more and more unbearable and these fantasies exert themselves, the mother who had torn the common skin apart in the first place is the one who can also repair it. Anzieu (1989) states:

> Fixation on one or other of these phantasies,…and the defence mechanisms mobilized to repress or project the phantasy, to transform it into its opposite or erotically to hyper-cathect it, plays a particularly obvious role in the two areas of dermatological disorders and masochism (pp. 63-64).

Anzieu (1989) mentions observing that many of his patients, who have masochistic fixations, also have fantasies of a flayed body that go hand in hand with their pre-conscious fantasies of fusion with the mother. If the Skin-Ego progresses more into the masochistic fixation, separation from the mother and the achievement of autonomy are depicted as tearing off and damaging that common skin, the skin which is figurative of the symbiotic reunion (Anzieu, 1989).

If the child passes beyond the anxieties related to these fantasies, he/she can achieve a Skin-Ego of his/her own by internalizing both the interface and the maternal environment (Anzieu, 1989).

1.2.2.2. Anzieu's View on Skin Diseases

Based on observations on dermatological patients, Anzieu (2016) argues that the skin diseases are closely linked to everyday stressors and emotional disturbances and most related to his theory of the Skin-Ego, to narcissistic failures, and the disturbances in the Ego structure. Anzieu (2016) suggests that in pathomimetic disorders in which there is a deliberate act of irritation and aggravation of the skin lesion, there lies an aggression of a very subtle kind in this behaviour as a reaction against intolerable inner dependency. Further, for the sake of recovering this need of dependency, these people make others who reproduce the earliest frustrating object of their attachment drive dependent on them. This strong need for dependency reflects a fragile and an immature psychic life, highly

undifferentiated topographic structure, insufficient self-cohesion, and failures in the development of the Ego. Pathomimics reflect the fragility of their Skin-Egos by the oscillation between fear of abandonment and fear of penetration (Anzieu, 2016).

Anzieu (2016) proposes that in the case of pruritus, while it can be related to sexual desires that produces guilt through auto-eroticism and self-punishment, an itch may also be the means to call attention to oneself, particularly to one's skin as a way to be contained by one's earliest love object in cases where the mothering and family environment did not harbour a warm, comforting, firm and meaningful relationship. Through repetition compulsion, with the observable suffering on the skin and suppression of the anger underneath, the psychical symptom of the skin revitalizes the early frustrations as in the primal form of communication of the skin. Since these people are stuck on a stage prior to the sufficient differentiation of the psyche and soma, irritation of the skin is confused with and reflects the irritation of a mental kind and delinquent eroticisation of the skin appears in order to bear the intolerable pain and hatred while attempting to reverse the unpleasurable into the pleasurable.

According to Anzieu (2016) generalized eczema may portray the regression to a state of infancy in which there is total dependency, *"the somatic conversion of a terror of psychical collapse and a mute, desperate appeal to an auxiliary Ego offering total support "* (p. 36). Anzieu questions whether eczema reflects an attempt to provide oneself with the stimuli which the mother has failed to provide or a demand to get provided with them.

In regard to the functioning of the ego and maternal relationship, Anzieu (2016) wonders if skin diseases are produced by the over-stimulation by the mother or the stimulation of an inadequate kind and implies that some may be in relation with an excess stimulation and some with an insufficiency in stimulation. For both cases, the problem lies with the notion of the primary taboo of touch and the importance of its implementation at the necessary time. If there is a lack of stimulation, this may be unconsciously experienced by the infant's growing psyche as an excessive, harsh and premature administration of the prohibition to stick on to another's body. On the other hand, over-stimulation can also be frustrating for

the reason that the infant's yet insecure protective shield gets overwhelmed *"because it transgresses and switches off the taboo on touching, which the psyche knows it needs in order to create a psychical wrapping that is truly its own"* (Anzieu, 2016, p. 37). By this excess stimulation, the psychical envelope becomes an envelope of both excitation and suffering which is the basis of masochism. In case of masochism, one has a compulsion to reactive this envelope which in this case, is the source of both excitation and suffering. (Anzieu, 2016).

Most importantly, Anzieu (2016) proposes the safest and simplest hypothesis; that there could be such an equivalence that the more disruption any of the functions of the ego suffers, the more severe the skin damage would be.

Anzieu (2016) suggests that the disruptions in the Ego development of the patients in borderline states who are confused about their identities and the dermatological patients may have similar features. According to him, the disruptions in the structuring of the ego in borderline and narcissistic patients are manifested as follows:

These patients in borderline states experienced difficulties in detaching themselves from the clinging relationship in early development. They prematurely experienced repeated oscillations between and conflicts around excessive clinging and abrupt, sudden separations which in turn were experienced as violent to their body Ego and/or psychical Ego. These patients are observed to be much more preoccupied with others' feelings and desires than theirs and are confused about their own feelings. They often speak in a narrative sense, lack reflexivity and perspective since they are buried into the experiences of the here and now, not representing those experiences as for themselves. "*They find it hard to stop clinging intellectually to a nebulous mixture of their own and others' life-experiences"* (p.26). They also remain fused to others while fearing penetration. They also cannot break away from their sensations and emotions.

A decay in the mother-infant dyad and the process of the achievement of the Skin-Ego affects the acquisition of the symbolic capacity and the capacity to separate oneself from the outside. Tearing off the skin could be due to the wish for tearing off the content, an adhesive identification or a second skin formation (Ulnik,

2008).

Anzieu (2016) emphasizes that *"the seriousness of the damage to the skin which can be measured by the increasing resistance of the patient to chemical or psychotherapeutic treatments is related to the quantitative and qualitative extent of flaws in the Skin-ego"* (p. 37).

1.2.3. Other Psychoanalytic Contributions on Skin

René Spitz (1951) uses the term *"somato-psyche"* referring to the infant's way of being in the first few months of life and suggests that the psychic system and somatic system are not differentiated and are even merged (p.256). Taking this view, Spitz (1951), reflects on his study conducted in collaboration with Katherine M. Wolf, in 1945 in which they focused on the mother-infant relations of 220 children. They observed 28 children who developed skin reactions in the first year of life. Out of these 28 children, 24 were studied extensively, and 22 were diagnosed with eczema. Spitz (1951) suggests that specific psychogenic disorders could be related to specific types of mother-infant interactions where the mother plays a provoking role acting as a psychological toxin in the emergence of a disease. Spitz (1965) in his book, *The First Year of Life*, concludes about their research as infants with eczema having two anomalie; the first one stems from mother's inability to provide the child with appropriate skin contact and the second one is attributed to the child's skin sensitivity. The infants in the first case had *"mothers with an infantile personality, betraying hostility as anxiety toward their child; mothers who do not like to touch their child or care for him, and who deprive him systematically of cutaneous contact"* (p.231). In the second case, the infants had higher levels of innate cutaneous response *"leading to increased cathexis of the psychic representation of cutaneous perception, in loose analytic terms, to a libidinization of the skin surface"* which reflects the very need that the mothers decline to satisfy (p.231). Spitz (1951) further elaborates that the anxiety-driven mother, with unconscious hostility underneath, very worried about her child being too vulnerable and fragile, avoids touching and makes it impossible for the child to identify with her. However, only by those various primary identifications with the mother, could

the infant have acquired an ego in the context of diverse sensory experiences, most importantly the tactile ones provided by her. Spitz (1965) links the identifications with the mother with Margaret Mahler's theory of Separation-Individuation. Spitz suggests that only through primary identifications, that is, acquiring the mother's attitudes and techniques of how she takes care of him/her and handle him/her, the infant can start on the road of Mahler's theory of separation.

Spitz (1965) further proposes that specific body parts such as the skin are predisposed to libidinization. This predisposition to libidinization has its biological basis; it is based on the chronology of mylenization and the skin is the first organ to be myelinized in the embryo. Keeping his proposition in mind, in his study with infantile eczema, Spitz (1965) links the disruptions in the skin with the congenital cutaneous hyperexcitability specific to these children combined with the insufficient fulfilment of the need of libidinization and disruptions in the quality of the mother-infant relationship.

Spitz (1965) suggests that skin reactions appear as a response to conflicting messages coming from the mother. However, like Didier Anzieu, he questions if the skin reactions reflect an effort, a way of call for the mother to make her touch her child more frequently or a narcissistic withdrawal as a defence where the infant finds a way to provide himself/herself with the stimuli within the somatic system.

Finally, Spitz (1965) puts forth the hypothesis that there is a link between movement and skin reactions and that the reason for the infantile eczema to disappear within the first years of life is because locomotor activity starts in which the child could now replace and compensate for the mother's care with other objects or people. This also corresponds to Esther Bick's theory of 'second muscular skin' which will be discussed below in detail (Ulnik, 2008).

Harriet M. Stone (1953) puts forth in terms of the mother's attitudes towards the child and the skin reactions, that some theorists observed the skin reactions to be related with neglect while others put emphasis on the over-protection, over-nursing and domineering love with regards to mother's attitudes. However, they all agree that there is an emotional maladjustment present within the mother-infant relationship. Stone (1953) suggests on the other hand, that neglect and over-

protection are inter-related; the mother usually assumes an over-protective role for the child who awakens conflictual emotions such as guilt and resentment in the mother. In line with this conflict of the mother, Flanders Dunbar (1968) further suggests that, having been introjected this kind of conflict of the mother, the most observable feature of the people who suffer skin diseases is the immense conflict between a deep wish for affection and fear of getting hurt if they pursue it.

Max Schur (1955) proposes that dermatosis could appear in regressive ego states where the skin works just like a neurotransmitter in which the most primitive and archaic symbols of thought are activated and communicated. Physiological regression is produced as in dermatoses when the ego loses its capacity to use secondary processes to think and fails to neutralize energy. Instead, resomatization occurs as a result of primary processes in action and failure of neutralization, leaving libido and aggression in their non-neutralized form. The capacity of neutralization is thought to have its precursors in the undifferentiated phase of the psyche and soma. In regression of this kind, preverbal stages prior to the development of the ego in which reaction to a stimulus is psychosomatic become activated "*where the conscious experience is limited to the awareness of the discharge phenomena which genetically have been present before the emergence of the affect anxiety*" (Schur, 1955, p. 127). Schur (1955) suggests that these discharges can be seen as the equivalent to anxiety.

According to Schur (1955), dermatosis may appear in situations in relation with unconscious sources of danger and anxiety as a reaction to this danger. In these states, the somatic discharge in order to get a relief may be dermatosis. The patients with dermatosis may experience ordinary features of their everyday life as sources of danger. Surrounded by the feeling of threat, these patients are observed to be vigilant and constantly ready to feel anxious. However, the actual content of the danger may be unconscious, reflecting the anxiety experienced in early infancy. Some may not be consciously aware even of the fact that they are feeling anxious. Physiological regression is the commonality in these anxiety reactions although the degree of it varies. The ego constantly tries to re-establish the equilibrium, repair secondary thought processes and operation of neutralized energy however attempts

to restore the equilibrium may be unsuccessful or renounced. Regarding the differences in responses, Schur (1955) states *"we may expect reactions differing not only in quantity but also in quality, with the differences extending to the somatic discharge phenomena"* (p. 18).

Dermatosis may also be an equivalent to hostile feelings; and it is possible to encounter a stratified aggression during the analysis of these patients. Aggression expressing itself through itching may represent a form of self-punishment; however more profoundly, it can also mean a punishment directed towards an external object represented on the skin (Schur, 1955).

Furthermore, Schur (1955) suggests that there may also be a link between libidinal drives and itching in dermatoses. As a matter of fact, Freud (1915a) in 'Repression', suggests that through external stimulus becoming internal because of the harmful excitation effects it produces on the organ, this organ becomes a source of continuous excitation and through an increase in tension, obtains a similarity just like an instinctual drive. Schur (1955) points out that itching can be the only way to get sexual gratification, creating feelings of guilt and humiliation just like it happens in the battle of masturbation. The regression to the autoerotic phase of the eroticism of the skin and increased cathexis corresponds to the discharge of the sadomasochistic drives.

Schur (1955) puts forth that the outbreaks of the disease is generally related to a particular conflictive situation. However, although specific circumstances may precipitate the outbreak, once the disease appears, patients with a floating anxiety and constant vigilance, can respond to any circumstance with a new outbreak having instinctive access to itching. Once the disease has begun, factors such as metabolic, nutritional and immunological influences may play a part and may eventually result in chronic evolution and incurability of the disease.

According to Schur (1955), in the states of the physiological regression, the distinction between the self and the external object can be very ambiguous and the skin is treated as a part of both the self and the other. Regression can be very deep; and narcissistic and exhibitionistic tendencies can exert themselves. While treating patients with psoriasis, Schur observes that they exhibit confusions about identity

and ambivalent identifications with their parents. Further, similar to Didier Anzieu's view, Schur observes that patients with dermatosis reveal degrees of borderline states as a common characteristic. This also corresponds to the findings of these patients on projective tests frequently revealing borderline types of responses (Schur, 1955).

Regardless, Schur (1955) puts forth that these patients can manage to live in a very functional way, encapsulating their pathological traits. He suggests that in treatment, the patients should be encouraged to use other channels of expression than their skin to think and feel. Verbalization is an excellent way to cut down the regression of the ego and the preverbal expression directed on the skin.

Pierre Marty (1958), in his paper, *'The Allergic Object Relationship'*, offers an explanation of the relationships of the patients with well-known allergic conditions such as eczema. By the allergic object relationship, Marty (1958) refers to the allergic patient's everlasting wish to get as closer as possible to the object, until he/she merges with it as if they are indistinct entities. The allergic ego has no existence of its own and is very weak, thus, the main objective is to find an object, cathect it and then seize control of it.

The merging and a deep, unbounded identification with the object results from the subject's difficulty and confusion in establishing boundaries which separates him/her from his/her object. In regard confusion over this differentiation, Marty (1958), offers some quotes of women who suffer from eczema; one says *"'I cannot live within myself, but only united with another person"*; another puts it as *"What bothers me is that the boundaries between myself and others vanish. This is perhaps why I seek physical contact. If I touch someone else's skin I become merged with him; I remove the barriers"* (p. 99). Further, these patients tend to deny any kind of conflict while constantly trying to make others happy (Szwec, 2008). According to Marty (1958), the intense need for identification happens through adjusting the object first by the endowment of the object with his/her own qualities and then adhesively identifying with them. This violent and intense need reflects a very archaic character and finds it's base a long way back in early identification problems with the mother and the pre-genital conflictual relationship between the

mother and infant. More specifically, in the allergic object relationship, the object that the individual wishes to merge with, unsurprisingly reflects the need to identify with the mother.

Regarding the regression aspect of the allergic patient, Marty (1958), suggests that these patients have a great capacity to find a substitute object for another. However, if an identification cannot take place for some reason, then regression occurs. Much like in neuroses, regression occurs if a cathected object disappears all of a sudden as in the case of death of someone. However specific to the allergic individual, two more events can trigger the regression. One is that when an already cathected object brings out a new quality which the allergic subject has trouble identifying with. This can cause a slight regression since the subject can easily find a new cathected object. If not however, allergic crises as a defense against further regression may take place. A second cause of regression is a more serious one where there is an incompatibility between two cathected objects which demands a multiplicity of identification to get a relief. For the allergic patient, the merging with the two is expected to create a massive incompatibility within the ego. The Oedipus conflict, for instance, correspond to this difficulty in the multiplicity of identification. The Oedipus situation is inevitably a triangular one; including the mother, the father and the child. Both the mother and the father are equally the objects of identification. Being attached to the one would mean having to suppress the other one and this would create a split in the subject. The inclusion of the third-the father-and the healthy resolution of the Oedipus conflict reflects an inevitable and expected breaking away from the symbiotic fusion within the dyadic exchange with the mother.

Marty (1958) quotes Mustapha Ziwar regarding the somatic allergic reactions; *"... the allergic reaction seems to play the part of a line of defence, hindering the disintegration of the personality"* (p. 101). Full regression of the psyche is interrupted by a restoration of a new object or as a last resort by an appearance of a somatic allergic reaction. If, however this does not occur, depersonalization may take place. *"The emotional defence is a regressive substitute for an object relationship in allergy"* (Marty, 1958, p. 102). For Marty, the allergic

crises including eczema, urticaria, and other skin inflammations can suddenly become worse, however, are reversible. Their progression reflects a part of a somatization process used as a way of regression until a somatic fixation point is found. In other words, outbreaks of this kind allow for a reorganization and an evolutionary restart to return to a previous state before the crisis (Szwec, 2008).

Marty (1958) further states that an allergic crisis is observed to occur in an analytic treatment when a possibility of fusion and the wish for an identification is disrupted by holiday breaks, cancelling of the sessions, changes in the number of sessions or an ending of the treatment.

Lastly, according to Marty (1958), these patient's avoidance of any conflict stems from a pre-genital conflict. In other words, *"these relationships all show that the allergic patient is seeking to merge with a mother who, however, is not exactly his since she is partly idealized by the patient"* (p. 100).

The function of the Skin-Ego as providing a boundary, which binds the personality's primitive parts, also fall within the Kleinian context especially in Esther Bick's work (Anzieu-Premmereur, 2015). Bick (1968), in her paper, *'The Experience of the Skin in Early Object-Relations'*, states that in the most primitive sense, the function of the skin as a boundary is expected to hold together the parts of the personality which at first have no binding force. The mother who *"is experienced concretely as a skin,"* is expected to contain the infant's anxiety and the infant introjects this skin container function. (Bick, 1968, p. 484). Introjection of an external object -the mother- is necessary for the integration of the primitive parts of the infant's personality, which then leads to the formation of internal and external space. However, in the absence of this introjection, projective identification will eventually become unabated; and confusions about identity will arise. Early projective identification process encompasses projection of a part of the self that may cause distress, such as anxiety, on to the mother. The mother's ability to contain and transform this part is crucial at this point since the infant then identifies with what the mother does with this projection. Accordingly, *"failure to introject the containing function and to accept the containment of self and object in separate skins leads to pseudo-independence, and to 'adhesive identification' and*

inability to recognize the separate existence of self and object" (Pines, 1980, p. 315). According to Bick (1968), this failure of introjection may eventually result in the development of what she calls a 'second muscular skin' as a substitute for the container function of skin. This expresses itself in states of disintegration as in disturbances in ego strength, its corresponding mental functions especially communication seen as verbal muscularity and of disintegration of body, posture and motility (Bick, 1968, 1986).

Michel Fain (1971), draws attention to the link between a developmental arrest and psychosomatics including skin reactions. He suggests that the mothers of psychosomatic infants are observed to be not a satisfying mother but a tranquilizer mother. They cannot provide a protective shield for the infant against exciting stimuli. Ironically, they tend to over-indulge the infant which leads him/her not being able to create a symbolic space for and on their own for a good internal state of being, which is necessary for an autoerotogenic activity. Thus, these infants may not sleep and seem unable to go on without the presence of their mothers. Possibly due to the mother's own anxieties or issues, she cannot allow for the necessary primary identification which facilitates the infant to create his/her own fantasy life and symbolic space to deal with the anxieties. These infants' egos are left impoverished.

Based on his observation, Fain (1971) proposes that the mothers of the children who develop asthma and other allergies allow for the satisfactions gained only by direct contact with their child and unconsciously desire to bring back their child inside their body; in a foetal bliss. McDougall (1974) comments on Fain's proposal as although providing a protective shelter for a new born infant is the mother's normal instinct and necessary until the infant is able to provide this protection for him/herself, these mothers seem unable to offer conditions that would enable the infant to acquire this function. Possibly due to her own needs and the lack of investment in other parts of her life, specifically her love life, she cannot restain herself from disinvesting and over-protection of her child which resembles the infant-nursling relationship. This would lead to an addictive function and total dependence on the object.

Roberto Fernández (1978), in "La piel como órgano de expression [The skin as an organ of expression]," proposes that the two functions of the skin, protection and acknowledgement, are parallel to the two maternal functions. The deficiencies in these functions leave the child feeling hurt and raw. Only by these functions of acknowledgement and protection, can the child construct a sense of a true self and well-being. Accordingly, skin diseases could reflect the traumatic loss of this narcissistic protective function. In the absence of a mother who protects and acknowledges, the subject's useful symbiosis is disrupted and its wish for contact and/or fusion remains registered. This could manifest itself in skin reactions, hypersensitivity and affective dependency or reactive hardness. Further, failure to internalize the function of acknowledgment could reveal the fantasy of rejection which could lead to a confusion about identity, the feelings of belonging and the feelings of being separated. Fernández concludes that somatizations such as hives, scratching, vomiting and allergies are expressions of getting rid of a maternal imago which is more harmful than protective; and tearing off from which is disgusting (cited in Ulnik, 2008). Fernández suggests that in an individual who has a predisposition to this disruption, a situation that demands to test his/her self-protection and/or a change in his/her identity could be *"expressed by means of an alteration in the "screen" of interiority constituted by the skin"* (cited in Ulnik, 2008, p. 75).

Noemi L. de Canteros' (1981) focuses on the link between allergy and problems regarding identity. According to her, the patients with hypersensitive reactions such as eczema seem to have had difficulties in the achievement of an adequate individuation. Their identity is based on the other person and seems to reflect a symbiotic kind of identity. The hypersensitive reaction occurs if an object or a situation demands a transformation of this symbiotic identity into a more individual identity. Their developmental arrest consists of extreme dependence; thus, these patients have difficulties adjusting to an independent life. Thus, they tend to avoid changes and have difficulties in adjusting the alterations in life situations which result in allergic reactions (cited in Ulnik, 2008).

1.3. SEPARATION-INDIVIDUATION THEORY

In terms of the meaning of the skin and the skin reactions, the psychoanalytic literature as previously presented, often refers to the early disturbances in the mother-infant interactions with regards to an adhesive identification, the confusions about identity, the disturbances in Ego functioning and the inability to establish boundaries, separate oneself from the other and construct an independent self.

Furthermore, in dealing with psychosomatic skin reactions, many psychoanalytic theoreticians present their clinical material and formulations regarding the difficulties in individuation and disruptions in the boundary formation by using the words such as 'merge', 'fusion', 'annihilation' and 'engulfment' (Biven, 1982). Based on this, the current study conceptualizes the early mother-infant relationship with a focus on the basis of Margaret S. Mahler's Separation-Individuation Theory.

By the separation-individuation process, Mahler and colleagues (1989) refer to the 'psychological birth of the individual'. Psychological birth is a progressive phenomenon and represents the infant's differentiation from the symbiotic relationship with the mother and the achievement of a sense of separateness and distinct identity via experiences with the primary love object (mother) and of his/her own body (Mahler et al., 1989). Thus, to grow up means to grow away from being as one entity with the mother and expands through the life-cycle (Mahler, 1972). The separation process and consecutively the individuation of the infant largely depends on the "*identifications with the mother from whom the child is differentiating but who is taken inside and made into a part of the "me"*" (Pine, 1992, p. 105).

Mahler (1967, 1974) conceptualizes the separation-individuation process in terms of developmental phases and sub-phases as follows: Normal Autistic Phase, Normal Symbiotic Phase and Separation-Individuation Phase which involves Differentiation/Hatching Sub-phase, Practicing Sub-phase, Rapprochement Sub-phase and Consolidation of Individuality and the Beginnings

of Emotional Object Constancy Sub-phase. Mahler et al. (1989) suggest that although this process is never finished and can be reactivated throughout the life cycle with regards to the old irresolution of a sense of identity and body boundaries or conflicts around separateness, the foremost psychological achievements occur within the period of fourth or fifth month to thirtieth or thirty-sixth month. Mahler et al. (1989) refer to this phase as the separation-individuation process.

In the initial phase from birth until approximately two months which is called the "Normal Autistic Phase", the infant is purely a physiological being in a *"primitive hallucinatory disorientation"* (Mahler, 1967, p. 741). The infant has no distinction between the inner and outer world and the sources of pleasure and pain, thus any satisfaction that comes from outside cannot be differentiated from his/her own tension reducing states such as urinating, defecating, sneezing, vomiting etc. Thus, any satisfaction is perceived as belonging to his/her omnipotence and autistic orbit. The only aim of the infant is to achieve homeostasis (Mahler, 1967).

The infant constantly tries to reduce unpleasable tension while at the same time gets gratifications through the mother's various administrations. Through the effects of these phenomena, the infant gradually starts to differentiate between the experiences of painful-bad quality and pleasurable-good quality (Mahler et al., 1989).

From the second month on, the infant gradually moves on to what is called the "Normal Symbiotic Phase" where the infant becomes slightly aware of the need-satisfying object (the mother) and that the tension accumulated is from within and tension reduction comes from outside. Thus, there must exist some kind of unsophisticated differentiation of the ego (Mahler, 1965, 1967). In terms of intrapsychic organization, however, the infant perceives and functions as if the mother and him/herself are a somatopsychic (Spitz, 1951) dual unity with a delusion of sharing a common boundary as if they are both an omnipotent system (Mahler, 1967). As this slight awareness of the need satisfying object appears, good and bad qualities of the mother or the basic caregiver start to be accumulated internally. This serves as the basis for the formation of internal mental

representations (Alkan, 2010). According to Mahler (1967), in severe cases of individuation disturbances, the ego regresses to this period of common boundary.

In accordance with the context of this study, Mahler et al. (1989) argue that perceptual and sensual experiences of contact especially of the body surface, play a crucial part in the proper entrance of this symbiosis and the distinction of the representations of the Body-Ego within the emergence of the matrix of symbiosis. Further, in this phase, sensoriperceptive traces provide support for the boundaries of the body self and the aggressive energy of unneutralized kind is expected to be ejected beyond the boundaries of the body-self (Mahler, 1967).

Developmental stages of the Normal Autistic Phase and Normal Symbiotic Phase complement each other and are essentially interrelated. Normal Autistic Phase and Normal Symbiotic Phase are the precursors and prerequisites for the progression of the separation-individuation process (Mahler et al., 1989). Thus, interactions and adaptability in these phases make it possible to evaluate the vicissitudes of the subsequent four sub-phases of the separation individuation (Mahler, 1965). It is also important to note that every developmental phase is bound to a previous one (Mahler et al., 1989).

The first sub-phase of the separation-individuation process is called "Differentiation/Hatching" and starts from about four to five months, at the peak of symbiosis. As the infant's perceptual activity gradually develops and he/she gains the ability to be awake for much longer, his/her inwardly directed attention during the first months of the symbiosis starts to shift to the outward. The infant starts to hatch from the symbiotic orbit. The smile of the infant becomes preferential which designates the special bond with the mother and the awareness that he/she now is not only a receiver but also is responsive towards outside. In this phase, the infant starts to scan the mother and her parts (hair, nose, jewelry) indicating that mental representations of the self and other are being formed. Scanning beyond his/her visual field, trying to move away from the mother's arms and crawling back are the characteristics. This first sub-phase of the separation individuation is the first step of the infant to break away from the dual unity in terms of bodily sense (Mahler, 1972).

In cases of delayed or premature hatching where basic trust cannot be formed, the disruptions in the differentiation process in terms of problems in libidinization, the first steps into emotional object constancy and socialization are also observed. This can be observed in various cases where the mother is emotionally ambivalent toward the child and/or her maternal role, is depressed, suffocating, or mechanical, and/or shows no real warmth or interest. The early differentiation patterns are consistent with the further processes of separation-individuation and possibly with the personality organizations in the future (Mahler et al., 1989).

The second sub-phase is called the "Practicing" which takes place from about seven to ten months until fifteen-sixteen months. The beginning of the practicing period overlaps the period of differentiation where the infant's ability to physically move away from the mother and his/her eagerness to explore increases. In the beginning, he/she starts to direct his/her attention from the mother to inanimate objects which are called 'transitional objects' by Winnicott (1953) as a substitute for maternal soothing. The proper practicing period takes place when the infant's movement capacity expands. The infant now gradually gains freedom and tries to practice his/her locomotor skills. He/she periodically wants to physically move away from the mother for the sake of exploring the environment and yet still needs to return to the mother as a stable home base when tired. After periodic explorations of his/her expanded environment and social reality, the mother is very much needed for emotional refueling. When the mother is absent from the infant's sight, his/her mobility and interest in the environment diminish. Once the mother returns, his/her self-reliance is established again (Mahler, 1972). The infant's great narcissistic investment in his/her own functions and body stands out as the main characteristic (Mahler, 1967) and libidinal cathexis is relocated on to the developing autonomous ego in this sub-phase (Mahler, 1972).

In this process, the optimal distance of the mother is important. The confidence of the mother in her child's self-reliance becomes an important prompt for the child's feeling of safety, to transform the omnipotence into autonomy and to develop self-esteem (Mahler, 1972). Furthermore, according to Mahler et al.

(1989), lack in optimal emotional availability and attention from the mother may result in the inability to master the environment and insufficient libidinal energy in order to cathect the external world, the autonomous ego functions and possibly her own body.

The third sub-phase which lasts from approximately about sixteen until twenty-five months is called the 'Rapprochement'. The child now gains the ability of upright locomotion and becomes a 'toddler'. This period is important in terms of ego structuring and the establishment of a cohesive self. With an increased ego capacity, he/she now well acknowledges his/her separateness from the mother and other love objects. The relative lack of interest in the mother and periodic re-fueling pattern seen in the previous sub-phase of the 'Practicing' is replaced by the child having an increased concern about the mother's whereabouts and actively approaching to the mother. As the child cognitively grows and increasingly gains the ability to psychically move away from the mother, he/she develops an increased need for the object's love and closeness, as well as sharing every newly learned skill and experience with the mother (Mahler et al., 1989). With regard to this turn of interest in the mother, Mahler et al. (1989) name this sub-phase as 'Rapprochement'.

According to Mahler et al. (1989), this sub-phase reflects a great deal of ambivalence for the child; while he/she wishes to re-unite with the love object, he/she also faces the fear of re-engulfment. Thus, there is a constant struggle between isolation and fusion. The pattern of 'warding-off' is observed against a possible violation of his/her recently acquired autonomy. The introduction of the father in this period is very crucial in order for the infant to realize that both mother and father are separate individuals and he/she must gradually and painfully break away from this fusion-like relationship with the mother.

The mother's optimal emotional availability in this period is extremely important; the child could cathect his/her self-representation with neutralized energy through the mother's love and tolerance for her child's ambivalence (Mahler et al., 1989).

The child's demand for the mother's constant attention creates a contradiction for the mother; while the infant now does not seem as dependent and vulnerable as before and willing to become more and more independent, he/she also insistently seems to be more and more in need to incorporate the mother into every aspect of his/her life. While some mothers may have a hard time tolerating the child's demandingness, others may be unable to accept the child's growing separateness and that the child is no longer a part of themselves (Mahler, 1965).

The fourth sub-phase is called the "Consolidation of Individuality and the Beginnings of Emotional Object Constancy" to which the child enters after approximately three years of age. The difference of this phase from the others is that it has no final point. The child is expected to internalize a constant image of the mother who is positively cathected. Emotional object constancy refers to the preservation of the inner representation of the mother when she is absent. It also constitutes the unification of the previously split 'good' and 'bad' object as one whole representation. Rapid development of a full ego differentiation and the individuation prepare the ground for the formation of self-identity. This sub-phase is characterized by role play, make-believe patterns, reality testing, growth of verbal communication and fantasy, autonomy and endurance for the separations (Mahler et al., 1989).

Regarding the separation-individuation theory of development, Mahler (1967) argues that in cases where the mother's preoccupation with regards to the mirroring function is anxiety-driven, conflictual, hostile, unpredictable or not stable and if she cannot be confident with herself as a mother, then the child, in his individuating process, cannot be able to find a reliable frame of reference. This would result in the disruption in the primitive self-feeling of the child since he/she cannot experience a pleasurable and safe state of symbiosis and an abrupt and a premature hatching takes place. On that note, Mahler (1967), gives an example of a child who is observed to have a disturbed body image which results in the disturbances in the formation of primary identity, thus in the sufficient cathexis of self with neutralized energy. Furthermore, the child is observed to have disturbances in the inter-systemic ego functions and have an intrapsychic

representational world which have no clear boundaries between self and other and between ego and id.

Moreover, Mahler (1965) introduces another example of a child whose mother has occasional flares of depression during the child's development. That one time coincided with the peak of symbiosis and it is observed that the child's development got impaired where the child showed increased discomfort with psychosomatic manifestations such as skin rash and upper respiratory problems.

Mahler (1975) advocates that while the concepts of libido and Oedipus complex are aspects of a drive-based psychoanalytic approach, they also have a role in the object relations theory. She puts forth the importance of not underestimating *"the potentiality of the ego and the superego precursors at early levels of development to create intrapsychic conflicts"* (p.328). When tracking back the first traces of internalized conflict, one must look into the very first phases of the infant's extra-uterine life, detachment from the symbiotic matrix and differentiation (Mahler, 1975).

Lastly, Mahler (1972) suggests that the type of early interactions of the separation-individuation process could expand through the life-cycle. She states:

> One could regard the entire life cycle as constituting a more or less successful process of distancing from and introjection of the lost symbiotic mother, an eternal longing for the actual or fantasied 'ideal state of self', with the latter standing for a symbiotic fusion with the 'all good' symbiotic mother, who was at one time part of the self in a blissful state of well-being (Mahler, 1972, p. 338).

1.4. MENTALIZATION

Mentalization is another concept that has close links to psychosomatization, especially skin-related issues. As the literature on psychodermatology suggests, many skin conditions have been associated with the awareness, processing and expression of psychic states.

The term 'mentalization' is diversely construed both in psychoanalytic theory and developmental psychology. In the psychoanalytic setting, the concept of

mentalization and deficiencies of it came about especially in working with borderline pathologies. The Ecole Psychosomatique de Paris as well as analysists like Alfred Bion, Otto Kernberg, Andre Green and North American object relations theorists focused on the notion (Fonagy & Allison, 2012). Influenced by The Ecole Psychosomatique de Paris, developmental psychology, particularly by the 'theory of mind' and neuroscience, Fonagy and Target (1997, 2002) operationalized mentalization capacity as 'Reflective Function' (RF), evolving through the development of psychic representations of mental states in the mind of an infant. The current study adopted Fonagy and colleagues' conceptualization and operationalization as a measurable indicator of the capacity of mentalization.

Hereby, *"the notion of mentalizing refers to the capacity to reflect on internal mental states such as feelings, wishes, goals, and attitudes, with regard to both the self and others"* (Fonagy et al., 2016, p. 2). Mentalization is an imaginary mental activity and indicates the effort of making sense of and interpreting other's behavior and mental states such as thoughts and feelings while at the same time being attentive to our own and act accordingly (Allen, Fonagy, & Bateman, 2008; Bateman & Fonagy, 2006). In terms of the relational context, it requires establishing realistic models of interpretation, acknowledging the limits to it, of how others act, think and feel as they do (Fonagy& Target, 1997). It refers to having one's mind in mind and to the ability to see ourselves from the outside and others from within the inside (Fonagy, 2015).

Mentalization or as a synonym, reflectiveness is a multidimensional construct (Fonagy & Allison, 2012). It accommodates within itself the polarities such as implicit and explicit perception, self and other, internal and external, cognitive- emotional (Fonagy & Luyten, 2009). At one level, it is in relation to introspection or mindfulness, which requires attending to one's own mental states such as feelings and thoughts, however, these concepts do not reflect mentalization since the process of mentalization also requires the understanding of others. Moreover, intentional self-reflection is an overlearned skill while reflective function is more of an automatic procedure. The concept is also different from empathy which is in relation to feelings towards others however, mentalizing

comprises both the self and other (Fonagy et al., 2002). Emotional intelligence on the other hand, refers to understanding feelings in general while psychological mindedness is solely a cognitive process (Fonagy, 2015). Fonagy (2006, 2015) suggests that mentalization sits at the intersection of these concepts.

Fonagy et al. (2002) put forth that mentalization or reflective function is mostly a preconscious process. The capacity to mentalize is shaped by and evolves through the development of self-organization and comprehends the development of the attachment system. The mentalization capacity is suggested to be formed based on the attachment relationship between the mother and the child and the mother's reflective capacity. Thus, mentalization depends on the early affect mirroring and the establishment of inter-subjectivity within the infant-caregiver system. To be more specific, the infant initially finds his/her mind in the mind of the mother. The infant understands himself/herself as an independent subject, having his/her own separate mental states only through the caregiver's recognition of and treating of him/her as a mental agent, having his/her own feelings, thoughts and mind. When the caregiver understands, reflects on and affectively mirrors the child, the child can create a representation of his/her own mental states, can make sense of and regulate his/her own affective states according to what he/she sees outside. Hence, attachment security can develop. That sense of being organized essentially leads to a sense of self and an experience of oneself as a mental entity. Only through the experience of being understood and mentalized, can the child learn to mentalize and, in safety, interpret others' display of affects accountable for their actions. If, however the child cannot have that experience, then confusions about the self occurs (Fonagy et al., 2002). According to Bion (1962), if the reflective object is absent, the affective world of the infant and later on of the adult, is left unlabeled, confusing and unregulated, creating a vacuum effect, the inner reality becomes dreaded. Thus, one ends up constantly trying to create or find meaning and take reflections from others that actually do not fit into their own inner reality. Moreover, Debray (2001) states that the achievement of mentalization in development, later on plays a crucial role in the adult individual's ability to cope with anxiety and other difficult affects and to resolve inner and relational conflicts.

Fonagy et al. (2002) suggest that there is a direct link between attachment security and the capacity to mentalize. In fact, using the reflective function scale based on Adult Attachment Interview (AAI), Bouchard and colleagues (2008) found that higher mentalization capacity is negatively correlated with the insecure attachment of AAI. Similarly, Fonagy and colleagues (1991*a*) interviewed mothers based on the AAI and evaluated their reflective function levels with the reflective function scale based on these interviews and observed that mothers with high scores in reflective function were more likely to have secure attachments. Further, this reflective capacity of the mothers highly predicted the secure attachment of their children within the first year. Measuring another construct called parental reflective capacity, Fonagy and colleagues (1991*b*) found that reflective parenting highly determines attachment security in infants at 12 and 18 months. Moreover, parental reflective capacity has been found to be positively correlated with the affective communication between the mother and the child (Kelly, et al., 2005).

Impairments in mentalizing have been shown to be involved in various disorders especially in Borderline Personality Disorder (Bateman & Fonagy, 2004) and others such as Eating Disorder (Skårderud, 2007), Depression (Luyten et al., 2012) and Antisocial Personality Disorder (Bateman &Fonagy, 2008). Fonagy and colleagues (2016) defined two types of impairments in the mentalization capacity and suggest that these impairments are also involved in the vulnerability of individuals to psychopathology. The first impairment is 'Hypomentalization' which indicates the inability to reflect on and interpret the complex mental states of one's own mind and others. It is characterized by the use of concrete thinking. Thus, this inability to consider the complexity of mental states can create confusions. On the opposite side, the other impairment is 'Hypermentalization'. It indicates an excessive mentalizing and focusing on overly detailed accounts which have the risk of obscuring the external reality. People who hypermentalize are 'too certain' and form inaccurate interpretations regarding one's own mind and that of others. They have a tendency to form mentalistic representations with little or no evidence that accounts for an observable external reality. Ironically, these people tend to experience themselves as 'good mentalizers' (Fonagy et al., 2016). However, they

often rely on rational and intellectual processes for the sake of avoiding affect and function in the pretend mode (Bateman & Fonagy, 2013). By contrast, genuine mentalizing is characterized by the acknowledgement of the opaqueness of the mind and the ability to create meaning with humility (Fonagy et al. 2016). Mature mentalizers internally feel free and safe in exploring the thoughts, feelings, desires and experiences. They are more eager to verbalize difficult emotions, memories or experiences (Bateman & Fonagy, 2013).

The relationship between mind and body is closely linked with the development of mentalization (Gubb, 2013). Prior to Fonagy and Target's (1997) conceptualization of mentalization, The Paris Psychosomatic School put mentalization capacity in the center for understanding and treating psychosomatic illnesses. According to the Paris School, the genesis of psychosomatic illnesses and the degree to which these symptoms form depends on the degree of achievement of the mentalization capacity (Gubb, 2013). Regarding mentalization, one of the founders of the Paris School, Pierre Marty (1968) suggests that the psychosomatic patients are observed to be lacking psychic representations and show an inability to use psychic functioning as if their minds were empty. As the members of the Paris School, Marty, M'Uzan and David (1963) put forth that in psychosomatic illness, the instinctual drives that have to be discharged urgently do not meet with psychic elaboration since the psyche lacks in the formation of representations and the affective regulation is left impoverished. In other words, instinctual demands and their conflictual relationship with external reality cannot be symbolized since the sufficient capacity to symbolize and elaborate fantasy which is necessary to cope with infantile or every day anxiety could not be formed. McDougall (1974) states the proposition of the Paris School as *"Instinctual energy, bypassing the psyche, thus affects the soma directly, with catastrophic results"* (p. 445). The theoreticians of the Paris School of Psychosomatics define the deficiencies in the capacity to mentalize as if the person has a 'speechless mind'. If the mind cannot speak, in other words when the mind's capacity to think is not fully developed and symbolic tasks such as speaking, thinking and remembering could not be achieved, then, physical experiences cannot be transformed onto a mental plane. Since the mind

cannot perform such symbolic tasks, its expressions have to rely rather on the body. The Paris School theoreticians suggest that psychosomatic patients exhibit difficulties in mentalization in terms of operational thinking, essential depression and alexitymia (Gubb, 2013). Operational thinking is characterized by a narrative that is mechanical and without affect. It is without fantasy or symbolization and it functions on the basis of facts (Aisenstein, 2008, 2010, cited in Gubb, 2013). Essential depression is characterized by a libidinal loss, lack of desire and an impoverished emotional life. Alexitymia indicates the inability to differentiate between affects and to verbally express emotions (Gubb, 2013).

From the perspective of an object relations tradition, disruptions in the psychosomatic patients' mentalization capacity may be the result of the difficulties in the separation from the mother and insecurities in the attachment (Gubb, 2013). According to Sloate (2010), the development of the capacity to mentalize is jeopardized during the difficulties in the separation-individuation process since the child's conflicts around separation remains unresolved and his/her affects are unprocessed. If the separation-individuation process is disrupted, the child cannot form the reflexivity of affect and thought between the internal and external space (Sloate, 2010). In fact, the mothers of psychosomatic patients are often mentioned as they treat their children with over-possesiveness and unattunement (Gubb, 2013), engaging with their child's body as if it is their possession satisfying their own narcissistic needs (Griffies, 2010& Sloate, 2010). McDougall (1989) uses the term 'one body for two' as an analogy for this state of fusion within the mother-infant system, the undifferentiation of body limits and the loss of the body self, thus, the individual self. As a result of the disruptions in separation-individuation, these patients internalize the mother's prohibitions towards knowing one self, resulting in the inability to grow up and transform past magical omnipotence into a more sophisticated level of mentalization (Sloate, 2008). The children who are either traumatized or not contained and who experience disruptions in the parental reflective function cannot properly connect emotions with symbols and words (Krystal, 1997). Hence, Gubb (2013) puts forth that since the mind cannot cope with and handle emotions, "*unbearable and chaotic feelings are forced from the*

experiencing mind, leaving behind them physical residues of affect that continue to work on the body" (p. 126). The body appears to think, symbolize and communicate; the functions of which the mind should have performed instead (Gubb, 2013).

In terms of the relationship between somatization and mentalization, Gubb (2013) further states "*The Attachment approach conceives of this in terms of the body behaving as if it was a mind; in the case of the Paris School, the mind is behaving as though it were purely body*." (p. 139).

1.5. RELEVANT STUDIES

The current study aims to investigate the psychic functioning of the individuals who have skin reactions in terms of separation-individuation difficulties and mentalization capacity. While looking into the associations of the skin reactions with separation-individuation and mentalization, the framework of this study finds its base mainly from the possible link between the functioning of the psychic apparatus and early developmental failures with regards to skin reactions. In this sense, variables of interest in this study as separation/individuation and mentalization are concepts that are related to the early developmental trajectory. In the review of literature, no studies were found such as this one that directly studies the relations between the skin reactions and these two variables. However, since the focus of this study derives from the failures in the developmental trajectory, in this section, some of the studies regarding the skin reactions that could be relevant to the disruptions in the developmental line will be discussed.

Pretorius (2004), in the article named "The skin as a means of communicating the difficulties of separation-individuation in toddlerhood", presents a case study of an infant who had infantile eczema and struggles with the separation-individuation process. The case report provides a discussion about the importance of early separation-individuation difficulties in psychosomatic skin reactions based on Margaret Mahler's theory of separation-individuation.

Jan, a male infant, was observed every week for ten months in Anna Freud Centre Toddler Group to which he attended with his mother. He was seventeen

months old when he started the sessions (Pretorius, 2004). The author presents observations about the relationship between Jan and his mother. Although Jan and his mother shared some moments of attunement, there were also times when his mother was not emotionally available for him. She sometimes seemed to be insensitive and unable to be aware of the difficulties that Jan had. There were also times that she seemed inconsistent. Although she seemed to participate in conversations very eagerly and actively, she was unable to remember the names correctly, showed up late to the sessions, and became disengaged with regards to events and concepts. It seemed that the mother's ambivalence to her child resulted with her impatience, undependability, unpredictability, inability to be aware of Jan's constant insecurity with regards to his sense of self. Jan was unable to use her mother as an auxiliary ego for a reassurance of sense of self and containment which in turn is necessary for the formation of autonomy (Pretorius, 2004).

Jan was observed to be unable to initiate play on his own and with toys of his choice. The opposite would require a certain level of ego development which seemed to be disrupted in Jan's case. Based on several observations, the mother was unable to be a secure base for Jan, thus he could not separate himself and continue on his own. The mother was inattentive to the toys that Jan seemed to be interested in, on the contrary, Jan played with a toy that his mother wanted to play in order be close to her (Pretorius, 2004).

Pretorius (2004) further states that Jan exhibited an increased separation anxiety which Mahler et al. (1989) describe to occur particularly in rapprochement sub-phase of separation-individuation as in Jan's case. Pretorius (2004) expresses that Jan was extremely anxious in the short absence of his mother and was unable to be consolidated. However, upon her arrival, neither Jan nor his mother made an attempt towards each other which reflect an ambivalence that the two shares.

Moreover, the mother reported that she was having a difficult time coping with his husband's absence for prolonged periods of time because of his work. Based on the observed occasional aggressiveness of the mother towards Jan, it was speculated by the author that the mother projects the anger that she experiences in her relationship with her husband as well on to Jan. The mother also reported that

at the times of her husband's absence, she took Jan to her bed to prevent him from scratching at nights which could be speculated as she is trying to maintain the closeness by this way. By holding his hands and soothing him, she made sure she is needed by Jan and seemed to gain the satisfaction that she is indispensable for him; a feeling that she could not get from her husband. Jan's dependence was further strengthened by this way (Pretorius, 2004). Pines (1980), defines this kind of relationship as a prolonged symbiosis which is common between the infants with infantile eczema and their mothers.

Besides the mother being sometimes aggressive towards Jan it was also observed that Jan was unable to express his anger safely (Pretorius, 2004). According to Mahler et al. (1989), one of the most challenging part for the infant's developing ego is to cope with the aggressive drive that inevitable separation brings upon. Pretorius (2004) proposes that the degree to which the infant can cope with this anger is determined by the strength of his/her primitive ego which can be facilitated by containment and the skin-ego function that the mother puts forth for the child, in other words, mother's capability to act as an auxiliary ego for the child. This seemed to be disrupted in Jan and his mother's relationship. Pretorius (2004) further puts forth that the mother must also provide a sufficient libidinal cathexis of the infant's body at the time of body-ego formation. Jan's difficulty in expressing his aggression safely in combination with the insufficient and ambivalent libidinal cathexis of his body by his mother and in turn, by himself seemed to have resulted in Jan's turning his aggression against his body; his skin.

To sum up, the inconsistent containment and insensitivity in combination with the intense encouragement of dependence, the disruptions in introjecting a positive sense of self, thus lacking an ego strength, insufficient libidinal cathexis and difficulties in safe expression of anger all reflect disruptions in the separation-individuation process and are observed to be resulted in Jan's turning his anger towards his own body. The eczema he suffers, serves to be a metaphor for tearing down the oneness and reflect his difficulties during the separation-individuation process (Pretorius, 2004).

In relation with this case study with regards to the difficulties in the process of separation-individuation, Sperling (1968) suggests that separation anxiety is in operation as early as the beginning of life, however if the conflicts around the separation-individuation process are unresolved, the pathological outcome for the adult life may be the psychosomatic reactions. The author further states as *"an individual with this type of object relationship will react to separation or separation threats which to such a patient mean object loss with the psychosomatic response, that is, with somatic symptoms"* (Sperling, 1968, p. 252).

A qualitative study study was conducted by Aydın (2013), as a master's thesis with 17 Turkish people who had a diagnosis of psychogenic pruritus. Aydın aimed to investigate the early object relationships on the basis of the skin, the functioning of their psyche and the unconscious processes via the Rorschach test. Psychogenic pruritus refers to the somatoform itching of the skin that is precipitated and/or exacerbated with psychogenic factors for which no organic cause or etiological factor is determined (Altunay & Köşlü, 2008).

One of the important findings obtained from the semi-structured interviews that Aydın (2013) conducted was that the participants mentioned some psychological distress such as heightened anxiety, depressive states and sleep problems right before the onset of pruritus. It was observed that the intensity of the anxiety experienced went parallel with the intensity of the itch. Moreover, they reported that the psychological disturbances mentioned above were decreased when attacks of itch appeared and they also reported that they got a relief from the anxiety only through the intense excoriation of their skin which indicate that their psychic functioning falls short in working through the psychological disturbances that they experience. Furthermore, they were observed to be incapable of expressing their emotions, most particularly their anger. Another important information was that they mentioned traumatic experiences such as migration, lost, birth and abuse which went parallel with the onset of pruritus, however, they could not draw any links between these events and the onset of their disease. The participants mentioned their mothers as distant, remote and incapable of showing their love and

affection. Most importantly, the mothers were reported as not allowing so much for a physical contact.

With regards to the general findings of the study based on the Rorschach protocols in combinations with the semi-structured interviews, Aydın (2013) concluded that these participants with pruritus could not have formed satisfactory and secure object relations due to disruptions in the maternal functions of containment, protection and holding in the early mother-infant relationship. The mothers were thought to had difficulties in fulfilling the emotional needs in combination with meeting and containing the excitations of their child. As a matter of fact, the wish for containment and support was often repeated in the protocols. Almost in all protocols, due to the insufficient primitive maternal envelope, the disruptions in Skin-Ego were observed. The mentioning of the skin with the themes of 'damage' and 'easy penetration' was thought to be an indication that these participants were incapable of protecting themselves against excitations coming from the outside. Moreover, aggressive drives in terms of the relationship with the object were also apparent. In line with this, İkiz (2005) suggests that the difficulties or disruptions in the mentalization capacity that prevents the acceptance of perceptual and sensory differences during the individuation process of the infant can result in the emergence of aggressive and hostile drives. Aydın (2013) suggests that the wish to be contained in combination with aggressiveness seemed to be resulted in maintaining a highly conflictual however symbiotic relationship with the object for these participants. Further, the anxiety about the loss of the object and the tendency to continue the symbiotic relationship were also observed in the protocols. Moreover, it was observed that the participants were having difficulties in differentiating the internal from the external and in establishing the boundaries of the self. The concept of the self was found to be very fragile and vague in combination with the difficulties in establishing a satisfactory sexual concept of the self. The observed insufficiencies in the symbolization capacity in the protocols were thought to be linked with the disruptions in the early object relationship. The ambivalent feelings of the participants and the conflictual yet symbiotic relationship regarding the early object and their need for containment and support were also

found to be reflected on their relationship with their partners. The participants who describe their marriage or relationships as symbiotic rather than satisfactory were observed to experience a heightened anxiety about the thought of leaving their partners despite their reported unhappiness (Aydın, 2013). Lastly, Aydın (2013) observed that these participants' psychic functioning contained aspects that could be related to borderline states.

Regarding the association of skin-related issues with mentalization, again no studies were found that investigate the direct link between them. However, some studies have found associations of some skin diseases with the attachment styles and alexithymia; the concepts which are closely associated with mentalization capacity.

One study looked at attachment security and relationship satisfaction in 62 outpatients with atopic dermatitis and the same number of a healthy controlled group (Dieris-Hirche, Milch & Kupfer et al., 2012). The study revealed that the patients with atopic dermatitis had significantly less attachment security than the control group. According to the sub-dimensions as anxiety, dependency and closeness of the Adult Attachment Scale (AAS), atopic dermatitis patients were more anxious about being abandoned or not loved, had more trust issues and difficulties in depending on others and showed lower degree of closeness. Moreover, it was observed that there was a significant positive correlation between attachment insecurity and severity of the symptoms. On the other hand, no significant difference was found between the control group and atopic dermatitis patients regarding the partner satisfaction (Dieris-Hirche, Milch & Kupfer et al., 2012). Furthermore, another study by Picardi and colleagues (2003) found that the cases of vitiligo had more insecure attachment styles than that of a control group with other skin diseases which were thought of as lacking a psychosomatic dimension. The vitiligo cases also scored higher on alexithymia. The vitiligo group and the control group did not differ in terms of the total number of stressful life events, however the vitiligo cases experienced three or more uncontrollable events more frequently. The authors concluded that the stressful life events do not appear to increase the vulnerability to vitiligo except for three or more uncontrollable

events. However, they suggest that alexithymia, insecure attachment and lack of social support appear to be in play in terms of increasing the susceptibility because these cases experience difficulties in affect regulation and coping with stressful life events. Several studies also found significant associations between psoriasis and alexithymia scores (Allegranti et al., 1994; Consoli et al., 2006; Picardi et al., 2005).

It is important to note that some other studies looked at the relationship between alexithymia and various specific skin diseases, however the results are still highly controversial (Willemsen et al., 2008). Contrary to the presented associations found between alexithymia and different skin diseases, other studies failed to demonstrate such an association (Fava et al, 1980; Rubino et al., 1989; Richards et al., 2005; Picardi et al., 2007). With regards to the conflicting results, McDougall (1989), based on her observations, suggests that many people who have alexithymia and operational thinking do not show psychosomatic manifestations and those who are somatically ill may not necessarily show alexithymic features. However, she states that sometimes the 'dead area' for these patients which harbors despair within itself is masked by the addictiveness and dependence on the significant one who is experienced as fused with them (McDougall, 1989).

1.6. PRESENT STUDY

In light of the presented literature, in terms of skin reactions, this study finds its base and focus mainly from the possible effects of early developmental failures on the functioning of the psychic apparatus with regards to separation-individuation and mentalization difficulties. Thus, the current study expects a relationship between separation-individuation level, mentalization capacity, and psychosomatic skin reactions. Further, as reported previously, women and individuals with a history of trauma are more prone to suffer skin reactions. In line with this, the study also expects that gender and history of trauma would be associated with psychosomatic skin reactions. The overall aim of the study is to predict psychosomatic skin reactions in a sample from Turkey.

1.6.1. Hypotheses

Hypothesis 1: Gender and trauma history will be associated with psychosomatic skin reactions.

a) Women are expected to have a higher level of psychosomatic skin reactions, as compared to men.

b) Individuals with a history of trauma are expected to have a higher level of psychosomatic skin reactions, as compared to individuals with no trauma history.

Hypothesis 2: Individuals who have more separation-individuation related issues are expected to have more psychosomatic skin reactions.

Hypothesis 3: The level of psychosomatic skin reactions will be negatively associated with the level of mentalization capacity.

a) Hypermentalization and Hypomentalization are expected to be positively associated with the level of psychosomatic skin reactions.

METHOD

2.1. PARTICIPANTS

The data was aimed to be collected from the participants whose age falls between 18 to 65 years. 793 people attempted to participate in the study. Out of these 793 participants, a total of 121 were excluded due to age restriction, invalid responses and non-completion of all the measures of interest. Thus, data was reduced to 672 participants.

The age of the participants ranged between 18 to 59 years (M = 29.62, SD = 9.670). Regarding gender, 76% of the participants were female while 23% were male. The majority of the participants had a high level of educational attainment; 40% were BA students, 31% were BA graduates, 12% were MA or PhD students and 11% were MA or PhD graduates, while 5% were high school graduates and 2% were primary school graduates. The percentage of participants who reported that they currently do not have a job was 50%, while 46% reported that they have jobs,

4% were categorized as other. In terms of relationship status, 38% of the participants had no relationship, 24% were in a relationship, 3% were engaged, 34% were married and 1% were categorized as other.

Regarding socio-economic status, the participants who defined their status as Middle were in the majority (47%). The participants who fall into the Upper Middle category was 28%, the Lower Middle was 14%, Lower was 5% and Upper was 5%.

Almost all participants (90%) reported that they live in a big city, whereas 8% live in a small city and 1% live in the country, a small town or a village.

In terms of traumatic experience, 67% of the participants reported that they had experienced trauma while 33% reported that they have no trauma history. The age that the participants had experienced trauma ranged from a minimum of 3 to a maximum of 55 (M = 18.78, SD = 9.518). Both the perceived intensity and effect of the traumatic experience were rated on a 4-point likert scale. The mean level of perceived intensity of the traumatic event was 3.11 (SD = .884) while the mean level of perceived effect was 3.013 (SD = .955)

2.2. INSTRUMENTS

Participants were presented with a survey package including The Demographic Information Form in order to gather background information about the participants in addition with their complaints regarding the skin, The Separation-Individuation Inventory (SII) for measuring the levels of separation-individuation related issues, and The Reflective Functioning Questionnaire (RFQ-54) for measuring the levels of the mentalization.

2.2.1. The Demographic Information Form

The Demographic Information Form was generated by the researcher. The form includes questions about the participants' age, gender, education level, perceived socioeconomic level, relationship status, medical history, psychotherapy history, perceived trauma experience and complaints about skin reactions. The skin

related questions were generated by the researcher based on the literature review of psychodermatology and expert opinion. First, the participants were asked if they have or have had any complaints regarding the skin. A diverse symptom list comprising symptoms such as itch, rash, redness, swelling, cracking, flaking, acne etc. was provided for which the degree of intensity for each symptom was also asked. One can have occasional skin symptoms, however they may not have a diagnosis. For this reason, other than skin related complaints, the participants were also asked separately, if they have or have had any diagnoses regarding the skin. A diverse list of skin related diagnoses including dermatitis in general, psoriasis, rosacea, urticaria, vitiligo etc. and 'other' section was provided. (see Appendix B)

2.2.2. The Separation-Individuation Inventory (SII)

The Separation- Individuation Inventory (SII), as presented in Appendix C, is a 39-item, 10-point Likert type self-report measure developed by Christenson et al. (1985), in order to examine the separation- individuation issues on the basis of the psychoanalytic developmental theory by Margaret S. Mahler. The inventory has 3 subscales measuring deficiency in differentiation, defence mechanism of splitting, and separation-individuation related relationship problems. The internal reliability of the inventory has been reported to be .92, and the unitary factor structure accounted for 49% of the variance (cited in Göral, 2010).

The Turkish version of SII was developed by Göral (2010) as a doctoral thesis. Cronbach's alpha for the whole scale was .90. Cronbach's alpha coefficients for the 3 subscales are as follows: .78 for the splitting subscale, .80 for the lack of differentiation, and .65 for the separation individuation related relationship problems subscale (Göral, 2010). The higher scores indicate more difficulties in separation-individuation. In this study, cronbach's alpha value for the whole scale was found to be .91.

2.2.3. The Reflective Functioning Questionnaire (RFQ-54)

The Reflective Functioning Questionnaire, as presented in Appendix D, is a 54-item 7-point Likert type self-report measure, developed by Fonagy and Ghinai

(2008) to examine mentalizing capacity, operationalized as reflective functioning, with regard to the interpretation of both internal and external mental processes such as feelings, wishes, goals, desires and attitudes.

Previous studies demonstrated that the RFQ-54 has satisfactory internal consistency of .82; and was positively correlated with measures of related constructs, such as mindfulness, $r = .40$, $p < .001$, and cognitive empathy, $r = .48$, $p < .001$ (Fonagy et al., 2016).

Based on the results of several research projects using RFQ-54, in addition to the total score, Fonagy and colleagues (2016) suggested a re-scoring of 26 of the items to generate independent scores for two sub-dimensions: RFQ Certainty / Hypermentalization (being too certain mental states about self and others) and RFQ Uncertainty / Hypomentalization (being too uncertain mental states about self and others). For both dimensions, higher scores reflect more impairment in the mentalization capacity. The Cronbach's α of RFQ Uncertainty was .77 for the clinical sample and .63 for the non-clinical sample. Internal consistency scores of RFQ Certainty were .65 and .67 for the clinical and non-clinical samples respectively.

The Turkish version of the scale was provided by the developers of the scale and used in a previous study by Köksal (2017). The Cronbach alpha coefficients for the Turkish version were reported to be .90 for the Certainty / Hypermentalization sub-dimension and .81 for the Uncertainty / Hypomentalization sub-dimension. Further, the validity of the Turkish version is supported by Köksal (2017). Köksal (2017) 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, $r = .261$, $p < .001$. Further, a significant negative correlation was found between Certainty and Uncertainty, $r = -.493$, $p < .001$. In this study, cronbach's alpha value for the Certainty dimension was found to be .90, while cronbach's alpha value for the Uncertainty was .87.

2.3. PROCEDURE

Ethical approval was obtained from the Ethics Committee Board of Istanbul Bilgi University prior to the collection of data. All the data was collected via an online survey software (www.surveymonkey.com). The online survey link was shared through e-mail and social media posts. First, in order to ask for a voluntary participation, the participants were given an Informed Consent Form (see Appendix A) in which the information regarding the confidentiality, 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 were provided. Subsequent to their approval for a voluntary participation, The Demographic Information Form, The Separation-Individuation Inventory (SII), and The Reflective Functioning Scale (RFQ) were presented respectively. Approximately 15-20 minutes was needed to fill in all the survey questions.

2.4. DATA ANALYSIS

Pearson product moment correlation, one-way analysis of variance (ANOVA), analysis of covariance (ANCOVA) and independent t- tests were used to test the associations between the measures of interest and psychosomatic skin reactions. In order to predict psychosomatic skin reactions, the data were analyzed using Multiple Stepwise Regression Analysis, with psychosomatic skin reactions as the dependent variable; the separation-individuation level, mentalization capacity, gender and trauma history as predictors. Multiple Regression Analysis provided information on the controlled association of each variable with psychosomatic skin reactions and allowed for the comparison of the strength of these associations.

RESULTS

3.1. PRELIMINARY ANALYSIS

The descriptive statistics for the two scales as The Separation-Individuation Inventory (SII) and The Reflective Functioning Questionnaire (RFQ) were calculated. In terms of the Separation-Individuation Inventory (SII), the mean level for the total score was 142.96 (*SD* = 48.50), ranging from a minimum of 46 and a maximum of 335. In terms of the subscales, the mean score for the splitting subscale was 47.04 (*SD* = 17.50), ranging from a minimum of 14 and a maximum of 115. The mean score for the differenciation subscale was 46.81 (*SD* = 19.70), ranging from a minimum of 14 and a maximum of 126. The mean score for the relationship problems subscale was 49.12 (*SD* = 15.88), ranging from a minimum of 13 and a maximum of 111. Further, in terms of The Reflective Functioning Questionnaire (RFQ), the mean score for the Certainty (Hypermentalization) dimension was 27.09 (*SD* = 15.34), ranging from a minimum of 0 to a maximum of 75. For the Uncertainty (Hypomentalization) dimension, the mean score was 13.82 (*SD* = 11.23), ranging from a minimum of 0 to a maximum of 58.

The relationships between psychosomatic skin reactions and the basic demographic variables which could not have been foreseen in the hypotheses were checked in preliminary analysis in order to include and control their effect in the multiple regression analysis. Further, the strength and direction of the associations between the hypothesized variables and psychosomatic skin reactions were also checked and will be discussed.

In order to measure psychosomatic skin reactions, three variables as skin related symptom number, intensity of these symptoms and skin related diagnosis were used. It was important to consider the number of skin related symptoms that an individual had as well as the varying degree of intensity of these symptoms in order to effectively establish the overall skin related disturbance level that participants experience. In other words, measuring the symptom number or symptom intensity alone would not capture the overall disturbance that one

experiences with regards to skin. The individuals who had only one symptom with high intensity must also be considered besides others who had a bunch of symptoms with varying intensities. Thus, a composite score was generated by multiplying the number of skin related symptoms with the intensity of the symptoms in order to find a composite skin disturbance level. Besides the composite skin disturbance level, the number of diagnoses related to skin was also included in all analyses.

3.1.1. Descriptive Statistics of Psychosomatic Skin Reactions

Out of the 672 participants who attempted to fill the variable of the skin related symptoms, 90.8 % reported at least one symptom and 9.2 % reported no symptoms (M = 4.15, SD = 2.348). The participants who reported a symptom or symptoms were expected to rate the degree of intensity on a scale from 0 to 6 for each symptom that they have reported. For every participant, a mean intensity score was calculated (M = 2.76, SD = 1.11). In order to differentiate between those who did not report a symptom and those who reported a symptom or symptoms with no intensity, the former mean intensity as through 0 to 6 was recoded as through 1 to 7. Further, by multiplying the number of symptoms with the recoded mean intensity, a composite skin disturbance score (M = 15.74, SD = 10.83) was created (see Table 1).

Table 1 *Descriptive Statistics of Psychosomatic Skin Reactions*

	Min	*Max*	*Mean*	*SD*
Composite Skin Disturbance Score	0	53	15.74	10.83
Skin-related Symptom Number	0	8	4.15	2.35
Skin-related Symptom Intensity	1	6	2.76	1.11
Skin-related Diagnosis	1	4	1.43	.704

In terms of the skin diagnosis, out of 372 participants, 52% of the participants reported at least 1 skin-related diagnosis, while 48% reported no diagnosis. The most frequently reported (28%) skin diagnosis was dermatitis/eczema. Besides, the subsequent most frequent diagnoses were, cold sore (25%), urticaria (11%), psoriasis (10%). The rest of the percentage was dispersed into diagnoses such as herpes zoster, rosacea, vitiligo, acne, liken planus, fungus and others. All the diagnoses that the participants reported were added up and a number of diagnoses score was used for analyses.

3.1.2. Background Characteristics and Psychosomatic Skin Reactions

The associations between all background characteristics and skin reactions were explored. Two of them, gender and trauma were hypothesized on the basis of previous literature in terms of women having a tendency to show a higher prevalence than men and the association of traumatic experience with skin diseases. Although not hypothesized, since this is one of the very few studies on a sample from Turkey and since the sample was quite diverse, other characteristics were also checked in order to identify any potential predictors or covariates.

The first hypothesis of the study expected that females will have a higher level of psychosomatic skin reactions than men. In accordance with the hypothesis, an independent t-test showed a highly significant difference in the composite skin disturbance level between female and male participants, t (666) = - 4.133, $p < .001$, with female participants showing a higher level of disturbance (M = 16.68, SD = 10.82) than male participants (M = 12.62, SD = 10.37). Moreover, in terms of the number of skin related diagnoses, again a highly significant difference between female and male participants is observed, t (329.722) = - 3.981, $p < .001$, with female participants showing a higher number of diagnoses (M = .80, SD = .915) than male participants (M = .52, SD = .696).

Moreover, there is a significant positive correlation between age and the number of skin related diagnoses, r (671) = .273, $p < .001$, however the correlation is found to be weak. Further, no significant correlation was found between age and the composite score of skin disturbance level, r (671) = .066, $p > .05$.

In terms of relationship status, the one-way analysis of variance (ANOVA) revealed that there is a significant difference between groups of relationship status and the number of skin related diagnoses, F (667) = 15.796, p < .001. Since the single participants were younger than participants of other marital status, the analysis was repeated controlling for age via analysis of covariance (ANCOVA), and the marital status still demonstrated a highly significant effect, F (667) = 8.119, p < .001. Post-hoc tests demonstrated that there is a significant difference between the married participants and participants who are not in a relationship; the married group showing a higher number of skin related diagnoses (*M* = 1.08, *SD* = 1) than the group with no relationship (*M* = .51, *SD* = .70). Moreover, there is a significant difference between married participants and participants who are dating; the married group again shows a higher number of skin related diagnoses (*M* = 1.08, *SD* = 1) than the group who are dating (*M* = .58, *SD* = .78). Regarding the composite disturbance level, there is also a significant difference between groups of relationship status, F (667) = 3.360, p = .01. There is a significant difference between the married participants and participants who are not in a relationship; the married group shows a higher level of composite skin disturbance (*M* = 16.88, *SD* = 11.33) than the group who are not in a relationship (*M* = 14.18, *SD* = 10.40).

Regarding socio-economic status, no significant difference was found between groups in terms of both the composite skin disturbance level, F (667) = .815, p > .05 and the number of skin diagnoses, F (667) = 1.062, p > .05.

In terms of educational attainment, the categories are combined into three, based on each category's frequency. Primary school graduates, high school drop outs, high school graduates and BA drop outs are combined as BA non- graduates. BA graduates, MA/PhD drop outs, MA/PhD students and MD/PhD graduates were combined as BA/ MA and PhD graduates. The third category was BA students. The one-way analysis of variance (ANOVA) showed that there is a significant difference between groups of educational attainment and the number of skin related diagnoses, F (669) = 20.665, p < .001. The post-hoc tests demonstrated that BA students (*M* = .48, *SD* = .679) had significantly lower number of diagnoses as compared to primary/high school graduates (*M* = .96, *SD* = .868) and BA/MA/PhD

graduates (*M* = .90, *SD* = .958). Since BA students were younger than participants of other educational status, the analysis was repeated controlling for age via analysis of covariance (ANCOVA), and it was observed that the signicance of the main effect faded, F (667) = 2.006, p > .05. However, the parameter estimate of being a BA student still remains marginally significant while controlling for age, *t* = -1.972, *p* = .049.

There is no significant difference between groups of educational attainment and the composite skin disturbance, F (669) = 2.421, p >.05.

In addition, the current study hypothesized that the individuals with a history of trauma would have a higher level of psychosomatic skin reactions, as compared to individuals with no trauma history. In accordance with this hypothesis, an independent t-test showed that there is a significant difference between participants who experienced trauma and participants with no trauma history in terms of the number skin diagnoses, *t* (669) = - 4.015, *p* < .001 with the participants with a history of trauma showing higher number of skin diagnoses (*M* = .83, *SD* = .898) than participants with no trauma (*M* = .54, *SD* = .800). A significant difference between participants who experienced trauma and participants with no trauma history was also observed in terms of composite skin disturbance, *t* (669) = - 5.193, *p* < .001 with the participants with a history of trauma showing higher level of skin disturbance (*M* = 17.20, *SD* = 10.39) than participants with no trauma (*M* = 12.67, *SD* = 11.06).

3.1.3. Separation-Individuation, Mentalization and Psychosomatic Skin Reactions

The current study expects a relationship between the separation-individuation level, mentalization capacity and psychosomatic skin reactions. In order to evaluate the direction and strength of these associations, Pearson correlation coefficients were calculated (see Table 2). Psychosomatic skin reactions were measured based on the composite score of skin disturbance level and the number of skin related diagnoses.

Table 2 *Pearson Correlation Coefficients between Separation-Individuation, Certainty and Psychosomatic Skin Reactions*

	Composite Disturbance	Number of Diagnoses
SII Splitting	.127**	-.026
SII Differentiation	.105**	-.051
SII Relationship Problems	.149***	-.053
SII Total	.137***	-.048
RFQ-Certainty	-.069	.139***

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

*** Correlation is significant at the 0.001 level (2-tailed)

The second hypothesis of this study expected that the separation-individuation level will be positively correlated with psychosomatic skin reactions. As shown in Table 2, there is a weak, however still significant positive correlation between the total score of the separation-individuation level and the composite score of skin disturbance level, r (672) = .137, $p < .001$. In terms of the subscales of separation-individuation, there was found to be a weak, however still significant positive correlation between the Splitting subscale and the composite skin disturbance level, r (672) = .127, p = .001. There is also a positive significant correlation between the Differentiation subscale and the composite skin disturbance level, however the correlation is found to be weak, r (672) = .105, $p < .01$. The subscale of Relationship Problems is also found to be positively correlated with the composite skin disturbance, however the correlation was again observed to be weak, r (672) = .149, $p < .001$. Furthermore, in terms of the number of skin related

diagnoses, no significant correlation was found either with any of the subscales or the total score of the separation-individuation.

The third hypothesis of the study expected that psychosomatic skin reactions would be positively correlated with the two indicators of impaired mentalization capacity; Certainty (Hypermentalization) and Uncertainty (Hypomentalization). However, since the distribution of the Uncertainty dimension was found to be extremely positively skewed, it was excluded from all the analyses. In accordance with the hypothesis, in terms of Certainty (Hypermentalization), there is a weak, however still significant positive correlation with the number of skin related diagnoses, $r\,(672) = .139$, $p < .001$. Moreover, no significant correlation between Certainty (Hypermentalization) and the composite skin disturbance level was found.

3.2. FACTORS THAT PREDICT PSYCHOSOMATIC SKIN REACTIONS

The overall aim of the study is to predict psychosomatic skin reactions. Thus, two stepwise regression analyses were carried out, assigning the composite score of skin disturbance level as one dependent variable and the number of skin related diagnoses as another dependent variable in order to predict psychosomatic skin reactions based on gender, the existence of traumatic experience, total score of Separation-Individuation level, and Certainty (Hypermentalization) as independent variables. Since age could be related to any physical disorder, it was included in the analysis as a covariate in order to observe and control its effect. Further, since relationship status was found to be significantly associated with psychosomatic skin reactions and educational attainment demonstrated an effect that might have been due to just age, yet remained inconclusive, in the preliminary analysis, they were also included in the regression equation. All the assumptions were checked and validated prior to analysis. In the preliminary analysis, the three subscales of the separation-individuation were found to be highly correlated both with each other and the total score of the separation-individuation level. Since this creates a

multicollinearity problem, only the total score of separation-individuation was included in the multiple regression analysis.

Firstly, a step-wise multiple regression was conducted to predict composite skin related disturbance based on age, gender, educational attainment, relationship status, traumatic experience, separation-individuation level and mentalization capacity. The step-wise regression analysis excluded educational attainment from the equation. Thus, educational attainment does not predict the composite skin disturbance level in this study. A summary of the models obtained from the stepwise regression analysis is presented in Table 3.

At Step 1 of the analysis, traumatic experience was entered into the regression equation and approximately 3.9 % of the variance of the composite score of skin related disturbance could be accounted for by traumatic experience, R^2 = .039, F (1, 659) = 26.564, p < .001. After gender was included in addition to traumatic experience in the equation at Step 2, the total variance explained by the model as a whole was 6 %, F (2, 658) =20.829, p < .001. Addition of Gender to the prediction of the skin related disturbance explained an additional unique 2.1 % of the variance, after controlling for traumatic experience, R^2 change = .021, F change (1, 658) = 14.547, p < .001. At step 3, the separation-individuation level was entered into the equation and the total variance explained by the model as a whole was 7.6 %, F (3, 657) = 18.054, p < .001. The Separation-individuation level explained an additional 1.7 % of the variance in the prediction after controlling for traumatic experience and gender, R^2 change = .017, F change (1, 657) = 11. 820, p = .001. At step 4, relationship status was entered into the equation and the total variance explained by the model as a whole was 9 %, F (4, 656) = 16.181, p < .001. The relationship status explained an additional 1.4 % of the variance in the prediction after controlling for traumatic experience, gender and separation-individuation level, R^2 change = .014, F change (1, 656) = 9.833, p < .01. At the final step, age was entered into the regression equation and explained an additional 0.6 % of the variance in the prediction of the skin related disturbance after controlling for traumatic experience, gender, separation-individuation score and relationship status, R^2 change = .006, F change (1, 655) = 4.490, p < .05. In the final model, five

of the variables as traumatic experience, gender, separation-individuation score, relationship status and age were entered into the model and the whole model explained 9.6 % of the total variance in the composite score of skin related disturbance level, $F (5, 655) = 13.911$, $p < .001$.

Further observation of the regression coefficients and standardized beta values which are presented in Table 4 reveals that experiencing trauma would lead to a 3.543 increase in the composite score of skin related disturbance level. Being a female would lead to a 3.891 increase in the skin related disturbance. Further, skin related disturbance level is increased by .041 for each unit of increase in the separation-individuation difficulties. Moreover, being in a relationship would lead to a 2.161 increase in the skin related disturbance. Lastly, the skin related disturbance level is increased by .099 for each unit of increase in age.

Table 3 *Summary of Stepwise Regression Analysis by Composite Skin Related Disturbance*

Model	R	R^2	Adjusted R^2	SE of the Estimate	R^2 Change	F Change	df1	df2
1	.197[a]	.039	.037	10.63	.039	26.564	1	659
2	.244[b]	.060	.057	10.52	.021	14.547	1	658
3	.276[c]	.076	.072	10.44	.017	11.820	1	657
4	.300[d]	.090	.084	10.37	.014	9.833	1	656
5	.310[e]	.096	.089	10.34	.006	4.490	1	655

a. Predictors: (Constant), Traumatic Experience
b. Predictors: (Constant), Traumatic Experience, Gender
c. Predictors: (Constant), Traumatic Experience, Gender, Separation-Individuation Level
d. Predictors: (Constant), Traumatic Experience, Gender, Separation-Individuation Level, Relationship Status
e. Predictors: (Constant), Traumatic Experience, Gender, Separation-Individuation Level, Relationship Status, Age
f. Dependent variable: The Composite Skin Related Disturbance

Table 4 *Results of the Stepwise Regression Analysis for Variables Predicting the Composite Skin Related Disturbance (N=668)*

	Unstandardized Coefficients		Standardized Coefficients		
	B	B SE	Beta	T	Sig.
Constant	.222	2.360		.094	.925
Traumatic Experience	3.543	.872	.154***	4.062	.000
Gender	3.891	.964	.152***	4.034	.000
Separation-Individuation	.041	.009	.184***	4.529	.000
Relationship Status	2.161	.886	.097*	2.439	.015
Age	.099	.047	.089*	2.119	.034

Another step-wise multiple regression was conducted to predict the number of skin related diagnoses based on age, gender, educational attainment, relationship status, traumatic experience, separation-individuation level and mentalization capacity. The step-wise regression analysis excluded the educational attainment from the equation indicating that educational attainment does not predict the number of skin related diagnoses in this study. A summary of the models obtained from the stepwise regression analysis is presented in Table 5.

At step 1 of the regression analysis, age was entered into the regression equation and it explained the 7.5% of the variance accountable for the prediction of the number of skin related diagnoses, R^2 = .075, F (1,659) =53.277, p < .001. At step 2, gender was entered into the equation and the total variance explained by the model as a whole was 9.3 %, F (2, 658) = 33.800, p < .001. Addition of Gender to the prediction of the diagnoses number explained an additional 1.8 % of the variance, after controlling for age, R^2 change = .018, F change (1, 658) = 13.327, p < .001. At step 3, traumatic experience was entered into the equation and the total variance explained by the model as a whole was 10.8 %, F (3, 657) = 26.432, p < .001. Trauma experience alone explained an additional 1.5 % of the variance in the prediction of the number of diagnoses after controlling for age and gender, R^2 change = .015, F change (1, 657) = 10. 700, p < .001. At step 4, relationship status was entered into the equation and the total variance explained by the model as a whole was 11.8 %, F (4, 656) = 21.877, p < .001. The Relationship status alone explained an additional 1 % of the variance in the prediction of the number of diagnoses after controlling for age, gender and traumatic experience, R^2 change = .010, F change (1, 656) = 7.437, p < .001. At step 5, Certainty score (Hypermentalization) was entered into the equation and the total variance explained by the model as a whole was 12.3 %, F (5, 655) = 18.442, p < .001. Certainty (Hypermentalization) alone explained approximately an additional 0.6 % of the variance in the prediction of diagnosis number after controlling for age, gender, traumatic experience and relationship status, R^2 change = .006, F change (1, 655) = 4. 263, p < .001. At the final step, the Separation-Individuation level was entered into equation and explained an additional 0.8 % of the variance in the prediction

after controlling for age, gender, traumatic experience, relationship status and Certainty (Hypermentalization), R^2 change = .008, F change (1, 654) = 5.682, p < .001. In the final model, six of the variables as age, gender, traumatic experience, relationship status, the certainty score (Hypermentalization) and the separation-individuation level were entered into the model and the whole model explained 13.1 % of the total variance in the number of skin related diagnoses, F (6, 654) =16.425, p < .001.

As the regression coefficients and standardized beta values in Table 6, reveal, the number of skin related diagnoses are increased by .022 for each unit of increase in age. Being a female results in .260 increase in the number of skin related diagnoses. Further, experiencing trauma leads to a .208 increase in the number of diagnoses. Moreover, being in a relationship results in .198 increase in the number of diagnoses. The number of skin related diagnoses are increased by .006 for each unit of increase in hypermentalization. Lastly, one unit of increase in separation-individuation difficulties would lead to a .002 increase in the number of diagnoses.

Table 5 *Summary of Stepwise Regression Analysis by Number of Skin Related Diagnoses*

Model	R	R^2	Adjusted R^2	SE of the Estimate	R^2 Change	F Change	df1	df2
1	.273[a]	.075	.073	.843	.075	53.277	1	659
2	.305[b]	.093	.090	.835	.018	13.327	1	658
3	.328[c]	.108	.104	.829	.015	10.700	1	657
4	.343[d]	.118	.112	.825	.010	7.437	1	656
5	.351[e]	.123	.117	.823	.006	4.263	1	655
6	.362[f]	.131	.123	.820	.008	5.682	1	654

a. Predictors: (Constant), Age
b. Predictors: (Constant), Age, Gender
c. Predictors: (Constant), Age, Gender, Traumatic Experience
d. Predictors: (Constant), Age, Gender, Traumatic Experience, Relationship Status
e. Predictors: (Constant), Age, Gender, Traumatic Experience, Relationship Status, Certainty (Hypermentalization)
f. Predictors: (Constant), Age, Gender, Traumatic Experience, Relationship Status, Certainty (Hypermentalization), Separation-Individuation Level
e. Dependent variable: Number of Skin Related Diagnoses

Table 6 *Results of the Stepwise Regression Analysis for Variables Predicting the Number of Skin Related Diagnoses (N=664)*

	Unstandardized Coefficients		Standardized Coefficients		
	B	B SE	Beta	T	Sig.
Constant	-.794	.207		-3.841	.000
Age	.022	.004	.237***	5.749	.000
Gender	.260	.077	.126***	3.398	.001
Traumatic Experience	.208	.069	.112**	3.007	.003
Relationship Status	.198	.070	.110**	2.810	.005
RFQ Certainty	.006	.002	.110**	2.744	.006
Separation-Individuation	.002	.001	.101*	2.384	.017

3.3. SUMMARY OF THE MAIN RESULTS

Based on the proposed hypotheses, the present study aimed to investigate the possible correlations of psychosomatic skin reactions with separation-individuation, mentalization, traumatic experience and gender. The study further looked into the predictive factors of psychosomatic skin reactions.

Supporting the proposed hypotheses, statistical analyses demonstrated that women and individuals with a history of trauma showed higher levels of psychosomatic skin reactions in terms of both the composite skin disturbance level and the number of skin related diagnoses. Moreover, in accordance with the second hypothesis, it was found that individuals who had more difficulties with separation-individuation showed higher scores of composite skin disturbance. However, no significant correlation was found between separation-individuation and the number of skin related diagnoses. Further, Certainty (Hypermentalization) as an indicator of the impaired mentalization capacity, was found to be positively correlated with the number of skin related diagnoses as expected, however no significant correlation was found with the composite skin disturbance level.

In terms of predicting psychosomatic skin reactions, having a traumatic experience was observed to be the strongest predictor for the increased level of composite skin disturbance. Besides traumatic experience, being a female, difficulties in separation-individuation, being in a relationship and age were found to be the significant risk factors respectively. In terms of the number of skin related diagnoses, age appeared to be the strongest predictor. Further, being a female, trauma history, being in a relationship, Certainty (Hypermentalization) and difficulties in separation–individuation were also observed to predict the number of diagnoses respectively.

DISCUSSION

4.1. DISCUSSION OF THE MAIN FINDINGS

The main objective of the study was to predict the psychological and experiental forerunners of psychosomatic skin reactions. Besides, associations of psychosomatic skin reactions in terms of both the increased levels of skin disturbance and the number of skin related diagnoses with the background characteristics, separation-individuation and mentalization were investigated and will be discussed.

4.1.1. Psychosomatic Skin Reactions and Background Characteristics

In the prediction of psychosomatic skin reactions, the present study found that being a female was a risk factor for an increased level of psychosomatic reactions in terms of both the skin disturbance and the number of skin diagnoses. The study also supported the proposed hypothesis that women in comparison to men show higher levels of psychosomatic skin reactions. In line with these findings, it was also reported in the literature that in general, women have a tendency to show more skin related diseases (Koblenzer, 1997; Schlosser, 2015; Andersen & Davis, 2016). Chen et al. (2010) further state that men are associated more commonly with infectious diseases related to skin while women are more susceptible to psychosomatic problems regarding the skin such as allergies, pigmentation problems, hair diseases. Schlosser (2015) reported that two thirds of the patients who apply for medical care regarding dermatological problems are women. In the same vein, the results of the present study may be in relation with the women's tendency to seek care more commonly, thus, get diagnosed more often. The consistency between this study and the literature may also stem from women's eagerness to acknowledge and put their problems in expression more openly on the basis of cultural norms (Kirmayer &Young, 1998). In contrast to women, men are usually brought up with the necessity to be more "resilient" and "tough" (Koblenzer, 1997). This could have affected their responses particularly as in this study in which the participants were asked about their skin issues in a self-report measure. Koblenzer (1997) further suggests that while men may be brought up as

tough, having a sense of inner freedom to express their anger more safely, girls are usually perceived as more bidabble. Thus, the author further adds that they may also have difficulties owning up their aggression and expressing it safely, thus, in regulation of their affects for which it prepares the ground for psychosomatic manifestations.

On the other hand, it has been proposed that gender difference in skin diseases may be in relation with the complex interaction of the sex hormones of estrogens and androgens differing in men and women. The sex steroids modulate the thickness of the skin in combination with the immune system functioning. These hormones also change and adapt though aging, affecting the disease process by altering with the skin's PH level (Dao & Kazin, 2007).

In terms of a psychoanalytic perspective, gender difference may also be in relation with the developmental difficulties that females are subjected to, particularly in conjunction with the separation-individuation process as the focus of interest in this study in terms of skin reactions. Navaro and Schwartzberg (2007) suggest that in terms of the Oedipus triangle, the competition with the same gender is a part of the process of separation and differentiation. In this sense, separation-individuation and gaining independence happen quasi-contrary for males and females. According to Lerner (1988), boys are more encouraged in the separation from the primary love object and differentiate. The author further adds that no matter how much the mother cannot differentiate herself from her son, is being possessive, wishes to remain fused to him and to see her reflection in her son, nevertheless she would want him to be masculine, hence, not entirely reflect her and be as same as her. On the other hand, in this sense, the girl is "not permitted" to differentiate as much. First and foremost, the anatomical similarity provides a constant emphasis on the sameness of the two, providing for the mutual identification. Absence of and/or the lack of support from the third in the Oedipus triangle, the mother's attitudes as overwhelming or conflictual reinforces the girl's faith of 'sameness'. Through not being able to separate, differentiate and gain her own subjective individuality, the girl pays the price of the arrestment of her own psychic growth (Lerner, 1988).

The present study further observed that the married participants showed a higher number of psychosomatic skin reactions in general than the participants that are not involved in a relationship and participants who are dating. This finding can be interpreted as marriage in particular may prepare the platform for the reactivation of the earliest object relations for these patients and skin may communicate the earliest conflicts. In the same vein, Aydın (2013), in her study conducted with pruritus (itching of the skin) patients found that these patients' intense need for containment which seems to find its base in the early disruptions of object relations, are also reflected in their expressions about their marriage life. These patients describe their relationships with their spouses as symbiotic and conflictual rather than fulfilling and express feelings of anxiety with regards to their fear of loss. Furthermore, in the prediction of psychosomatic skin reactions, being in a relationship in general was found to be a risk factor in the increase of the skin disturbance level and the number of skin diagnoses. Marty (1958) defines 'allergic object relationship' in which the allergic individual in relationships tends to capture an object violently and immediately. He/she then projects himself/herself onto the object and through a gradual, deep and an adhesive identification, he/she tries to control the object. The allergic patient thus cannot bear any kind of conflict since it would interfere with the fusion state that he/she wishes for (Marty, 1958). In this sense, the findings of the study could be in relation with the inevitable conflicts around the relational context since the 'other' is different from the subject and has his/her own identity, and thus, the old irresolution around early object relations may have been exerting itself.

Another finding of the present study was that the participants with a history of trauma showed higher levels of psychosomatic skin reactions compared to the ones with no trauma history. Having experienced trauma was also found to be a risk factor in the prediction of both the increased level of skin disturbance and the number of skin diagnoses. The relationship between trauma and somatization in general is investigated extensively in the literature. Levine (2014) suggests that trauma breaks down emotional homeostasis and one's psychic capacity to represent, thus, until represented and mentalized, trauma finds its way for discharge

through somatization or projection. Somatization has been found higher in individuals who are raised in a traumatic family environment in terms of emotional neglect and physical abuse (Waldinger, 2006; Annemiek et al., 2011; Brown et al., 2005). In addition, the possible relationship of trauma with skin reactions has also been suggested in the literature (Gupta, Gupta & Jarosz, 2017). The association of traumatic experiences with specific skin diseases as pruritus (Wolf et al., 1988), psoriasis (Bascarino, 2004), and urticaria (Shoemaker, 1963; Gupta & Gupta, 2012) has also been put forth.

4.1.2. Separation-Individuation, Mentalization and Psychosomatic Skin Reactions

As presented in the literature section of the study, although diverse opinions exist regarding skin reactions and the meaning of the skin in psychoanalytic literature, it is generally agreed that the skin has a central importance in the developing psyche of the infant on the basis of interactions with the main care giver. Further, it is thought that the deteriorations of the skin reflect and are a way of communicating the early disruptions regarding the ego functions, establishing boundaries and subjective identity, wish for containment and support and also the ability to symbolize and represent. When it comes to adult life, the early object relations seem to be reactivated through the skin. Marty (1953) suggested that the patients who have commonly known allergic reactions including skin eruptions have a tendency to get as closer as possible with an object until he/she merges with it. They also show an inability to acknowledge themselves as differentiated from their object of choice, thus, inevitable conflicts between the subject and object may create a crisis, where the patient uses the skin a way of emotional defense and partial regression until he/she returns to a previous state of homeostasis (Marty, 1953). Schur (1955) also pointed out the difficulties of the patients with skin reactions in terms of establishing boundaries between the self and outside world and inabilities to separate oneself from the other. Canteros (1981) further added that allergic patients seem unable to create an independent life for themselves thus, experience problems taking responsibilities that an independent identity is subject to face.

Moreover, mentalization stands out as one of the important concepts of the early development which is achieved through the interactions within the mother-infant system. Attachment insecurity has been associated with the impaired capacity for mentalization (Fonagy et al., 2002). Further, although not directly with the skin reactions, mentalization has been associated with somatization both from the perspectives of the Paris School of Psychosomatics and Attachment theorists (Gubb, 2013).

On the basis of the literature, the present study aimed to investigate the possible relationship of skin reactions with the early life predicaments by looking at the participants' separation-individuation levels and mentalization capacity. It should be noted that there are no studies found in the review of the literature that investigated the relationship of skin diseases and/or skin reactions either with separation/individuation or mentalization. Thus, this study provides preliminary results for the investigation of these two variables.

This study hypothesized that individuals who experience more separation-individuation problems and more impairment in the mentalization capacity will show higher psychosomatic skin reactions. Psychosomatic skin reactions were measured based on the composite score of skin disturbance level and the number of skin related diagnoses in order to capture the problems regarding the skin more extensively. The study revealed that the composite skin disturbance level was higher in participants who experience more difficulties in separation-individuation. This finding suggests a partial support for the proposed hypothesis since no significant relationship was found between the number of skin diagnoses that the participants had and difficulties in separation-individuation.

On the other hand, it was found that the higher the number of skin diagnoses that the participants had, more impaired they were found in terms of Certainty (Hypermentalization) level. The finding partially supports the hypothesis since no significant association was found between the composite skin disturbance and Certainty. The Uncertainty dimension as another impairment of mentalization was excluded from all the analyses since it created a multicollinearity problem for the study.

Anzieu (1989) suggests that the severity of the skin damage is in proportion with the depth of the disruptions that the psyche suffers. In line with Anzieu's proposition, the current study's main interest of investigation was the general deteriorations that people experienced regarding their skin whether it means a symptom or several symptoms in combination with varying intensities without a diagnosis or having a skin disease or a bunch of diseases. However, different correlations were found with the two variables of interest as separation-individuation and mentalization in terms of composite skin disturbance and the number of skin diagnoses. Statistical analyses showed that the comprising variables of the composite skin disturbance as the number of symptoms and the intensity of each symptom are found to be positively correlated with the number of diagnoses that the participants reported. However, the common variance that the number of diagnoses and the number symptoms share was approximately 14%, and the common variance between the number of diagnoses and the intensity of the symptoms was approximately 16%. The remaining variance among them remains different and may suggest that the diagnosis number may not always reflect the skin disturbance in general in terms of the number of symptoms and intensity of the symptoms. The finding that separation-individuation difficulties is positively correlated with skin disturbance, but not with the number of diagnoses, may be because the two variables regarding the skin may not reflect the same meaning. This may also be true for the reverse association of the mentalization capacity. The human psyche is highly complex and many other factors other than the two variables of interest of this study including genetics, factors in the developmental line and also throughout the life cycle can influence the vicissitudes of the psyche when it comes to capturing the correlations of the composite skin disturbance or the number of diagnoses. However, in what way and what meaning the diagnosis number and the composite skin disturbance may differ from each other when it came down to the correlations with separation-individuation and mentalization necessitates further investigation. Still, speculations can be made in terms of the findings of the correlations. Even though, no significant correlation was found between separation-individuation and the number of skin diagnoses, this does not

necessarily mean that separation-individuation is not associated with skin diagnosis in any way. However, the correlation results could suggest that individuals with higher difficulties in separation-individuation and who have skin problems may not seek appropriate help since they more likely to keep away from taking responsibility for their problems and to wait, wishing to be saved. Further, getting a diagnostic evaluation necessitates "being touched" and/or "being looked at". The dermatologist in the sense of a caregiver, may represent the mother that the individual had difficulties separating from. Enactments within doctor-patient relationship can be evoked on the basis of the early object relations in the separation-individuation process. Thus, these individuals may keep away from this dermatologist-patient relationship for the sake of avoiding a merger. Getting a diagnosis which requires allowing for being touched may awaken the feelings of annihilation and the fear of engulfment.

On the other hand, it is found that individuals who show more hypermentalization, have more skin diagnoses. These individuals who are pseudomentalizers (Hypermentalizer) are more likely to depend on external reality (Fonagy et al., 2002) and are likely to be too certain on the basis of external reality. They may want to be absolutely sure, thus, be more likely to seek a professional opinion or it may that the more certain they are about their own process regarding their skin, the more likely they seek help and get a diagnosis for it. Being too certain means a mental state that denies the opaqueness of the mind, therefore, getting a diagnosis may reflect an over-controlling and a concrete act.

In terms of prediction on the other hand, in accordance with the proposed literature, separation-individuation was found to predict psychosomatic skin reactions both in terms of the increased levels of composite skin disturbance and the number of skin related diagnoses. The prediction was stronger for the composite skin disturbance. Furthermore, impaired mentalization capacity as Certainty (Hypermentalization) was found to predict an increased number of skin diagnoses.

The current study is the first study to investigate the relationship of psychosomatic skin reactions with separation-individuation and mentalization capacity. Thus, the positive correlations between the composite skin disturbance

level and separation-individuation and between the number of diagnoses and mentalization impairment provided a preliminary basis for the possibility of associations of skin reactions with separation-individuation and mentalization. Furthermore, as the main aim of the study, the finding that separation-individuation difficulties and impaired mentalization capacity predict psychosomatic skin reactions gives a preliminary evidence for the risks that they accommodate for the deterioration of the skin.

4.2. LIMITATIONS AND FUTURE RECOMMENDATIONS

Although the study reached its main goal of providing evidence for the associations of psychosomatic skin reactions with separation-individuation, and mentalization, there were some limitations. The cross- sectional design of the study may be considered as one of the main limitations. The Psychodermatology literature often suggests that people may experience outbursts and exacerbation of skin symptoms suddenly and at different points of their lives and it could depend on the subjective life circumstances and their subjective meaning for the individuals. From the psychoanalytic perspective, the crises in the skin may be in relation to the breakdown of emotional homeostasis or the regression of the psyche in the face of early disruptions of the psyche, however other than these crises, these people may be encapsulating their psychic sufferings (Schur, 1955; Marty, 1953). In the same vein, measuring the skin problems at one point in time with the constructs like separation-individuation and mentalization capacity which may not be static constructs and may fluctuate on the basis of the individual's current life situations may not fully allow for the examination of the developmental trajectory of the individuals who experience problems regarding the skin.

Although, on the one hand, it allows for the representation of larger number of people, investigating constructs that could be highly unconscious with self-report measures could be another limitation. Especially mentalization capacity is vulnerable in this sense, since reflective functioning largely happens as an automatic response, without awareness and conscious elaboration (Fonagy et al.,

2016). For this reason, reducing the sample size, further studies could also involve qualitative and/or projective measures that might capture the unconscious process.

Another limitation of the study is that a majority of the sample were highly educated women who lived in a big city and had higher socioeconomic level. Like gender, education and socio-economic factors may also be influential in the experience and expression of emotions. Thus, a more diverse sample might allow for comparisons of these groups regarding skin complaints and associated dynamics.

Moreover, the current study revealed the relationship of traumatic experience with psychosomatic skin reactions, however since the data was collected through an online survey, retrospective questions regarding traumatic experience could not be asked to prevent re-traumatization. Further, trauma was not one of the main variables of this study and the aim of the study was to investigate in the preliminary analysis if the basic demographic variables such as trauma history are associated with psychosomatic skin reactions in order to include the associated variables as possible predictors in the regression analyses. For this reason, traumatic experience was not examined in- depth. On the other hand, the association of traumatic experience with skin reactions was found to be prominent for this study. Thus, more elaborate investigation of the relationship between trauma and skin reactions is needed in further studies. Moreover, it appears that designs which allow for the in-depth examination of the relationship between trauma and mentalization and/or the relationship between early trauma and separation-individuation within the frame of somatization could be beneficial in further studies.

In order to fully comprehend the underlying psychic mechanisms of the skin reactions, it would be preferable to conduct a longitudinal design, with mixed procedures such as qualitative measures, self-report, interviews, in collaboration with dermatologists.

4.3. CLINICAL IMPLICATIONS

The objective of this study which was basically to put an emphasis on the integrality of the skin and psyche stemmed from the enormous necessity to collaborate the fields of psychology and dermatology and for more research that investigates the interconnectedness of skin and psyche. Gupta & Gupta (1996) state that as the psychosomatic factors play a significant role in wide range of skin reactions, it necessitates a biopsychosocial approach, the collaboration of dermatologists and psychiatrists/psychologists and more research in this field for an effective management.

Dermatologists should also be open to discussion with mental health professionals and informed about the possible psychic structures in play for these patients rather than relying solely on traditional treatments. Koblenzer (1983) and Ulnik (2013) both suggest that many dermatology patients exert their own personality dynamics in their relationship with their dermatologists. Koblenzer (1983) further proposes that non- compliance with the treatments on the basis of transference –countertransference between the patient and dermatologists is very common. It is also commonly observed that no matter what the dermatologists do, these patients do not seem to get better. Although they state otherwise, for conscious or unconscious reasons, some may also not really want to be cured from their skin problems. Some patients express an excessive clinging attitude, some may be very anxious and angry towards their dermatologists for not understanding and not being able to “cure” their problems, some may visit various dermatologists at the same time and get over diagnosed constantly (Koblenzer, 1983). Thus, a traditional dermatological approach for these patients only creates a vicious cycle and a dead end both for dermatologists and patients (Koblenzer, 1983; Ulnik, 2013). Hence, understanding and acknowledging the underlying character structure of the individuals who have skin issues is extremely important, thus, psychotherapy should also be integrated in addressing the problems regarding the skin since only the traditional dermatological treatments seem to fall short for many cases.

Moreover, as the skin related symptoms may be a way for the communication of early frustrations, psychotherapists in the therapeutic setting

should be vigilant to the meaning of these symptoms. Thus, studies like the current one could provide more understanding of the psychic functioning of the individuals who have skin reactions and in the working through the transference and countertransference issues and enactments that are likely to occur in the therapy room. In this sense, the results of the current study suggest that mental health professionals might benefit from focusing on working through the separation-individuation difficulties and the possible impairments in mentalization capacity that could be particularly important for the individuals who present skin reactions. Mentalization-based treatment (MBT) could also be considered. As a contemporary psychodynamic therapeutic approach, MBT is based on the attachment system and takes an active role in the exploration of patients' experiences of their subjectivity. An attachment based mentalization approach explores the capacity for mentalization by focusing on the patient's hyperactivation (being too dependent) and deactivation (being emotionally withdrawn) strategies as a result of their hypersensitivity to their attachment processes when faced with stressful situations (Bateman & Fonagy, 2013).

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APPENDICES

APPENDIX A

Bilgilendirilmiş Onam Formu

Sayın Katılımcı,

İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Zeynep Kızılkaya'nın Yrd. Doc. Dr. Alev Çavdar Sideris'in danışmanlığında yürütmekte olduğu tez çalışmasına katılımınızı rica ediyoruz.

Çalışmanın amacı katılımcıların ilişkilenme tarzları, duygusal farkındalıkları ve var ise deri ile ilgili yakınmalarına dair bilgi toplamaktır.

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

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

Çalışma hakkında daha fazla bilgi almak için sorularınızı araştırmayı yürüten Zeynep Kızılkaya'ya zeynep.kzlk@gmail.com adresi üzerinden iletebilirsiniz.

Araştırmamıza katkıda bulunduğunuz için teşekkür ederiz.

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

APPENDIX B

Demografik Form

A. Kişisel Bilgiler

1. Cinsiyetiniz: Kadın Erkek Diğer

2. Yaşınız: _____

3. Lütfen eğitim durumunuzu en iyi tanımlayan seçeneği işaretleyin.

İlköğretim terk İlköğretim mezunu

Lise terk Lise mezunu

Üniversite öğrencisi Üniversite terk Üniversite mezunu

YL/Doktora öğrencisi YL/Doktora terk YL/Doktora mezunu

4. Şu anda çalışıyor musunuz?

Evet Hayır Diğer

5. Lütfen medeni durumunuzu en iyi tanımlayan seçeneği işaretleyin.

Bekarım.

Evliyim.

Boşandım.

Eşimi kaybettim.

Diğer_____

6. Lütfen ilişki durumunuzu en iyi tanımlayan seçeneği işaretleyin.

İlişkim yok

Evliyim

Sözlüyüm/Nişanlıyım

Sevgilim var

Diğer _____

7. İlişkiniz varsa, lütfen ne kadar zamandır devam ettiğini belirtin.

___ yıl ___ ay

8. Çocuğunuz var mı?

Evet Hayır

9. Kendinizi aşağıdaki gelir seviyelerinden hangisinin içinde görüyorsunuz?

Alt Alt-Orta Orta Orta-Üst Üst

10. Lütfen şu anda yaşadığınız yeri en iyi tanımlayan seçeneği işaretleyin.

Köy/kasaba Küçük şehir Büyük şehir Diğer

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

Evet Hayır

Bu olayı/olayları yaşadığınızda kaç yaşındaydınız? _____

Bu olayın/olayların sizin için ne şiddette yaşandığını 0 ile 4 arasında bir sayı vererek derecelendiriniz.

Hiç şiddetli değildi				**Çok şiddetliydi**
0	**1**	**2**	**3**	**4**

Bu olayın/olayların hayatınız boyunca sizi ne oranda etkilediğini düşündüğünüzü 0 ile 4 arasında bir sayı vererek derecelendiriniz.

Hiç etkilemedi				**Çok etkiledi**
0	**1**	**2**	**3**	**4**

B. Deri ile İlgili Yakınmalar

1. Deri ile ilgili mevcut herhangi bir yakınmanız/şikayetiniz var mı? Ya da hayatınızın bir döneminde oldu mu?

Evet Hayır

2. Aşağıda deri ile ilgili sıklıkla görülen yakınmaların bir listesini görebilirsiniz. Lütfen her bir şikâyeti ne şiddette deneyimlediğinizi 0 ile 6 arasında bir sayıyı işaretleyerek değerlendirin. Eğer deri ile ilgili mevcut bir yakınmanız yok ise fakat hayatınızın bir döneminde oldu ise, bu deneyim (ler)i düşünerek soruları yanıtlayınız.

	Hiç			**Orta şiddette**			**Çok şiddetli**
Kaşıntı	0	1	2	3	4	5	6
Kızarıklık / döküntü	0	1	2	3	4	5	6
Kabarma	0	1	2	3	4	5	6
Pullanma / soyulma	0	1	2	3	4	5	6
Çatlama / yarılma	0	1	2	3	4	5	6
İltihaplanma / su toplama	0	1	2	3	4	5	6
Lekelenme	0	1	2	3	4	5	6
Akne	0	1	2	3	4	5	6
Uçuk	0	1	2	3	4	5	6

3. Herhangi bir deri hastalığınız var mı? Eğer deri ile ilgili mevcut bir hastalığınız olmamasına rağmen hayatınızın bir döneminde oldu ise, buna göre soruları yanıtlayınız.

Evet Hayır

Evet ise, aşağıdaki tablodan sizde olan hastalık/hastalıkları işaretleyiniz. Birden fazla işaretleme yapabilirsiniz.

Sedef

Egzama

Gül hastalığı

Ürtiker (Kurdeşen)

Zona

Vitiligo

Liken

Uçuk

Diğer _____

4. Lütfen deri hastalığınız ve/veya deri ile ilgili yakınmalarınızın hayatınızın farklı alanlarını ne kadar etkilediğini 0 ile 6 arasında bir sayı vererek değerlendirin.

	Hiç			**Orta**			**Aşırı**
Aile ilişkileri	0	1	2	3	4	5	6
Arkadaşlık ilişkileri	0	1	2	3	4	5	6
Sevgili ilişkileri	0	1	2	3	4	5	6
İş/okul hayatı	0	1	2	3	4	5	6
Cinsel hayat	0	1	2	3	4	5	6
Benlik algısı	0	1	2	3	4	5	6
Ruhsal sağlık	0	1	2	3	4	5	6
Dini/manevi inançlar	0	1	2	3	4	5	6

5. Deri ile ilgili hastalığınızın ya da yakınmalarınızın nedeninin ne/neler olduğunu düşünüyorsunuz? Birden fazla işaretleme yapabilirsiniz.

Yaralanma / yanık

Bakteri / Virüs / Enfeksiyon

Hormonal

Kalıtımsal

Psikolojik

Diğer _____

6. Deri yakınmalarınızla ilgili hiç tıbbi yardım aldınız mı?

Evet Hayır

Evet ise, bu yardımın ne kadar faydalı olduğunu düşünüyorsunuz?

Hiç faydası olmadı						**Çok faydası oldu**
0	1	2	3	4	5	6

7. Deri yakınmalarınızla ilgili hiç psikolojik/psikiyatrik yardım aldınız mı?

Evet Hayır

Evet ise, bu yardımın ne kadar faydalı olduğunu düşünüyorsunuz?

Hiç faydası olmadı						**Çok faydası oldu**
0	1	2	3	4	5	6

C. Genel Sağlık Bilgileri

1. (Deri hastalığı dışında) Kronik bir fiziksel hastalığınız/şikâyetiniz var mı?

Evet Hayır

Evet ise, lütfen belirtin _____

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

Hiç etkilemiyor						**Çok etkiliyor**
0	1	2	3	4	5	6

Evet ise, bu konuda tıbbi bir yardım alıyor musunuz?

Evet Hayır

2. Psikolojik/psikiyatrik bir hastalığınız/şikayetiniz var mı?

Evet Hayır

Evet ise, lütfen belirtin _____

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

Hiç etkilemiyor						**Çok etkiliyor**
0	1	2	3	4	5	6

Evet ise, bu konuda psikolojik/psikiyatrik bir yardım alıyor musunuz?

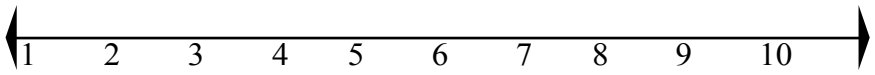
Evet Hayır

APPENDIX C

Ayrışma-Bireyleşme Envanteri (SII)

Aşağıdaki cümleler genel olarak insanlarla ve kendimizle ilgili düşüncelerimizi yansıtmaktadır. Her ifadeyi aşağıda verilen 10 dereceli ölçeği kullanarak değerlendiriniz. Yaptığınız derecelendirmeyi cümlenin yanındaki boş kutuya yazınız. Lütfen hiçbir soruyu boş bırakmayınız.

Hiç Katılmıyorum Tamamen Katılıyorum



1. İnsanlar birine gerçekten çok değer verip bağlandığında, sıklıkla kendileri hakkında daha kötü hissederler.	
2. Bir kişi, başka birine duygusal olarak aşırı yakınlaştığında, çoğu zaman kendini kaybolmuş hisseder.	
3. İnsanlar birine gerçekten öfkelendiğinde genelde kendilerini değersiz hisseder.	
4. İnsanların birine karşı duygusal olarak çok fazla yakınlaşmaya başladıkları zaman, büyük bir olasılıkla incinmeye en açık oldukları zamandır.	
5 İnsanlar zarar görmemek için başkaları üzerindeki kontrolü elinde tutmaya ihtiyaç duyar.	
6. İnsanları tanıdıkça değişmeye başladıklarını hissederim.	
7. Hem iyi hem kötü yanlarımı aynı anda görebilmek benim için kolaydır.	
8. Bana öyle geliyor ki insanlar benden ya gerçekten hoşlanıyor ya da nefret ediyorlar.	
9. İnsanlar bana karşı çoğu zaman sanki ben yalnızca onların her isteğini yerine getirmek için oradaymışım gibi davranıyor.	

10. Kendimden gerçekten hoşlanmak ile kendimi hiç beğenmemek arasında ciddi anlamda gidip geliyorum.	
11. Kendi başıma olduğumda bir şeylerin eksik olduğunu hissederim.	
12. İçimde bir boşluk hissetmemek için etrafımda başka insanların olmasına ihtiyaç duyarım.	
13. Başka biriyle aynı fikirde olduğumda bazen kendime ait bir parçamı kaybetmiş gibi hissederim.	
14. Herkes gibi ben de, ne zaman gerçekten saygı duyduğum ve hürmet ettiğim biriyle karşılaşsam kendimi daha kötü görürüm, kendimle ilgili daha kötü hissederim.	
15. Kendimi ayrı bir birey olarak görmek benim için kolaydır.	
16. Anne babamdan ne kadar farklı olduğumu fark ettiğim zamanlarda çok rahatsızlık duyarım.	
17. Önemli bir karar almadan önce neredeyse her zaman anneme danışırım.	
18. Diğer insanlarla bağlılık kurup bunun gereklerini yerine getirmek benim için oldukça kolaydır.	
19. Duygusal yönden biriyle yakınlaştığımda ara sıra kendime zarar veriyormuşum gibi hissediyorum.	
20. Ya birini çok sevdiğimi ya da kimseye katlanamadığımı hissediyorum.	
21. Sıklıkla, düşmekle ilgili beni korkutup tedirgin eden rüyalar görürüm.	
22. Gözlerimi kapatıp, benim için anlamı olan kişileri zihnimde canlandırmak bana zor geliyor.	
23. Birden fazla kere nasıl ya da neden olduğunu anlayamadığım şekilde, uykudan uyanır gibi kendimi biriyle bir ilişkide buldum.	
24. Kabul etmeliyim ki kendimi yalnız hissettiğimde çoğunlukla sarhoş olmak isterim.	
25. Ne zaman biriyle kavgalı ya da birine çok kızgın olsam kendimi değersiz hissederim.	
26. En derin düşüncelerimi söyleyip paylaşacak olsaydım içimde bir boşluk hissederdim.	
27. İnsanların benden hep nefret edermiş gibi olduklarını hissederim.	

28. Anne- babama ne kadar çok benzediğimi fark ettiğim zamanlarda kendimi çok rahatsız hissediyorum.	
29. Biriyle yakın bir ilişki içinde olduğumda sıklıkla kim olduğum duygusunun kaybolduğunu hissederim.	
30. Başkalarını aynı anda hem iyi hem kötü özelliklere sahip insanlar olarak görmek benim için zordur.	
31. Bana öyle geliyor ki kendim olabilmenin tek yolu diğerlerinden farklı olmaktır.	
32. Duygusal açıdan birine aşırı yakınlaştığımda, benliğimin bir parçasını kaybettiğimi hissediyorum.	
33. Ne zaman ailemden uzakta olsam kendimi çok rahatsız hissediyorum.	
34. Fiziksel yakınlığı ve şefkati almak, kendi başına, onu bana kimin verdiğinden daha önemliymiş gibi olabiliyor.	
35. Bir başka insanı gerçekten iyi tanımak bana zor geliyor.	
36. Bir karar vermeden önce annemin onayını almak benim için önemlidir.	
37. İtiraf etmeliyim ki, başka birinin kusurlarını gördüğümde kendimi daha iyi hissediyorum.	
38. Diğer insanları yakınımda tutabilmek için, içimde onları kontrol etme dürtüsü duyarım.	
39. İtiraf etmeliyim ki birine duygusal olarak yakınlaştığımda, bazen onlara acı çektirme isteği duyarım.	

APPENDIX D

Yansıtıcı İşleyiş Ölçeği – (RFQ-54)

Lütfen, aşağıdaki 54 ifadeyi detaylı bir şekilde inceleyiniz. Her ifade için, o ifadeye ne ölçüde katıldığınızı ya da katılmadığınızıbelirten 1 ile 7 arasında bir sayı seçiniz, ve bu sayıyı ifadenin yanına yazınız. İfadeler üzerinde çok fazla düşünmeyiniz- ilk yanıtlarınız çoğunlukla en iyisidir. Teşekkürler.

1'den 7'ye kadar olan aşağıdaki ölçeği kullanınız.

Kesinlikle Katılmıyorum.	1	2	3	4	5	6	7	Kesinlikle Katılıyorum.

1.__ İnsanların düşünceleri benim için gizemlidir.

2.__ Birinin ne düşündüğüya da hissettiğini anlamak benim için kolaydır.

3.__ Ben değiştikçeebeveynlerimin zihnimdeki resmi de değişir.

4.__ İnsanların ne düşündüğü ve ne hissettiği konusunda oldukça endişelenirim .

5.__ Yaptıklarımın/Eylemlerimin başkalarının duyguları üzerindeki etkisini dikkate alırım.

6.__ İnsanların ne düşündüğünü ve hissettiğini anlamam uzun zaman alır.

7.__ Yakın arkadaşlarımın ne düşündüğünü tam olarak bilirim.

8.__ Ne hissettiğimi her zaman bilirim.

9.__ Nasıl hissettiğim, başka birinin davranışını anlamamı kolayca etkileyebilir.

10.__ Birinin nasıl hissediyor olduğunu gözlerine bakarak söyleyebilirm.

11.__ En yakın arkadaşlarımın tepkilerini bazen yanlış anlayabileceğimin farkındayım.

12.__ Ne hissettiğim konusunda sık sık kafam karışır.

13.__ Rüyalarımın ne anlama geldiğini merak ederim.

14.__ Başkalarının zihnindekileri anlamak benim için hiçbir zaman zor değildir.

15.__ Ebeveynlerimin bana karşı davranışlarının onların nasıl yetiştirildikleriyle açıklanmaması gerektiğine inanıyorum.

16.__ Yaptıklarımın nedenlerini her zaman bilmem.

17.__ İnsanların başkalarına verdikleri tavsiyelerin aslında kendi yapmak istedikleri şeyler olduğunu fark ettim.

18.__ Başkalarının zihninden geçenleri anlamak benim için gerçekten zordur.

19.__ İnsanlar bana iyi bir dinleyici olduğumu söyler.

20.__ Sinirlendiğim zaman neden söylediğimi gerçekten bilmediğim şeyler söylerim.

21.__ Başkalarının eylemlerinin ardındaki anlamları genellikle merak ederim.

22.__ Başka insanların hislerine anlam vermeye gerçekten çabalarım.

23.__ İnsanları genellikle onlardan yapmalarını istediğim şeyi yapmaları için zorlamam gerekir

24.__ Bana yakın olanlar genellikle yaptığım şeylerin nedenini anlamakta zorlanır.

25.__ Eğer dikkatli olmazsam başka bir insanın hayatına burnumu sokabileceğimi hissediyorum.

26.__ İnsanların düşünceleri ve hisleri kafamı karıştırıyor.

27.__ Başka birinin ne yapacağını çoğunlukla tahmin edebilirim.

28.__ Güçlü hisler genellikle düşüncelerimi bulandırır.

29.__ Birinin nasıl hissediyor olduğunu tam olarak bilmek için ona sorma ihtiyacı duyarım.

30.__ Biri hakkındaki sezgilerimde neredeyse hiç yanılmam.

31.__ İnsanların olayları kendi inanç ve deneyimlerine bağlı olarak oldukça farklı görebileceğine inanırım.

32.__ Bazı zamanlar kendimi bazı şeyleri söylerken bulurum ve neden onları söylediğime dair bir fikrim yoktur.

33.__ Eylemlerimin ardındaki nedenler üzerine düşünmekten hoşlanırım.

34.__İnsanların zihindekilere dair genellikle iyi bir fikrim var.

35.__ Hislerime güvenirim.

36.__ Sinirlendiğimde sonradan pişman olacağım şeyler söylerim.

37.__ İnsanlar hisleri hakkında konuştuklarında kafam karışır.

38.__ İyi bir zihin okuyucuyum.

39.__ Genellikle zihnimin boş olduğunu hissederim.

40.__ Güvensiz hissedersem başkalarını çok sinirlendirecek şekilde davranabilirim.

41.__ Başka insanların bakış açılarını anlamakta güçlük çekerim.

42.__ Başka insanların ne hissettiğini genellikle tam olarak bilirim.

43.__ Hislerimin şiddetle/gerçekten inandığım şeyler hakkında dahi değişebileceğini ön görmekteyim.

44.__ Bazı şeyleri bazen nedenini gerçekten bilmeden yapıyorum.

45.__ Hislerime önem veririm.

46.__ Bir tartışmada, başkalarının bakış açısını aklımda tutarım.

47.__ Birinin ne düşündüğü hakkındaki içgüdüsel duygum genellikle doğrudur.

48.__ İnsanların tepkilerininin nedenini anlamak onları affetmem için bana yardımcı olur.

49.__ Herhangi bir durumu anlamak için doğru bir yolun olmadığına inanırım.

50.__ İçgüdelerimdense nedenler tarafından yönlendirilirim.

51.__ Çocuk olduğum zamanları çok hatırlayamıyorum.

52.__ Birinin zihninden geçeni tahmin etmeyi denemenin hiçbir anlamı olmadığına inanıyorum.

53.__ Benim için eylemler kelimelerden daha çok şey ifade eder.

54.__ İnsanların onları anlama zahmetine girmek için fazla kafa karıştırıcı olduklarına inanıyorum.

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: Zeynep Kızılkaya

Proje Başlığı / Project Title: The relationship between separation-individuation level, mentalization capacity and psycosomatic skin reactions

Proje No. / Project Number: 2017-20024-100

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: 21 Kasım 2017

Kurul Başkanı / Committee Chair

Doç Dr. Itır Erhart

Üye / Committee Member

Prof. Dr. Aslı Tunç

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