

İSTANBUL BİLGİ UNIVERSITY
INSTITUTE OF SOCIAL SCIENCES
CLINICAL PSYCHOLOGY MASTER'S DEGREE PROGRAM

ASSOCIATION OF MOTHERS' MENTALIZATION AND
PSYCHOSOMATIZATION WITH ADULT DAUGHTERS'
PSYCHOSOMATIZATION: A MIXED-METHOD STUDY

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İSTANBUL
2022

Association of Mothers' Mentalization and Psychosomatization with Adult
Daughters' Psychosomatization: A Mixed-Method Study

Annelerin Zihinselleştirme ve Psikosomatizasyonunun Yetişkin Kızların
Psikosomatizasyonu ile İlişkisi: Karma Yöntem Çalışması

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Date of Approval of Thesis: 22.06.2022

Total Page Number: 135

Anahtar Kelimeler (Turkish)

- 1) Psikosomatizasyon
- 2) Zihinselleştirme
- 3) Anne-Kız ilişkisi
- 4) Kuşaklar Arası Aktarım
- 5) Karma Yöntem

Keywords (English)

- 1) Psychosomatization
- 2) Mentalization
- 3) Mother-Daughter Relationship
- 4) Intergenerational Transmission
- 5) Mixed Method



*This thesis is dedicated to
my lovely grandfather,
Mehmet Turgut Kartal*

with endless love and longing...

ACKNOWLEDGEMENTS

First of all, I would like to express my gratitude to my thesis advisor, Alev Çavdar Sideris for presence throughout the journey of thesis writing. It was a source of inspiration for me to hear her views and to feel her support and guidance. I would like to thank my committee members for their participation in the jury and their contributions. I would like to thank Yudum Söylemez for her feedback and availability. Also, it was a pleasure to encounter my professor from the university, Nesteren Gazioğlu, at the end of my master's journey.

I owe big thanks to my lovely sister, for always being with me, for encouraging me, and for making the distances close. I would like to thank my dear mother and father, whose presence I always felt by my side, who supported me and always respected my decisions since my childhood. I feel very lucky because of the unconditional love and support of my family.

The presence of my beloved friend Selhan, with whom I walked this long road with great endeavor and desire, was a great chance for me. I am grateful to her for carrying my thesis into her inner world, and containing presence in my life. I could not imagine this academic and professional journey without her. I would also like to express my gratitude to my dear therapist, for containing and soothing attitude, and for facilitating this compelling process with unconditional support.

I would like to offer my special thanks to Eda who is my beloved friend from the graduate program. I am grateful for her emotional support and containing presence. Also, I would like to owe special thanks to Gülay, Gözde, Beyza, Öyküm, and my childhood friends, for making my thesis process more bearable, and for their valuable friendship.

Last but foremost, I would like to thank all the mother and daughter participants who contributed to my thesis.

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LIST OF ABBREVIATIONS

APA: American Psychiatric Association

DSM: Diagnostic and Statistical Manual of Mental Disorders

ICD: International Classification of Diseases and Related Health Problems

CM: Certainty about Mental States

IC: Interest and Curiosity

IBS: Irritable Bowel Syndrome

IBD: Inflammatory Bowel Disease

PRFQ: The Parental Reflective Functioning Questionnaire

IPSO: The Paris School of Psychosomatics

PM: Pre-Mentalizing

RA: Rheumatoid Arthritis

RFQ-8: The Reflective Functioning Questionnaire

ABSTRACT

The primary purpose of the current study was to understand the association of the psychosomatization and mentalization of the mothers with the psychosomatization of the daughters. In order to achieve this aim, the current study was designed as mixed-method research, including a quantitative component to address maternal psychosomatization and mentalization as predictors of adult daughter's psychosomatization, and a qualitative component to complement the findings by providing information on the relational context and subjective experience. For the quantitative part of the study, 78 mother-adult daughter dyads aged between 18-65 were included. The survey package consisted of the Informed Consent Form, the Demographic Information Form, the Somatization Scale (SS), the Reflective Functioning Questionnaire (RFQ-8), Parental Reflective Functioning Questionnaire (PRFQ). PRFQ, was only given to mothers. The results of the quantitative study showed that the somatization level of mothers was predictor on daughter somatization. The research hypotheses were tested via Multiple Stepwise Regression. The physical diagnosis of daughter was found as the strongest predictor. Also, while mother mentalization significantly did not predict daughter somatization, daughters' own hypomentalization predicted their somatization. In the qualitative part of the study, semi-structured interviews were conducted with 6 mother-adult daughter dyads aged between 18-65. These interviews were analyzed by Thematic Analysis, the five main themes emerged: (1) triggers of psychosomatic complaints, (2) effects of somatization, (3) dealing with emotions, (4) relationship with the mother, and (5) intergenerational transmission. The qualitative study findings showed that the tendency of withhold negativity and somatization was transmitted from mother to daughter. In addition, the burden of unexpressed and unverbilized emotions found expression in their bodies as a symptom. In the last section of the study, the findings of the quantitative and qualitative studies were discussed in the scope of the relevant literature convergently and divergently.

Keywords: Psychosomatization, mentalization, mother-daughter relationship, intergenerational transmission, mixed-method

ÖZET

Bu çalışmada annelerin bedenselleştirme ve zihinselleştirme düzeyleri ile kızlarının bedenselleştirmesi arasındaki ilişkiyi anlamak amaçlanmıştır. Çalışmanın nicel kısmında yetişkin kız çocuklarının bedenselleştirmesinin yordayıcıları olarak annenin bedenselleştirme ve zihinselleştirme düzeyleri araştırılırken, niteliksel kısımda ise anne-kız çiftlerinin öznel deneyimleri ve ilişkisel bağlamları hakkında bilgi edinilerek bulguların bütünleştirilmesi hedeflenmiştir. Araştırmanın nicel kısmına 18-65 yaş aralığında olan 78 anne-kız çifti dahil edilmiştir. Anket paketi, Bilgilendirilmiş Onam Formu, Demografik Bilgi Formu, Somatizasyon Ölçeği (SS), Yansıtıcı İşleyiş Ölçeği (RFQ-8), Ebeveyn Yansıtıcı İşleyiş Ölçeği (PRFQ)'den oluşmakta olup, PRFQ ölçeği sadece annelere verilmiştir. Nicel araştırma bulguları, annenin bedenselleştirme düzeyinin kızının bedenselleştirme düzeyini yordadığını göstermiştir. Araştırma hipotezleri Çoklu Adımsal Regresyon analizi ile test edilmiştir. Kız çocuklarının fiziksel tanı almış bir hastalığa sahip olması en güçlü yordayıcı olarak bulunmuştur. Ayrıca, annenin zihinselleştirme düzeyi kız çocuğunun bedenselleştirmesini önemli ölçüde yordamazken, kız çocuğunun kendi zihinselleştirme kapasitesindeki yetersizliğin (hipomentalizasyon) bedenselleştirmesini yordadığı görülmüştür. Araştırmanın nitel kısmında, 18-65 yaş aralığında olan 6 anne-kız çifti ile yarı yapılandırılmış görüşmeler yapılmıştır. Bu görüşmeler Tematik Analiz ile analiz edilmiş, ve beş ana tema ortaya çıkmıştır: (1) psikosomatik şikayetlerin tetikleyicileri, (2) bedenselleştirmenin etkileri, (3) duygularla başa çıkma, (4) anne ile ilişki, (5) kuşaklar arası aktarım. Nitel araştırmanın bulguları, negatif duyguları paylaşmama ve bedenselleştirme eğiliminin anneden kızı aktarıldığını göstermiştir. Çalışmanın son kısmında, nitel ve nicel araştırma bulguları ilgili literatür kapsamında yakınsayan ve farklılaşan noktalarıyla birlikte tartışılmıştır.

Anahtar kelimeler: Psikosomatizasyon, zihinselleştirme, anne-kız ilişkisi, kuşaklar arası aktarım, karma yöntem

INTRODUCTION

The root of psychosomatics is predicated on the association between mind and body, so this association between mind and body takes an important place in the understanding of psychosomatics (Steck, 2016). The word psychosomatic is frequently used to reverberate a dualistic sense of mind and body as different entities that interact in some way (Meissner, 2006). Psychosomatization is the condition in which psychic problems appear with somatic complaints (Marty, 1998). In other words, psychosomatic symptoms emerge when the psychological states are physically felt in the body. The Paris School of Psychosomatics has founded on the premise that each person is a psychosomatic individual. As a result, it is expected that each person experiences psychosomatic symptoms at different times in their lives (Marty, 1998).

Mentalization which is the second important concept of this study plays an important role in comprehending psychosomatic symptoms. The person both develops the ability to read and understand their mental states and learns to interpret the minds of others through the development of mentalization ability (Fonagy & Target, 1997; Jurist & Meehan, 2009; Luyten et al., 2020). Fonagy and Luyten likened the acquisition of the mentalization ability to learning a language (Fonagy & Luyten, 2018). Mentalization ability, which is a developmental achievement, is acquired based on the attachment relationship between mother and child during the first six years of life (Fonagy & Luyten, 2009; Fonagy et al., 2007). Some characteristics of the mother are seen as vital for the development of mentalization: containing the infant's affect in a secure attachment relationship, providing the infant's bodily and psychological needs, and encouraging the infant to adjust to the external world (Fonagy et al., 1991; Fonagy & Luyten, 2018). The infant feels understood and contained when the mother responds to these needs. In this way, the mother provides the infant with the fundamental psychological foundation for the development and construction of the sense of self. Furthermore, as the child's capacity for reflective self and emotion regulation develops, the child begins to understand oneself as an entity with emotional intents and to make sense of their

mental states (Fonagy et al., 1991; Fonagy & Target, 1997). From this point of view, the quality of this relationship has an essential place in the degree of mentalization ability (Fonagy et al., 2007; Fonagy & Luyten, 2018).

When the conducted studies on psychosomatization and mentalization in the literature are examined, the psychoanalytic literature demonstrates that an individual's mentalization impairment can lead to psychosomatic symptoms (e.g., Ballespi et al., 2019; Bizzi et al., 2021; Bouteloup et al., 2020; Gubb, 2013; Gürkan, 2020; Kızılkaya, 2018; Köksal, 2017; Marty, 2012; Preid et al., 2017; Riem et al., 2018; Smadja, 2011).

Furthermore, studies in the literature suggest the association of somatization with maternal factors (e.g., Craig et al., 2002; Craig et al., 2004; Garber et al., 1998; Reilly et al., 1999; Schulte & Petermann, 2011; Walker et al., 1991). In a word, mentalization is described in the theoretical foundation as a basic ability to determine whether maternal variables are passed from generation to generation to the child.

The present literature asserts that somatization can be transmitted from the mother to the next generation (Bialas & Craig, 2007; Craig et al., 2002; Craig et al., 2004; Schulte & Petermann, 2011; Walker et al., 1991). However, how this transmission relates to other possible predictors and how it is subjectively experienced have not been studied. In the mentalization theory, as in other psychoanalytic perspectives, special emphasis is put on the attachment relationship with the caregiver. Also given that psychosomatization is more prevalent among women, this study concentrates on how psychosomatization, its transmission to the infant, and their interface with mentalization unfold in the mother-daughter context. Thus, the purpose of the current study is to examine to understand the association of the psychosomatization and mentalization of the mothers with the psychosomatization of the daughters.

CHAPTER 1

LITERATURE REVIEW

1.1. PSYCHOSOMATIZATION

1.1.1. Definition of Psychosomatization

The word psychosomatic is composed of the words “psyche” (ψυχή) meaning soul and “soma” (σῶμα) meaning body (Steck, 2016). The spelling of the word psychosomatic gives a clue about the connotation of this term. Psychosomatic is not written with a connecting line by dividing it into two words; it is written as a single word (Parman, 2005), because there is a tendency to think as psyche-soma and mind-body instead of thinking psyche and soma, mind and body (Meissner, 2006). This highlights that the bodily and psychic processes are intertwined (Baudin, 2008). The term psychosomatic is commonly used to convey a dualistic understanding of the mind and body as separate entities that interact in some way (Meissner, 2006).

The origin of psychosomatic is based on the relationship between the mind and body and this relationship has a vital place in understanding psychosomatization (Steck, 2016). Psychosomatization refers to the conditions in which psychic problems are experienced as somatic complaints (Marty, 1998). In other words, psychosomatic symptoms occur when the psychological states are physically experienced in the body. The first person to use the term psychosomatic was the German psychiatrist Heinroth in the second half of the 19th century. Heinroth stated that the source of somatic symptoms stems from affective conflicts in the psyche by emphasizing the interaction between the psyche and the soma (cited in Smadja, 2011). That is to say, the term psychosomatic indicates that psychodynamic and physiological factors are interconnected and cannot be considered separately. In this sense, diseases cannot be considered purely biological or purely psychological. For this reason, it cannot be claimed that there is a purely biological or purely psychological treatment (Meissner, 2006).

1.1.2. Diagnostic Approaches to the Psychosomatization

Two basic classification systems are accepted and widely used today: (1) Diagnostic and Statistical Manual of Mental Disorders (DSM), and (2) International Classification of Diseases and Related Health Problems (ICD). Both classification systems will be respectively presented below.

Somatoform Disorders as a category was introduced in the 3rd edition of the DSM (DSM-III) in 1980, as a combination of medically unexplained bodily symptoms that were previously categorized as part of hysteria and hypochondriasis (Noyes et al., 2008). DSM-III contains five discrete disorders under this heading: Somatization Disorder, Conversion Disorder (or Hysterical neurosis, conversion type), Psychogenic Pain Disorder, Hypochondriasis (or Hypochondriacal neurosis), Atypical Somatoform Disorder.

All these disorders included distressing experiences of or preoccupation with bodily issues. Although recognition of these disorders was considered to be progressive at first as it offered psychiatrists a way to classify the frequently encountered physical complaints, DSM-III's approach was criticized for (1) fostering mind-body duality by keeping the medical and psychological explanations exclusive, and (2) not indicating etiology (Hiller & Reef, 2005; Noyes et al., 2008)

Somatization disorder is classified as Somatoform Disorders in DSM-IV (American Psychiatric Association, 2000). In the latest version, Somatoform Disorders are replaced with *Somatic Symptom and Related Disorders*. The new category of somatic symptoms and related disorders include these diagnoses: Somatic Symptom Disorder, Illness Anxiety Disorder, Conversion Disorder, Psychological Factors Affecting Other Medical Conditions, Factitious Disorder, and Other Specified and Unspecified Somatic Symptom and Related Disorders (American Psychiatric Association, 2013).

In the latest version, DSM-V, one of the most important changes is that somatic symptoms do not have to meet the criteria of 'medically unexplained symptoms' as in the previous version of DSM. In other words, as an attempt to resolve the mind-body duality issue in DSM-V, somatic symptoms were evaluated

through the emotional, intellectual, and behavioral bond that patients establish with their symptoms (as cited in Duruk & Sertel Berk, 2019). Another critical change in the most recent version, somatic symptoms must be significantly disruptive to the patient's functionality. So, excessive thoughts, feelings, or behaviors should accompany these somatic complaints (APA, 2013).

In the current version of the International Classification of Diseases (ICD-11), disorders are listed under the heading of *Bodily Distress Disorder* which is characterized by the presence of bodily symptoms that are distressing to the individual and excessive attention directed toward the symptoms. Disorders listed under the heading of bodily distress disorder are Mild Bodily Distress Disorder, Moderate Bodily Distress Disorder, Severe Bodily Distress Disorder, and Bodily Distress Disorder, Unspecified (World Health Organization, 2019).

1.1.3. Prevalence and Epidemiology of Psychosomatization

Epidemiological studies show that the prevalence of somatization disorders in adults is around 5 to 7 percent. Nevertheless, the incidence of somatization disorders is still not precisely known. According to American Psychiatric Association's statistics, women report more psychosomatic symptoms than men (APA, 2013). Also, in Turkey, women reported more somatic complaints than men (Özden, 2015). In addition, it has been observed that somatic complaints decrease with the increased age (Karşlı, 2018).

Apart from being a woman and younger age, low socioeconomic status, low education level, unemployment, and stressful life events are indicated as risk factors for psychosomatization (e.g., APA, 2013; Chapman, 2005; Escobar & Canino, 1998; Kirmayer & Young, 1998; Köksal, 2017; Ozaner, 2011). Many studies support these statistics. For instance, the study by Aslund and colleagues reveal that having high financial stress with low social support is a considerable risk factor for psychosomatization (Aslund et al., 2014). Also, the study by Escobar and Canino (1998) asserts that gender, low socioeconomic and education levels as prominent factors associated with psychosomatic symptoms (e.g., Chapman, 2005; Escobar &

Canino, 1998; Karşlı, 2018; Kirmayer & Young, 1998; Kızılkaya, 2018; Özden, 2015).

Psychosocial factors are thought to play a role in medically unexplained physical symptoms. For example, a study by Dorfmann (1974) on the relationship between depression and psychosomatic illness demonstrated that depression triggers somatic illness. In another study, Madhukar (2004) examined of the type of relationship between depression and physical symptoms. He stated that the most common physical symptoms associated with depression are “chronic joint pain, limb pain, back pain, gastrointestinal problems, tiredness, sleep disturbances, psychomotor activity changes, and appetite changes” (Madhukar, 2004, pp. 12). Also, other psychiatric disorders are related to psychosomatization. Kinnunen and his colleagues (2009) explored the relationship between psychosomatic symptoms in adolescence and mental health symptoms in early adulthood. The results of the study are remarkable in the longitudinal study that the data collection period lasts 14 years. Young adults who had a lot of psychosomatic symptoms in adolescence have more somatization tendencies in adulthood. Besides, these young adults suffer from anxiety symptoms more often. From this point of view, experiencing psychosomatic symptoms in adolescence might be seen as a sign of future mental health issues (Kinnunen et al., 2009).

As seen, there are so many factors that affect the psychosomatization tendency of individuals. To summarize all this, the literature reports on the relationships of psychosomatization with gender (e.g., Karşlı, 2018; Kızılkaya, 2018; Özden, 2015; Kirmayer & Young, 1998; Chapman, 2005; Escobar & Canino, 1998); age (Karşlı, 2018); socioeconomic status and education level (e.g. Chapman, 2005; Escobar & Canino, 1998; Kirmayer & Young, 1998; Karşlı, 2018; Kızılkaya, 2018; Özden, 2015), stressful life events (e.g., APA, 2013; Chapman, 2005; Escobar & Canino, 1998; Kirmayer & Young, 1998; Köksal, 2017; Ozaner, 2011); mental health (e.g., Dorfmann, 1974; Kinnunen et al., 2009; Madhukar, 2004).

1.1.4. Psychoanalytical Perspectives on Psychosomatization

In this section, theoretical information about psychosomatics will be given from a psychoanalytic point of view. Although the term of psychosomatic is not mentioned in the studies of Freud, the origins of the psychoanalytic psychosomatic be rooted in Freud's studies. From this viewpoint, first the Freudian view, then the theory of Chicago School and finally the theory of Paris School of Somatization will be mentioned, respectively.

1.1.4.1. Freudian Roots

Psychoanalysis began with Freud's exploration of bodily symptoms without any organic cause (Freud & Breuer, 1893). In this sense, the body has almost always been the focus of Freud's concern (Baudin, 2008). Although Freud did not use the word psychosomatic throughout his work, he created a theory that would form the basis of psychosomatics (İkiz, 2008).

In the article "On the Psychical Mechanism of Hysterical Phenomena," written by Freud and Breuer in 1893, they asserted that the source of hysterical symptoms is precipitating factors that leave a psychical trauma effect on the person. Any experience that evokes distressing emotions like fear, anxiety, and physical pain in the person can be processed such as trauma. When this kind of experience or memory in the consciousness is repressed into the unconscious, hysterical symptoms occur (Freud & Breuer, 1893). Also, it is emphasized that the origins of the psychical conflicts are based on the psychical traumas experienced especially in early life (Gubb, 2013). From this perspective, Freud and Breuer said that "*hysterics are suffering from reminiscences*" (Freud & Breuer, 1893, p. 84).

In the following years, Freud started to see the source of the hysterical symptoms as an expression of unconscious fantasies rather than an actual sexual trauma (Taylor, 2003). In a word, Freud shifted his focus from real trauma to unconscious fantasies (cited in Gubb, 2013). In Freud's 1895 work titled "On Anxiety Neurosis," he distinguished psychosomatic symptoms from hysterical

conversions that show themselves with physical symptoms (Freud, 1895). In other words, he made a basic distinction between actual neurosis and psychoneurosis. While actual neurosis causes somatic disorders, psychoneurosis causes psychic symptoms (Debray et al., 2015; Mitrani, 1995). Actual neurosis includes neurasthenia, anxiety neurosis, and hypochondriasis. On the other hand, psychoneurosis includes hysteria, phobia, and obsessive-compulsive neurosis (Gubb, 2013).

Psychoneurosis has a psychological origin, and these symptoms are symbolic manifestations of childhood conflicts (Freud, 1985). Hysterical conversions that result from internal conflicts are repressed into the unconscious, then manifest themselves with physical symptoms (Mitrani, 1995). In other words, the bodily symptoms that are representations of psychic experiences are derived from unconscious conflicts (Gubb, 2013). However, an actual neurosis has a somatic origin and bodily expressions are not symbolic manifestations of childhood conflicts and so don't have symbolic meaning (Debray et al., 2015; Parman, 2005; Taylor, 2013). These symptoms originate from the case of absence or inadequacy of sexual satisfaction, do not stem from psychic trauma (Debray et al., 2015; Taylor, 2013).

1.1.4.2. The Chicago School

Franz Alexander, the founder of the Chicago School, developed a movement of psychosomatics called Psychosomatic Medicine (Aisenstein & Smadja, 2011; Smadja, 2011). Alexander's psychoanalytic psychosomatic theory is widely accepted (Kaplan, 1957). The main focus of his studies is to establish a connection between diseases and personality structures (Kaplan, 1957; Parman, 2015; Smadja, 2011). From this perspective, Alexander adopted a dualistic approach by using a combination of psychoanalytic and physiopathological approaches in understanding diseases (Smadja, 2011). While mentioning the unconscious and the importance of psychological conflicts in his theory (Taylor, 2003), he additionally

emphasized that unexpressed and repressed emotions have an important place in the etiology of psychosomatic symptoms (Waller & Scheidt, 2002).

Psychosomatic medicine is built on two theoretical principles. The first one is the organ neurosis that originates from Freudian roots. According to this principle, unexpressed emotions are repressed at the psychic level and then these repressed affects are transmitted to the organs through the autonomic nervous system. Due to this transmission, alterations in the functioning of these organs occur, and these alterations cause functional disorders (Aisenstein & Smadja, 2011).

The second theoretical principle comes from the theory of specificity. This theory asserts that each affect corresponds to a specific physiopathological syndrome (Aisenstein & Smadja, 2011; Debray et al., 2015; Gubb, 2013). With the hypothesis of specificity, Alexander limited his theory to seven psychosomatic diseases known as the Chicago Seven. These diseases consist of “*bronchial asthma, gastric ulcer, essential hypertension, rheumatoid arthritis, ulcerative colitis, neurodermatitis and thyrotoxicosis*” (Gubb, 2013, p. 86). For example, he suggested that oral dependency issues displayed by an ongoing desire to be satisfied resulted in ulcers; however, these direct causal connections were later disputed (Bloch & Singh, 2001).

1.1.4.3. The Paris School of Psychosomatics

The main focus of Freud was the impulsive economy, and he explored the psychic processes underlying somatization (İkiz, 2008). Pierre Marty and his colleagues were inspired by Freud's theory. The Paris School of Psychosomatics (IPSO) was founded in 1972. The pioneers of this school are Pierre Marty, Michel Fain, Michel de M'Uzan, and Christian David (Marty, 1998). While Pierre Marty and his colleagues work with psychosomatic patients to understand their psychic world and heal them, they concluded that psychoanalytic treatment was necessary (Marty, M'Uzan, & David, 1968). The feature of these patients is that they had diseases but their complaints are somatic (Debray et al., 2015).

For this reason, the main focus of IPSO is based on the psychic functioning of the patients, not medicine. Primarily, they highlight the important role of mental processing in these patients who tend to somatization (Aisenstein, 2006; Smadja, 2005; Szwec, 2008;).

Marty and his team observed that psychosomatic patients have a similar way of thinking. Patients can describe anything they perceive in length and detail but are devoid of symbolization and meaning. In other words, their discourse is disconnected from their unconscious content. They are not able to mentalize, symbolize, and fantasize (Aisenstein, 2006; Bronstein, 2011). This way of thinking is called operational thinking, psychosomatic patients, whose complaints are somatic, and have diseases, try to relieve their anxiety and soothe themselves (Debray et al., 2015).

According to the view of the Paris School of Psychosomatics (IPSO), psychosomatic symptoms have no symbolic meaning or significance. The definitive aspect is that the person is producing psychosomatic symptoms (as cited in Gubb, 2013). In other words, the Paris School of Psychosomatics, which distinguishes psychosomatic from the hysterical conversion, is concerned not with the form or meaning of psychosomatic symptoms, they are interested in the psychic functioning of patients (Oliner, 2010; Sechaud, 2010 as cited in Gubb, 2013).

Psychic representations form the basis of human mental life (Marty, 2012). Instincts sustain the psychosomatic economy. If instinct is associated with a representation, instinct becomes a drive (as cited in Bronstein, 2011). Marty draws attention to two movements in the psychosomatic economy: (1) excitations and (2) discharge of excitations. Excitations are divided into internal and external. While external excitations are experienced consciously, internal excitations are experienced both consciously and unconsciously (Parman, 2015). These excitations create a state of tension in the human psyche. It is important to discharge this energy in order to prevent the psychic world from being overloaded and overflowing and to maintain the psychic balance (Aisenstein, 2006). Individuals can discharge these tensions in three ways: mentalization, somatization, or action-behavior way (Parman, 2015).

The discharge of drive that waits to be satisfied is also dependent on mental processing. The discharge through thinking is possible through mentalization (Marty, 2012). However, it is crucial to state that the mentalization conceptualization of IPSO is not grounded in this study. According to IPSO, mentalization is all the symbolic processes used by the psychic apparatus to regulate instinctual, impulsive, libidinal, and aggressive energies (Parman, 2015). The concept of mentalization, which is related to the quality and quantity of the individual's psychic representations, refers to the working of the representations and also to the quality of the structuring of the preconscious (Marty, 2012). This increase in mental capacity indicates good mentalization capacity, which is an indicator of development (İkiz, 2008; Marty, 2012). Conversely, a decrease in this capacity indicates poor mentalization capacity, which is an indicator of regression. Also, mentalization has an important place in understanding the mental processing of psychosomatic patients, whose complaints are somatic, and have diseases. (Debray et al., 2015; İkiz, 2012).

When the instinctual impulses are not achieved to discharge, mental representations create anxiety and discomfort in the human psyche (Aisenstein, 2010). Repressing these representations does not eradicate them.

On the contrary, these representations continue to exist in the unconscious. So, impulsive stimuli that cannot be discharged through mentalization can appear through somatization. Somatization occurs as follows: the ego cannot cope with the tensions created by bodily arousal and the functional system becomes disorganized (as cited in Bronstein, 2011).

In other words, psychosomatic symptoms occur when psychic conflicts increase, and impulses cannot be discharged. According to Marty, excitations that cannot be discharged accumulate and then either take the somatic pathway or are discharged through the action-behavior way (Marty, 2012). The action-behavior way involves daily behaviors that provide a quick and partial discharge of impulsive, libidinal, aggressive excitations such as shouting, getting angry, crying, and smoking.

Freud described a diagram of the mental structure of humans in his 1923 work titled “The Ego and The Id”. Afterward, Freud (1933) revised this diagram, in which the psychic apparatus is portrayed, by adding the superego to this diagram in the article “New Introductory Lectures on Psycho-Analysis” (Freud, 1933). Freud emphasized with this diagram that the source of the drives is in the body, in other words, in the somatic.

As previously stated, the Paris Psychosomatic School is based on Freud's theory. Debray, one of the pioneers of the Paris school, reconsidered this diagram within the psychosomatic frame by adding to Freud's view. Debray suggested calling the outside part of the mental apparatus that Freud saw as the censorship barrier constituted by repression as the “outer psyche” (Debray et al., 2015). For this reason, the id opens towards the somatic ground in the revised diagram.

Debray and his colleagues (2015) emphasized that the somatic ground originates from in utero life and continues after birth. It is stated above that non-mentalized excitations are repressed. Things that cannot be mentalized are repressed and pushed towards the somatic ground seen. Every individual has a somatic basis (Debray et al., 2015). At this point, the relationship that is established between the mother and the baby, and the care provided by the mother to the baby are the significant factors to acquire the ability to transform impulses into representations. Thus, the individual's mentalization ability is based on this relationship (Parman, 2015).

A sense of reality and mentalization ability have not yet formed when the baby is born. As the mother takes care of her baby's needs and holds her baby in her mind, the baby's ability of mentation begins to develop. This is because the baby starts to reverie in the mother's absence (İkiz, 2008; 2012). However, although the mother fulfills her baby's needs, it is not naturally possible to meet all the needs. These impulses, which could not have been mentalized, processed, and discharged, are pushed out of the psyche towards the somatic ground and discharged in the somatic way (Debray et al., 2015; İkiz, 2008). Therefore, from this perspective, the word psychosomatic does not describe the symptomatic presentation; instead, it refers to the person (Marty, 2012).

From this point of view, every individual experience psychosomatic symptoms within a lifetime. These somatic transitions vary across individuals. For example, individuals who are good at mentalizing have a quieter somatic basis. Conversely, those who are not good at mentalizing have a noisier somatic basis (Debray et al., 2015).

In a word, the mother's psychic activities transform the baby's excitations into affects and representations. The deficiency in these functions of the mother interrupts the first stage of mental functioning and affects the person's mentalization ability. Consequently, the individual with a low level of mentalization becomes psychosomatic.

The present literature emphasizes the importance of the mother-child relationship in the development of psychosomatization. The following section mention relevant studies about the presented theory will be mentioned.

1.1.5. Studies on Maternal Factors and Psychosomatization

Family members are effective in the intergenerational transmission of psychopathology. The most important of these members, especially in terms of psychic development, is the mother as the primary caregiver in most families. Thus, an attempt at understanding the psyche, especially from a psychoanalytic perspective, requires exploring the relationship between mother and infant established in the early period of life (Craig et al., 2004). At the beginning of life, the infant's mother is the only important object for the infant. The relationship between mother and infant, which forms the basis of all loves, is also a precursor experience in the dynamic of relationships with other objects (İkiz, 2002). Therefore, the quality of this interaction between mother and infant has a wide place in the literature of psychosomatization (Gaddini, 1974).

When the infant is born, the protective shield function of the infant has not yet been formed. That is the infant cannot process psychic conflicts and cannot protect itself against internal and external excitations. For this reason, the maternal psychic apparatus has a vital function for the infant who cannot process its

excitations. The mother offers her protective shield to her infant to protect her infant from overstimulation. In other words, the infant leans into the mother's psychic functioning capacity (Belot, 2013; Parman, 2015).

When the mother provides the infant with a good-enough mothering and a facilitating environment, the infant begins to feel as a whole oneself. Consequently, a good-enough relationship between mother and infant in the early years of life serves as a protective factor for the mental health of the individual in later life (Köhler et al., 2017). In cases where there is no such relationship between mother and infant, the infant cannot feel like a whole oneself (Winnicott, 1989). Excitations, which cannot be contained and made sense of, cause an infant to be overstimulated, resulting in psychosomatic manifestations for some cases (Belot, 2013).

Several studies aimed at understanding this acclaimed role of the mother and mother-child relationship in psychosomatization, which are summarized below. Two types of study groups will be discussed below: (1) mother-child relations, (2) mother's physical and psychological well-being.

Wenar and his colleagues (1960) asserted that the faulty caretaking of the mother in earliest infancy is the common denominator in all psychosomatic disorders. Their study suggested that the main factor in the development of psychosomatic disorders is related to the faulty caretaking of the mother to her infant during early infancy. The quality of this relationship has an unsatisfactory quality and has no maternal affection. Mother and child have been intertwined in this kind of frustrating relationship (Wenar et al., 1960). In another study, Hermanns and his colleagues (1989) investigated the relationships of asthmatic and non-asthmatic children with their mothers. They observed that mothers of children with asthma have a higher maternal critical attitude than mothers of non-asthmatic children. It has been observed that these mothers, who are more critical of their children, demonstrated a more negative verbal interaction in their mother-child dyads (Hermanns et al., 1989). Similarly, Craig and colleagues (2004) investigated the mother-child dyads of mothers with psychosomatic disorders and without. Also, they examined how they interacted with each other. The research findings show

that during the play task, mothers of infants with psychosomatic disorders showed less joint attention and were less engaged in the play. Also, it was noted that they were emotionally flatter than the other group (Craig et al., 2004).

As well as the mother-child interaction, factors such as maternal somatization (e.g., Craig et al., 2002; Schulte & Petermann, 2011; Reilly et al., 1999; Walker et al., 1991), exposure to ill parent (e.g., Craig et al., 2002; Garber et al., 1998; Köhler, 2017; Schulte & Petermann, 2011), maternal childhood adversity (e.g., Craig et al., 2002; Schulte & Petermann, 2011), maternal mental health (e.g., Craig et al., 2004; Garber et al., 1998; Schulte & Petermann, 2011, Walker et al., 1991; Wenar et al., 1960) predict the development of psychosomatization.

The mother's health status is seen as a predictor of the child's psychosomatic symptoms. In Köhler's study (2017), mothers of children with recurrent abdominal pain (RAP) were found to have poor health compared to the control group. Just as physical health is important, maternal mental health is also another important factor in the etiopathogenesis of psychosomatic disorders (Schulte & Petermann, 2011). Garber's study (1998) shows that mothers of children with Functional Abdominal Pain are more anxious and depressed (Garber et al., 1998).

Craig and colleagues (2002) stated that exposure to ill parents as a child is a risk factor for adult psychosomatization. Somatizing mothers reported being exposed to ill parents and neglected as children compared to non-somatizing mothers. The study of Craig and his colleagues (2002) supports a strong relationship between maternal psychosomatization and maternal childhood adversity (Craig et al. 2002).

In summary, studies have shown that there is a significant relationship between maternal psychosomatization and child psychosomatization. Maternal psychosomatization increases the possibility of psychosomatization in the child, indicating a mother-to-child transmission. When the mechanism through which this transmission occurs is considered, the theory suggests that the child internalizes the primary impulse and/or affect regulatory functions from the mother and thus, when the mother is low on these capacities to symbolize and regulate, the child will also end up being low on these. Accordingly, as also emphasized by the approach of

Psychosomatic School of Paris, mentalization capacity appears as a crucial component and potential mediator of this transmission.

1.2. MENTALIZATION

People have been interested in reading each other's intentions since ancient times (Jurist & Meehan, 2009). The effort of people to understand both themselves and the other is one of the most crucial aspects of human nature (Slade, 2005). In this sense, it can be said that the sociobiological origin of mentalization is based on people's interest in understanding each other (Jurist & Meehan, 2009). The effort of individuals to understand their own and others' minds manifests itself in situations of love or hate, in times of peace or war, or the ordinary moment of life (Slade, 2005). The concept of mentalization of the Paris School of Psychosomatics and Peter Fonagy is theoretically based on a different ground. The theory of the Paris School of Psychosomatic, which originated from Freud's theory, is focused on instinctual impulses (Marty, 2012). The concept of mentalization which is rooted in psychoanalysis is developed on the ground of Bowlby's attachment theory by the Paris Psychosomatic School. Bowlby highlighted the importance of that accepting the child as a separate individual from his/her mother is emphasized.

Over the years, this concept has been developed by Fonagy and colleagues from a different theoretical perspective that combines psychoanalysis, developmental psychology, and attachment (Mikic & Terradas, 2014; Gubb, 2013). Fonagy and his colleagues indicated secure attachment provides a basis for the development of mentalization. Also, the concept of mental state talk comes to the forefront in their theory (Duman & Oral, 2008). In this study, Fonagy and colleagues' mentalization theory is adopted.

1.2.1. Definition of Mentalization

The concepts of mentalization and reflective function frequently appear in the literature. Both mentalization and reflection functions are used synonymously in the literature (Fonagy & Target, 1998). Also, the concept of mentalization is closely related to the theory of mind. Still, it is more comprehensive than the theory of mind as it involves attachment, affect regulation, and the development of the self (Weinberg, 2006).

Mentalization describes the process of transforming the brain into a mind (Jurist & Meehan, 2009). Fonagy and colleagues defined mentalization as an individual's ability to recognize and imagine internal mental states (including wishes, intentions, beliefs, goals, feelings, and attitudes) in both the self and others (Fonagy et al., 2002; Fonagy et al., 2016). It is described as unconscious imaginal mental activity (Fonagy & Allison, 2013); because a person can only imagine what others think and how they feel (Busch, 2008). In this way, the person acquires the ability to see oneself from the outside, as well as to see others from the inside (Bateman & Fonagy, 2016). In other words, mentalization is keeping the mind within the mind (Jurist & Meehan, 2009). Mentalization differs from the process of conscious self-reflection in that mentalization occurs unconsciously and naturally while conscious reflection indicates a deliberate effort with awareness (Weinberg, 2006).

1.2.2. The Development of Mentalization

Understanding the thoughts, feelings, and intentions behind the behavior of others is not an inborn or constitutional ability (Fonagy et al., 2007; Nicolas et al., 2019; Fonagy & Luyten, 2018). Learning to mentalize is like learning a language (Fonagy & Luyten, 2018). In this context, it can be said that the mentalization ability is a developmental achievement (Fonagy & Luyten, 2009; Fonagy et al., 2007; Fonagy & Luyten, 2018). The origin of this ability is based on the attachment relationship between mother and child during the first six years of life (Fonagy &

Target, 1996; Slade, 2005; Weinberg, 2006). The degree of mentalization ability the person will have been shaped depending on the quality of this relationship (Fonagy et al., 2007; Fonagy & Luyten, 2018).

For the mentalization skills of the infant to develop, the mother should have some characteristics such as containing the infant's affect in a secure attachment relationship, fulfilling the infant's physical and psychological needs, and helping the infant adapt to the outside world (Fonagy et al., 1991; Fonagy & Luyten, 2018). Because when the infant is born, the infant does not have the psyche to understand own feelings, and to tolerate negative emotions (Fonagy, 2001; Jurist & Meehan, 2009). That is, the infant is not born with mentalization skills, nor is the infant born with the capacity to regulate their emotions (Fonagy & Target, 1997). The infant is in a helpless state both physically and mentally (Fonagy et al., 1991). Therefore, the infant seeking a relationship at the beginning of life is fully dependent on their mother to tolerate and regulate their own feelings (Fonagy, 2001; Freeman, 2016). In the mother's mind, the infant's mental image is formed, and the infant seeks their own image of the mother's mind (Freeman, 2016). It is required that the infant can see both themselves and how the infant feels when they look at the mother's face and facial expressions. In other words, the mother can reflect back to them how the infant is feeling through her facial expressions and reactions. The child's self-perception is only possible to occur when the infant can see it in the mother's mind (Fonagy & Target, 1997). As the mother responds to her infant's psychic capacity and needs, understands the infant, and mirrors them affectively, the child feels understood and contained. In this way, the mother offers the basic psychological structure to the infant for the construction of the sense of self (Mantilla, 2007; Nicolas et al., 2019; Fonagy et al., 1991; Fonagy & Target, 1997).

The mother's mirroring responses are very important for the organization of the infant's internal state the child to feel understood and contained (Allen & Fonagy, 2006; Fonagy & Luyten, 2018). As long as a mother is responsive to her infant's mental states, the child becomes responsive to her own and others' mental states and emotional experiences (Karterud & Bateman, 2010 as cited in Halfon & Coşkun, 2021). Mental representations involve affects, ideas, beliefs, thoughts, and

intentions. Also, as long as the capacity for reflective self and emotion regulation begins to develop, the child begins to see himself as an entity with emotional intentions and to make sense of his own mental states (Fonagy et al., 1991; Mikic & Terradas, 2014).

The representations of emotions, thoughts, desires, and beliefs are created by the reflective self. The person with a reflective self realizes that the person feels, perceives, and responds (Mikic & Terradas, 2014). In short, it can be said that mentalization has a very important place both in the development of affect regulation capacity and in the development of a coherent sense of self (Fonagy et al., 2002; Morel & Papouchis, 2015).

1.2.2.1. Pre-mentalizing Modes of Thinking as the Developmental Stages of Mentalization

Fonagy and Target (1996; 1997; 2007) proposed a developmental mentalization model to explain humans' psychic functioning. They suggested three pre-mentalizing modes as the teleological mode, the psychic equivalence mode, and the pretend mode. With the integration of these 3 modes, the child reaches mentalization.

The mental functioning of children from birth to 18 months is characterized by the teleological mode. In this mode, the child is not capable of recognizing the mental states of oneself or others. Children in this age range are able only to physically observe the behavior of others. In the teleological mode, they can recognize behavior, but they cannot make sense of the intentions behind it (Fonagy, 1997; Luyten et al., 2020)

Psychic equivalence mode develops from 18 months to 3 years. During this period, the child believes that their inner experience is the same as the outer world. Since there is no boundary between inside and outside, the child's own subjective experience merges with external reality. That is, the child's perception of subjective reality and external reality is equivalent. In psychic equivalence mode, the child cannot think of any other point of view than their own and believes their own way

of thinking is the only point of view. There is no place for alternative thinking ways of others (Busch, 2008; Fonagy, 1997; Fonagy & Luyten, 2018; Luyten et al., 2020). Therefore, the child assumes that what the child know is also known to the other, because the distinction between 'me' and 'not-me' has not yet occurred.

The mental functioning of children from 3 to 4 years is characterized by the pretend mode. The role-playing capacity and imaginal thinking of the child begin to develop. Also, the distinction between the inner world and the external world begins to occur (Fonagy & Luyten, 2018; Luyten et al., 2020). If the child is confronted with external reality, the child's imagination is inhibited because this distinction between inner and outer is not yet fully formed. That's why the child keeps his own fantasy world separate from external reality. As the distinction between inner and outer, 'me' and 'not-me', 'other' begins to form, the child begins to understand the meaning behind thoughts, feelings, and intentions (Fonagy, 2002; Luyten et al., 2020). In other words, mental states begin to be understood as representations by the child.

These pre-mentalizing modes are integrated around the age of 4 or 5. With this integration, the child understands that both oneself and others have a separate inner world and mind. In other words, the child's capacity to mentalize is formed (Fonagy & Target, 2000; Fonagy et al., 2002; Luyten et al., 2020).

1.2.2.2. Returning to the Pre-mentalizing Modes

Two theoretical backgrounds about pre-mentalizing modes will be mentioned in this section below: (1) returning to the pre-mentalizing modes as an adult, and (2) returning to the pre-mentalizing modes as a parent.

Fonagy and his colleagues (2002) put forward that returning to pre-mentalizing modes is possible in later years of life. When the person is very stressed and overstimulated, the person may lose the mentalization ability and revert to these modes (Fonagy et al., 2002). Also, having a personality disorder is a risk factor to adopt these modes more frequently (Fonagy & Target, 1997). For example, when adults return to the teleological mode, visible and observable behaviors are

prominent for the adult. The adult can recognize mental states only in the case of physical and concrete situations. In the psychic equivalence mode, the inner world of the adult becomes equivalent to the external world. The adult who applies this mode is not possible to think from others' perspectives except their point of view. Lastly, the adult's feelings and thoughts detach from reality in pretend mode. Due to the distortion of reality, mentalization impairments such as hypermentalization and hypomentalization are associated with this mode. These mentalization impairments will be described in the next section.

In addition, Terradas and his colleagues (2020) have proposed the operationalization of these pre-mentalizing modes: the teleological mode, the psychic equivalence mode, and the pretend mode (Terradas et al., 2020). They highlighted the characteristics of different psychic functioning by observing the relationship between parent and child, examining their behavior, relational patterns, and characteristics of children's play (Terradas et al., 2020).

Parents with a predominantly teleological mode in psychic functioning show little interest in their own and children's mental states. In addition, these parents approached their children's feelings and thoughts from a more concrete and observable point of view (Terradas et al., 2020). Also, the teleological mode is dominant in the cases of neglect where parents are not interested in their children's mental states, or the absence of the parents (Fonagy et al., 20002). These parents' understanding of their children's emotions focuses on bodily sensations. Therefore, these children tend to experience their emotions in a somatic way because they are not able to form mental representations. They tend to express their feelings with actions, not with words because of the insufficiency of symbolization capacity (Terradas et al., 2020).

Parents who are predominantly in the psychic equivalence mode are not able to recognize and understand the mental states of their children due to the fact that the distinction between 'me' and 'not-me' is not distinguished. In other words, the boundary between parents and children has been intertwined. For this reason, what the parents feel and think, they assume their children feel and think as the same. It has been observed that the child, that plays with the clinician, does not talk about

the play because the child assumes that the clinician knows the child's inner world before the child talks (cited in Terradas et al., 2020).

Lastly, Parents with a predominantly pretend mode are not able to contact their own emotions. For this reason, they are not able to think about their children's mental states (Leroux & Terradas, 2013). Parents who try to escape thinking about their own emotions urge their children to rationalization and intellectualization. For this reason, these children feel alienated about their mental states and have difficulty recognizing their experiences (Leroux & Terradas, 2013). Also, it is observed that these children choose to speak in preference to play (Terradas et al., 2020).

1.2.3. Mentalization Impairments

Fonagy and his colleagues (2016) described two types of mentalization impairments as 'hypermentalization' and 'hypomentalization' (Fonagy, 2016). While hypomentalization refers to the situation of too much uncertainty about the mental states of one's own and others, hypermentalization refers to the certainty about the mental states of one's own and others. Individuals who tend to hypomentalizing have difficulties recognizing the mental states of others and their own, and they think in a concrete way (Fonagy et al., 2016). From this point of view, hypomentalization is related to the psychic equivalent mode of functioning that characterizes by concrete thinking (Luyten et al., 2020). In other words, the individual cannot attribute an intention to others' minds. Nevertheless, they are aware of the difficulty they have in understanding people, and they are aware of their obstacles to recognizing themselves and others.

On the contrary, individuals who are prone to hypermentalizing point out the excessive and inaccurate attributions of mental states without appropriate evidence. They are not aware of this inability. Moreover, they see themselves as a good mind reader (Fonagy, 2016). Thus, pretend mode functioning is related to hypermentalization, which is known as pseudomentalizing or excessive mentalizing, in terms of distortion of reality (Luyten et al., 2020). Research findings support that there is a significant relationship between mentalization impairments

and acting out like substance abuse, violence, eating disorders, and self-harm (Luyten et al., 2020). Also, mentalization impairments are strongly related to teleological mode, in which visible and observable behaviors are prominent (Fonagy & Target, 2002).

Contrary to hypermentalization and hypomentalization, genuine mentalization refers to the opaqueness of mental states. Individuals, who draw on genuine mentalizing, recognize the mental states of themselves and those of others at a certain level. They are aware of the opaqueness of mental states that they never have full access to the minds of others and even of the self (Fonagy et al., 2016). Individuals as genuine mentalizers feel comfortable understanding and exploring the other's experiences, feelings, and intentions, and they are good at understanding others (Bateman & Fonagy, 2013).

1.2.4. Intergenerational Transmission of Mentalization

Mentalization is a developmental achievement that is acquired in the presence of a caregiver through interaction between the caregiver and the child. The mentalization capacity of the caregiver who is mostly the mother affects the quality of the child's mentalization (Fonagy & Luyten, 2018) because the way parents respond to their children's behaviors is closely related to how these caregivers are responded to their own caregivers. For this reason, parents respond to their children's needs with expectations based on their own past experiences (cited in Fonagy et al., 1996). For instance, while good mentalizing of a caregiver provides a basis for good mentalizing of a child, poor mentalizing of a caregiver provides a basis for poor mentalizing (Fonagy & Luyten, 2018). A lot of studies in the literature support this intergenerational transmission of mentalization (eg. Camoirano, 2017; Ensink et al., 2015; Fonagy et al., 1991; Fonagy et al., 2002; Meins et al., 2002; Rosso et al., 2015; Sharp & Fonagy, 2008; Slade, 2005).

First of all, if the parent has a good mentalization capacity, their ability to understand, recognize and regulate emotions will be good (Meins et al., 2002; Gergely & Watson, 1996), so that the mother metabolizes the intense emotional

experience of the infant by regulating emotions (Fonagy et al., 2010). A mother with a good mentalization capacity recognizes, mirrors, and contains her infant's emotions in the early period (Slade, 2005). The mother tends to understand what's going on in her child's inner world by trying to understand the intentions behind her child's behavior. In this context, it can be said that the mentalization capacity of the mother paves the way for the development of the child's ability to regulate their own emotions (Fonagy et al., 2002). In a study by Rosso and his colleagues, they suggested that especially the mother's ability to mentalize her child's negative and complicated mental states is determinative in the child's mentalization development (Rosso et al., 2015). It has been observed that caregivers who do not have a good mentalization capacity are not able to tolerate and make sense of painful, intense, and negative emotional experiences coming from their children. Therefore, it has been determined that their children are not able to regulate their emotions (Camoirano, 2017).

The child-mother talk is associated with affective understanding (Dunn et al., 1991). With the acquisition of affective understanding, the child can talk about feelings, desires, and emotions (Ruffman, 2002). Meins and his colleagues (2002) found that the mental state talk of mothers in interaction with their infants in the preverbal stage predicts the mentalization skill of children at the age of 3-4. The crucial point here is that the quality of mental state talk should attune with the child's inner world (Meins, 2002). In addition, growing up in a family where emotions are spoken and expressed and exposing the internal state talk of family members was found to be a good predictor of mentalization.

Another important point is that the mother behaves with the awareness that her child has a mind, as well as fulfilling the needs of the child (Meins et al., 1998; 2001). The mother's tendency to treat their children with this kind of attitude is defined as maternal mind-mindedness (Meins et al., 2021). In other words, it means the tendency of mothers sees their children as having minds. Caregivers with maternal mind-mindedness use mental state terms by interacting with them and showing consideration of their current level of understanding (Meins, 1998). This maternal mind-mindedness centering upon a child's mental characteristics affects

the future improvement of mentalization skills of children. The study of Meins and his colleagues (1998) found that mothers who reflect mental states rather than behaviors are better at completing the mentalization development of their 3-year-old children (Meins, 1998). It has been observed that the 3-year-old children of mothers who reflect their mental states rather than their children's behaviors complete their mentalization development when they reach the age of 4-5. Research findings support that maternal mind-mindedness strongly predicts to child's mentalization ability compared to the attachment security of infant-mother (Meins, 2001).

1.3. STUDIES ON PSYCHOSOMATIZATION AND MENTALIZATION

When the studies on psychosomatization and mentalization in the literature are examined, it is seen that some studies focused on a specific psychosomatic disease, and some studies discussed from a broader perspective such as psychosomatization tendency or psychosomatic complaints. In this section of the literature review, both qualitative and quantitative studies on the association of psychosomatization with mentalization are summarized.

The findings of many studies in the literature show that people who experience psychosomatic symptoms or complaints experience mentalization impairments (Bizzi et al., 2021; Bouteloup et al., 2020; Gürkan, 2020; Köksal, 2017; Preis et al., 2017; Riem et al., 2018). In the studies of Gürkan (2020) and Köksal (2017), it was found that people with a high tendency for psychosomatization are also more likely to hypomentalize. On the contrary, Kızılkaya's study (2018) has shown that people who have skin reactions tend to hypermentalize.

There is a strong relationship between emotion regulation and mentalization, the findings of Özden's study (2015) showed that people with psychosomatization tendency have difficulties in emotion regulation and especially, people who have difficulty coping with their worries and sadness have been more prone to psychosomatization (Özden, 2015).

While Dzirlo and his colleagues (2021) investigated the mentalization levels of inpatients with irritable bowel syndrome (IBS), Agostini and his colleagues (2019) investigated the mentalization abilities of patients with inflammatory bowel disease (IBD). In addition to that, irritable bowel syndrome and inflammatory bowel syndrome are considered as psychosomatic diseases (Asahine et al., 2006; Sajadinejad et al., 2012). So, both studies have shown that these patients with IBS or IBD have a low mentalizing ability (Agostini et al., 2019; Dzirlo et al., 2021).

Griffies (2010) and İnanç and his colleagues (2019) investigated the mentalization abilities of fibromyalgia patients whose symptoms are characterized by general muscle aches, fatigue, and chronic pain at specific points in the body. Griffies' study (2010) has shown that these patients' self-reflective mentalization capacity is restricted. In İnanç's study (2019), the mentalization levels of fibromyalgia patients were compared with the mentalization levels of the healthy control group. Significantly, fibromyalgia patients have been found to have a lower mentalization level than the healthy group (İnanç et al., 2019).

In addition to these studies, the studies of Riem et al. (2018) and Preis et al. (2017) also have shown that people with somatoform diseases have mentalization impairments. The study of Riem and his colleagues (2018), which examines the role of mentalization, especially in medically unexplained somatic symptoms (MUSS), emphasizes that the inability to mentalize one's own emotions is an important mediator role (Riem et al., 2017). In the study by Preis and his colleagues (2017), they researched the association between the theory of mind (ToM) and emotional awareness with somatic symptoms in the general population. This study indicated the relationship between somatic symptoms and mentalization impairment (Preis et al., 2017). It is noteworthy that there are qualitative studies as well as quantitative studies on this subject. The findings of studies in which a specific disease is evaluated with projective tests present more specific features. In addition, the concept of mentalization in these qualitative studies is discussed with Marty's psychosomatic economic theory.

In the study of Uncu (2017), the mentalization abilities of 3 female patients diagnosed with alopecia areata (spot baldness) have been evaluated by

psychoanalytic clinical observation and interview. The mentalization and symbolization capacity of these patients has been observed as limited. Besides, it has been pointed out that these patients are not able to connect with their past and remained in an emptiness (Uncu, 2017). It can be said that they have noise in their bodies and silence in their psyches (İkiz & Dricu, 2013). Similarly, Göçer (2019) evaluated the mental functioning of 15 patients with chronic eczema through projective tests and observed that these patients have weak symbolization and mentalization abilities. Also, these patients express their mental conflicts through body and skin (Göçer, 2019). Besides, Aydoğan (2018) conducted a process analysis study with two adolescents with eczema, allergic asthma, and migraine. Like the findings of other studies, the mentalization difficulties of these two adolescents have attracted attention (Aydoğan, 2018).

Another qualitative study was conducted by Akın (2020) on the mentalizing capacities, impulsive-affective traits, and functioning of the death drive of rheumatoid arthritis patients. Akın's findings, interpreted within the framework of psychosomatic theory, showed that patients with rheumatoid arthritis have difficulty in mentalization and have an apathetic psychic world (Akın, 2020).

Another qualitative study that is conducted by Bouteloup and his colleagues (2020) is about the psychic functioning of migraine patients. This study pointed out that migraine patients have difficulties in mentalization. Also, it supports the findings of other studies that their representations and their affective expression are limited (Bouteloup et al., 2020).

To summarize, the studies in the literature both highlight the strong relationship between mentalization and psychosomatization and show that mentalization ability can be a protective factor against psychosomatic diseases or symptoms.

1.4. THE PRESENT STUDY

Studies in the literature support the relationship of somatization with both maternal factors (e.g., Craig et al., 2002; Craig et al., 2004; Garber et al., 1998; Reilly et al., 1999; Schulte & Petermann, 2011; Walker et al., 1991) and mentalization (e.g., Bizzi et al., 2021; Bouteloup et al., 2020; Gürkan, 2020; Köksal, 2017; Preid et al., 2017; Riem et al., 2018). The theoretical foundation base points to mentalization as a basic ability to determine whether maternal factors are transferred onto the child.

Looking at the studies in the literature, Gürkan (2020), Özden (2015), and Köksal (2017) found that somatic complaints of the mother are related to somatization. These studies support that somatization can be transmitted from the mother to the next generation. However, how this transmission relates to other possible predictors and how it is subjectively experienced has not been studied. In summary, many studies have indicated that psychosomatization tendencies and mentalization abilities are transferred from mother to child. However, no research has been found in the literature specifically among mothers and adult daughters about this issue. In addition, it is seen that the studies in the literature are either qualitative or quantitative. There is no mixed-method study in which quantitative and qualitative studies together on this subject are carried out.

On the basis of the literature summarized above, this study aims at understanding the association of psychosomatization and mentalization of the mothers with the psychosomatization of the daughters. Within the scope of this aim, first psychosomatization and mentalization of the mother and their interaction will be investigated as possible predictors of the psychosomatization of the daughter. Second, this study will further investigate the experience of the mother–daughter relational context in which the transmission might or might not be experienced as well as the subjective in-depth reflections on this process.

To achieve this aim, the current study is designed as mixed-method research, including a quantitative component to address maternal psychosomatization and mentalization as predictors and a qualitative component to

complement the findings by providing information on the relational context and subjective experience. The mixed-method design provides a more comprehensive understanding and a deeper perspective to the researcher. The convergent parallel design, one of the mixed research models, will be used in this study. While the quantitative component will offer a solid ground to portray a more representative picture of the psychosomatic symptoms of adult daughters today in Turkey in relation to their mothers' somatization and mentalization, the qualitative component will provide a deeper understanding of their psychosomatic complaints from both the daughters' and mothers' perspective.

1.4.1. Hypotheses and Research Questions

For the quantitative component of the study, on the basis of literature, the following hypotheses are specified:

1. The somatization level of the mothers will positively predict the somatization level of their daughters.
2. The mentalization impairment of the mothers will positively predict the somatization level of their daughters.
3. The interaction of the mentalization impairment and somatization level of the mothers will predict the somatization level of their daughters.

For the qualitative component of the study, the main research questions are determined:

1. How does the way mothers experience psychosomatic complaints affect their daughters' psychosomatic complaints?
2. What are the similarities and differences between mothers and adult daughters in expressing their feelings?
3. How do mothers' mentalization characteristics affect daughters' psychosomatic complaints?

CHAPTER 2

METHOD

The current study was designed as mixed-method research, including a quantitative component to address maternal psychosomatization and mentalization as predictors of adult daughter's psychosomatization and a qualitative component to complement the findings by providing information on the relational context and subjective experience. The quantitative data and qualitative data were collected and analyzed as two separate datasets and then the findings were compared and converged during interpretation.

In this section the participants, data collection tools, procedures, and data analytic strategies of quantitative and qualitative studies will be presented as two separate subsections: 2.1. Method of the Quantitative Study and 2.2. Method of the Qualitative Study

2.1. METHOD OF THE QUANTITATIVE STUDY (STUDY 1)

2.1.1. Participants

The sample of the quantitative part of the study has consisted of the mother and adult daughter dyads. Before the data collection, the minimum number of participants required was determined by the G*Power program. The minimum required sample size was determined as 64 when the effect size was 0.3, alpha 0.05, and power was 0.80. The only criterion for participation was determined as being aged between 18 and 65. All volunteering adult participants who provided valid responses constituted the sample of this study.

A total of 325 individuals attempted to participate in this study. However, 66 participants did not complete the survey, 1 participant did not meet the age criterion for inclusion, and 102 participants' responses could not have been matched with their mother or daughter. Thus, the remaining 156 participants, combined as 78 mother-daughter dyads, constituted the final sample of this study.

The ages of the mother participants ranged between 43 and 70 years, with a mean of 53.36 ($SD = 6.02$). The daughter participants' ages were between 20 and 37 years with a mean of 26.86 ($SD = 3.36$). Almost half of the mother participants (47.4%) were high school graduates, 25.6% were primary school graduates, and 21% had BA, MA, or PhD degrees. On the hand, the majority of the daughter participants were highly educated; 34 participants (43.6%) had BA degrees and 27 participants (34.6%) had MA or PhD degrees, while only 21.8% of the daughter participants were high school graduates.

Regarding socioeconomic status, the majority of the mother participants (66.7%) defined their socioeconomic status as Middle and below, and the remaining mother participants (33.3%) defined their status as above middle. In regard to socioeconomic status of daughter participants, almost half of the participants (45%) defined their socioeconomic status as Middle and below, remaining participants (42.3%) defined their socioeconomic status as Upper-Middle.

In regard to relationship status, almost all of the mother participants (90%) were in a relationship, and only 10% had no relationship. On the other side, while 55% of the daughter participants were in a relationship, 45% of participants were single. Among those who have relationships, 85% of mother participants and 21% of daughter participants are married. Additionally, while almost all of the mother participants (90%) were living with their husbands and children, half of the daughter participants (51%) were living with their parental families. Of the remaining daughter participants, 21 daughters (27%) were living alone, and 17 daughters (22%) were living with their spouses and/or children.

In brief, the majority of the mother participants were high school graduates, in a relationship, from middle and lower socioeconomic status, not working, and living with their husband and children. On the other side, the majority of the daughter participants were highly educated, in a relationship, from middle and lower socioeconomic status, employed, and living with their own parental family.

2.1.2. Instruments

For the quantitative study, the instruments of the mothers and daughters were designated separately. The Demographic Information Form, the Somatization Scale (SS), and the Reflective Functioning Questionnaire (RFQ-8) were administered to the daughters. On the other hand, the Demographic Information Form, the Somatization Scale (SS), Reflective Functioning Questionnaire (RFQ-8), and Parental Reflective Functioning Questionnaire (PRFQ) were administered to the mothers.

2.1.2.1. The Demographic Information Form

The Demographic Information Form was prepared by the researcher to obtain general information about the participants. This form consisted of two sections: (a) personal information and (b) information about health status. The first section included questions as regards the participants' age, level of education, working status, perceived socioeconomic level, and birth order of the daughter. The other section included questions about the presence or history of any chronic disease, psychological or psychiatric disorders, and whether any are getting treatment. Additionally, there was one more section about how adult daughters perceived their mothers' health status (See Appendix B for mother form, and See Appendix C for daughter form)

2.1.2.2. The Somatization Scale (SS)

The Somatization Scale was developed by Hathaway and McKinley (1943) from the Somatization Disorder items of the Minnesota Multidimensional Personality Inventory (MMPI; Hathaway & McKinley, 1951). This scale consists of 33 items answered as yes or no. The items in the somatization scale measure the level of psychosomatic complaints. The Somatization Scale is adapted to the Turkish population by Dülgerler (2000). In Dülgerler's study, the Kuder-

Richardson-20 reliability coefficient of the Somatization Scale was found as .83, and the test-retest reliability coefficient was found as .96. The validity of the Turkish version of the scale was also assessed by Dülgerler with the SCL-90 and the correlation was found as .80 (Dülgerler, 2000). With these findings, the Turkish version of the Somatization Scale was found to be reliable and valid. In this study, the Kuder-Richardson-20 coefficient was found as .82 for the mother sample and as .83 for the daughter sample indicating good reliability as in the adaptation study by Dülgerler (2020). The scale is given in Appendix D.

2.1.2.3. Parental Reflective Functioning Questionnaire (PRFQ)

The Parental Reflective Functioning Questionnaire (PRFQ) is developed to assess the reflective functioning capacity of parents by Luyten and his colleagues (2009). PRFQ includes 39 items that are rated on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). PRFQ has 3 subscales as Pre-Mentalizing (PM), Certainty about Mental States (CM), and Interest and Curiosity (IC). The Cronbach's alpha values of the 3 subscales are at .70 or greater. The Turkish adaptation of PRFQ was conducted by Karabulut, Ilhan, Kumru, and Arıkan to provide a brief and multidimensional assessment of parental reflective functioning (Karabulut et al., 2016). For this reason, the adapted version of PRFQ is consist of 18 items. Cronbach Alpha reliability coefficients were found as .86 for PM, .75 for CM, and .76 for IC (Karabulut et al., 2006).

In the current study, the scale of PRFQ was only given to mothers. Before presenting the scale to mothers, the items referring to early childhood (4, 7, and 15) were rephrased in the past tense because the scale was planned to be used for adult daughters. The Cronbach's alpha coefficients were found to be .71 for PM, .82 for CM, and .62 for IC. The scale is given in Appendix F.

2.1.2.4. The Reflective Functioning Questionnaire – Short Form (RFQ-8)

The Reflective Functioning Questionnaire was developed by Fonagy and colleagues (2006) to assess an individual's level of reflective functioning. Reflective functioning is used interchangeably with mentalization refers to the mind's ability to envision the mental states of oneself and others (Fonagy et al., 2006). The short form of the Reflective Function Questionnaire (RFQ-8) is a self-report questionnaire, and this measure consists of 8 items that are scored on a 7-point Likert scale from strongly disagree to strongly agree. The scale allows for the calculation of 2 scores referring to certainty and uncertainty about mental states. While RFQ Certainty (Hypermentalization) refers to being too certain about the mental states of self and others, RFQ Uncertainty (Hypomentalization) refers to being too uncertain about the mental states of self and others.

The short form of the Reflective Functioning Questionnaire (RFQ-8) has not been adapted to Turkish. For this reason, the short form of the RFQ-8 that was translated into Turkish was retrieved from the UCL website. Nevertheless, the short version of the RFQ-8 was used in several studies (e.g., Çüçülayef, 2020; Dal, 2021; Göktaş, 2021). Göktaş (2021) reported the Cronbach's alpha values as .76 for the Certainty dimension, and .75 for the Uncertainty dimension. Also, Dal (2021) reported the Cronbach's alpha values as .78 for the Certainty dimension and .73 for the Uncertainty dimension.

In the current study, initially, the Cronbach alpha values of Certainty and Uncertainty dimensions were calculated for both the mother and daughter participants. The internal consistency of the Certainty dimension was found to be acceptable to good ($\alpha = .74$ for the mothers and $\alpha = .81$ for the daughters). On the other hand, the internal consistency of the Uncertainty dimension was problematic, especially for the mothers ($\alpha = .52$). Elimination of item 7 provided an at least minimally acceptable level of consistency ($\alpha = .59$ for the mothers and $\alpha = .60$ for the daughters). Considering that the Turkish adaptation has not been complete yet and there was no resource to guide the scoring other than the original instructions, item 7 was eliminated during score calculations to avoid confounding the score by

including an item with a low covariance. The version used in this study is given in Appendix E.

2.1.3. Procedure

After obtaining ethics approval from the institutional review committee, a study announcement was prepared by the researcher stating basic information about the study and the requirement that both the mothers and daughters should participate. The announcement and the links to the survey available on an online survey platform were shared in e-mail groups and social media accounts. In the announcements, the participants were instructed to click either the mother survey link or the daughter survey link. Upon the approval of an informed consent form (See Appendix A), the Demographic Information Form was administered first as it includes information regarding the nickname and initials to be able to match the mother-daughter data. This was followed by a warning for the dyad to complete their surveys independently and not to share their answers. The rest of the instruments Somatization Scale, Parental Reflective Functioning Questionnaire PRFQ (only for mothers), and the Reflective Functioning Questionnaire (RFQ-8) were presented in random order. It took approximately 15-20 minutes to complete all scales. Participants were provided the option of withdrawal at any time.

2.1.4. Data Analysis

The data analysis was conducted as planned in the initial data analytic strategy. Participants with missing data on any of the study variables were excluded. All analyses were done using The Statistical Package for the Social Sciences (SPSS 28.0). Descriptive statistics were calculated for all the demographic variables and study variables. Preliminary analyses were conducted to identify any control variables and to check the assumptions for further testing. Given that the assumptions were met and that preliminary analyses supported the model, to test the hypotheses, a Regression analysis was conducted with daughters'

psychosomatization level as the dependent variable and mothers' psychosomatization, mothers' mentalization, and their interaction as predictors.

2.2. METHOD OF THE QUALITATIVE STUDY (STUDY 2)

2.2.1. Participants

The sample of the qualitative study consisted of 6 mother-adult daughter dyads. Braun and Clarke (2006) indicate that 6-10 interviews are sufficient for a small project. The convenience sampling method was used to recruit participants. The inclusion criteria for participation were determined as follows: being aged between 18 and 65 and knowing to read and write in Turkish. Also, having a medical/neurological difficulty was set as an exclusion criterion.

Six mother-adult daughter dyads participated in this study. The age range of the mother participants was from 48 to 62, and of the daughter, participants were from 26 to 37. Nearly all the participants had medically diagnosed diseases. The detailed information was presented in Table 2.1.

Table 2. 1

Information about the Participants

	Marital Status	Medical Diagnosis
Mother A	Married	Endocrinology
Daughter A	Single	Endocrinology
Mother B	Divorced	Endocrinology & Neurology
Daughter B	Engaged	Dermatology & Neurology
Mother C	Married	Orthopedy
Daughter C	Married	None
Mother D	Married	Neurology
Daughter D	Single	Neurology & Orthopedy
Mother E	Married	Orthopedy
Daughter E	Single	Dermatology
Mother F	Married	Gastroenterology

Daughter F	Engaged	Neurology
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2.2.2. Materials

2.2.2.1. Semi-Structured Interview Question Form

For the qualitative part of the study, a Semi-Structured Interview Question Form was used. The questions were prepared by the researcher separately for mothers and adult daughters. The interview form included questions about the general health of the participants, followed by their physical complaints and their reflections on the triggers, reasons, and meanings of these complaints. There were also questions about how participants experience and express emotions. Last, the mother-daughter relationship was asked of the participants (See Appendix H for mother form and See Appendix I for daughter form).

2.2.3. Procedure

After the approval from Ethics Board, semi-structured interviews were held with mother-daughter pairs who give consent to take part in the interview as a mother-daughter dyad (See Appendix G for the Informed Consent Form). Participants were informed that participation was on voluntarily basis and, the participants were free to leave the study whenever they want. There was no institution or location specified for face-to-face data collection because the location was decided according to the availability of the participants. In the study, some interviews were conducted face-to-face, and some were conducted via Zoom depending on the convenience of the participants. Mothers and daughters were interviewed separately. Each interview took approximately 30 minutes. Due to confidentiality risks, the voice recorder feature of the Zoom application was not used. After the participants allowed their voices to be recorded, the voice was recorded via the researcher's phone's voice recorder. After the transcription of

digital recordings, all recordings were deleted from the phone. Participants were encouraged to contact the researcher in case of questions or concerns.

2.2.4. Data Analysis

Firstly, all audio records of the interviews with 6 mother-adult daughter dyads were transcribed by the researcher. Then these transcribed data were analyzed by using Thematic Analysis via the MAXQDA Software program. In the analysis process, the researcher followed the guidelines of Braun and Clarke (2006) for thematic analysis. These guidelines consist of six phases as data familiarization, generations initial codes, generating themes, reviewing themes, defining, and naming themes, and interpretation and reporting. During the data analysis process, the data of mothers and daughters were analyzed together. After the codes were transformed into themes, similar and different points of mothers and daughters were evaluated.

2.2.5. The Primary Investigator's Perspective

The reason why I especially examined the transference between mother and daughter and why I chose adult daughter instead of daughter was due to my personal history. The message from upper-generation women in my own family can be illustrated with the following example. Me, my mother, my grandmother, and other female family members are not people who can share and express their concerns. In addition to this, with this common pattern that I encountered in female participants, my ears were also opened to the issue of intergenerational transmission. During the interviews and analysis process, while thinking about this issue, I learned from my grandmother that my grandmother's mother's favorite song was "*Söyleyemem Derdimi*". It might be that my grandmother's mother's favorite song was almost an expression of the message from the upper-generation women.

Additionally, many times, I felt overwhelmed when analyzing the mothers' and daughters' interviews. For me, the analysis process has been one that I

experience from time to time like nausea or headache in my body. Although each experience of every participant is unique, I felt deeply that the common thread of the interviews intersected with my personal history. Just like in my family, the participants had difficulty expressing their emotions and they were expressing their emotions with their bodies rather than their words. On the other side, I felt having similar experiences to theirs helped me in the coding process to name their experiences. During the interview and analysis process, I was very excited to find partnerships between mothers and daughters and to catch clues about intergenerational transmission.



CHAPTER 3

RESULTS

The findings of this study will be presented in three sections. First, the findings of the quantitative study (Study 1) will be reported, and second, the findings of the qualitative study (Study 2) will be reported. In the third and the last section, the converging and diverging aspects of the findings from the quantitative and qualitative studies will be summarized.

3.1. FINDINGS OF THE QUANTITATIVE STUDY (STUDY 1)

The hypotheses of this study expected the somatization and mentalization of the mothers and their interaction to predict the somatization of their daughters. Prior to the statistical tests pertaining to the hypotheses testing, a series of preliminary analyses were conducted for exploratory purposes, assumption checking, and identification of control variables. Then, the hypotheses were tested via Regression analysis.

3.1.1. Preliminary Analyses

The preliminary analyses reported in this section included (1) the inspection of mothers' and daughters' somatization levels and their association, (2) the inspection of the association of daughters' somatization with background characteristics, and (3) the initial inspection of the association of daughters' somatization with mentalization.

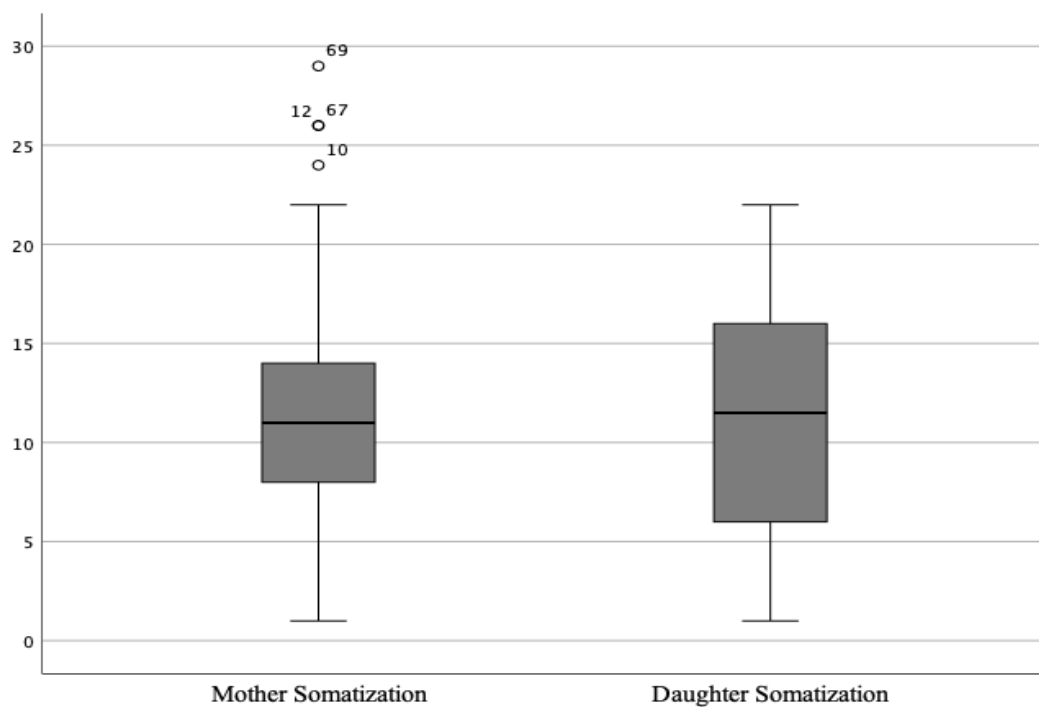
3.1.1.1 Psychosomatization Levels of Mothers and Daughters

Initially, the somatization levels of mother and daughters were inspected as to their central tendency and dispersion as well as their association with each other. The distributions of somatization scores are demonstrated as boxplots in Figure 1.1.

Despite 4 cases of non-significant outliers for mothers, the distributions of somatization scores of mothers and daughters did not significantly deviate from normal.

Figure 1.1.

Boxplot of Somatization Scores



The somatization scores of the mothers ranged from 1 to 29, with a mean of 11.41 ($SD = 6.214$) and a median of 11.00. The somatization scores of the daughters ranged from 1 to 22, with a mean of 10.96 ($SD = 5.593$) and a median of 11.50. The only differences observed between mothers' and daughters' somatizations score distributions were a slightly higher range for mothers and a slightly higher interquartile range for daughters. Mean comparison was conducted for exploratory purposes via a paired t-test and the difference was not statistically significant. The paired samples correlation, on the other hand, indicated that mothers' somatization and daughters' somatization had a significant positive correlation, $r(78) = .278$, $p = .014$. This observation supported the further testing of the first hypothesis

portraying mothers' somatization as a potential predictor of daughters' somatization.

3.1.1.2. Background Characteristics and Daughters' Psychosomatization

Since this study attempts at assessing whether daughters' somatization could be predicted by mothers' somatization, mother's mentalization, and their interaction, the association of the demographic variables of the mothers and daughters with daughters' somatization were inspected prior to the model testing, in order to decide on the inclusion of control variable(s) to the final model. Mean comparisons of the categorical background variables were conducted via One-way ANOVAs and associations of the continuous background variables were examined via Pearson correlations coefficients.

Daughters' somatization level was found to be significantly negatively correlated both with their own age, $r(78) = -.226, p = .047$ and their mothers' age, $r(78) = -.293, p = .009$. It was observed that as the ages of the mother and daughter increased, the level of somatization decreased.

Daughters' somatization level was not found to be significantly associated with the background characteristics of relationship status and socioeconomic status of the mother and daughter; the educational level of the mother; the number of siblings and birth order. The only characteristic that revealed a significant difference in terms of somatization was the educational level of the daughter that participants with a primary or high school degree ($EMM = 17.63, SE = 1.862$) had higher somatization scores than participants with BA degrees ($EMM = 12.35, SE = 1.774$), and MA / PhD degrees ($EMM = 12.17, SE = 1.797$), $F(2, 78) = 5.512, p = .006, \eta^2 = .155$. However, given that the level of education was highly associated with age, the analysis was repeated by ANCOVA controlling for age, and the main effect of the education level of the daughter was not found to be significant. Thus, this observed difference between the education level categories was due to age, which is negatively correlated with somatization.

In addition to the demographic characteristics reviewed above, data regarding the second set of background variables pertaining to the physical and psychological health of the mothers and daughters were collected. In terms of having a physical diagnosis, while 48 (61.5%) of the mothers reported a physical diagnosis, 23 (29.5%) of the daughter participants did so. Of these 48 mothers with a physical diagnosis, 39.6% had an endocrinological disorder, 14.6% had an orthopedic disorder, 20.8% reported more than one diagnosis, and 25% reported other diagnoses that could not have been classified. Of the 23 daughters with a physical diagnosis, 5 reported a dermatological-immunological disorder, 5 reported a neurological disorder, and the remaining 13 reported other disorders that could not have been classified. The presence of a physical diagnosis for mothers and daughters was cross-tabulated and a Chi-square test revealed that they were not significantly associated.

Participants were also asked to report whether they had any undiagnosed physical complaints. While 16 (20.5%) mothers reported having undiagnosed physical complaints, 14 (17.9%) of daughters did so. Among the ones who reported having physical complaints, 9 mothers and 4 daughters reported suffering from unexplained pains/aches while the rest reported other and/or mixed complaints. The presence of an undiagnosed physical complaint about mothers and daughters was cross-tabulated and a Chi-square test revealed that they were not significantly associated.

The associations of the presence of a physical diagnosis for both the mothers and daughters with daughters' psychosomatization were analyzed via One-way ANOVA tests. As expected, the somatization level of the daughter participants with a physical diagnosis ($EMM = 14.30$, $SE = 1.081$) was significantly higher than the ones without a physical diagnosis ($EMM = 9.56$, $SE = 0.599$), $F(1, 78) = 13.550$, $p < .001$, $\eta^2 = .151$. On the other hand, the presence of a diagnosed physical health issue in the mother was not significantly associated with the daughter's somatization.

Lastly, mothers' and daughters' psychological issues were also assessed. It was observed that 39.7% of the mothers and 29.5% of the daughters reported having

experienced a psychological issue. Approximately half of both the mothers and daughters with a psychological issue reported anxiety-related problems and half reported mood-related problems. Mothers' or daughters' having a psychological issue was not significantly associated with daughters' level of somatization.

On the basis of these preliminary analyses, daughters' age and presence of a physical diagnosis appeared as associated with somatization levels. It was also deemed important to include the presence of a physical diagnosis in further analyses to account for the expected associations while controlling for the effect of physical diagnosis on somatization.

3.1.1.3. Association of Mentalization with Daughters' Somatization

Prior to the examination of the association of daughters' somatization with mentalization, descriptive statistics for the mentalization measures were calculated (See Table 3.1). Although not hypothesized, in order to be able see whether it is another potential predictor that is partially independent of the mothers' mentalization, daughters' mentalization was also measured and presented.

Table 3.1

Descriptive Statistics of the Scale Scores

	N	Min	Max	<i>M</i>	<i>SD</i>
<i>Mentalization Measures of Mothers</i>					
PRFQ Pre-Mentalizing	78	1.00	3.83	1.84	.761
PRFQ Interest and Curiosity	78	2.50	7.00	5.86	.982
PRFQ Certainty of Mental States	78	1.00	7.00	4.95	1.306
RFQ-8 Hypomentalization	78	.00	2.40	.39	.526
RFQ-8 Hypermentalization	78	.00	3.00	1.71	.832
<i>Mentalization Measures of Daughters</i>					
RFQ-8 Hypomentalization	78	.00	2.40	.55	.568
RFQ-8 Hypermentalization	78	.00	3.00	1.31	.853

The descriptive statistics indicate an overall good level parental mentalization as indicated by high scores of Interest and Curiosity (IC), low scores of Pre-mentalizing (PM), and moderate scores of Certainty of Mental States (CM). Both mothers' and daughters' Hypermentalization scores on RFQ-8 were around a moderate level and Hypomentalization scores were closer to the low end of the score range. Noting the slight positive skewness of Hypomentalization scores that would be expected from a non-clinical population, the distributions of mentalization scores were approximately normal.

The Pearson Correlation coefficients were calculated for an initial inspection of the association of daughters' somatization and mentalization scores with the aims of (a) warranting the inclusion of the proposed predictors in the model to be tested and (b) evaluating daughters' mentalization as a potential check (See Table 3.2).

Table 3.2

Associations of Daughters' Somatization with Mentalization

	Daughters' Somatization
<i>Mentalization Measures of Mothers</i>	
PRFQ Pre-Mentalizing	.098
PRFQ Interest and Curiosity	-.212
PRFQ Certainty of Mental States	-.254*
RFQ-8 Hypomentalization	.115
RFQ-8 Hypermentalization	-.174
<i>Mentalization Measures of Daughters</i>	
RFQ-8 Hypomentalization	.331**
RFQ-8 Hypermentalization	-.311**

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

It was observed that daughters' somatization had a significant negative correlation with mothers' Certainty of Mental States with reference to parental reflective functioning, $r(78) = -.254$, $p = .025$. Similarly, Hypermentalization of the mother was negatively, but not significantly, correlated with daughters'

somatization, $r(78) = -.174, p = .128$. This pattern of decreasing somatization with an increasing certainty of the mother, while affirming mothers' mentalization as a potential predictor of daughters' somatization, fails to support the direction of the expectation. Increased certainty, delineated as a mentalization impairment, negatively predicted somatization.

The other impairment dimension of parental reflected functioning, Pre-mentalizing, as well as Hypomentalization of the mother were not significantly associated with somatization in the daughter. On the other hand, the dimension that refers to the reflective functioning ability to have Interest and Curiosity is negatively, but not significantly, correlated with somatization as would be expected by second hypothesis, $r(78) = -.212, p = .063$.

On the other hand, indicators of daughters' own mentalization, which were not significantly associated with parental reflective functioning, had the highest correlations with their somatization among the inspected measures. As Hypomentalization increased, somatization also increased, $r(78) = .331, p = .003$; as Hypermentalization increased, somatization decreased, $r(78) = -.311, p = .006$. However, as for the mothers, the direction of this correlation indicated Hypermentalization not as an impairment, but as an asset.

On the basis of these preliminary analyses, mothers' parental reflective functioning markers of Certainty of Mental States, and Interest and Curiosity were further analyzed. Despite the non-significant correlation, Interest and Curiosity was tentatively analyzed mainly intended for its interaction with somatization. Impairments of Pre-mentalizing and Hypomentalizing were excluded from further analyses due to their very weak associations with somatization; and Hypermentalization was excluded due to its semantic overlap statistical collinearity with Certainty of Mental States. Daughters' Hypermentalization and Hypomentalization were also included in the list of predictors to be tested.

3.1.2. Factors That Predict Daughter Somatization

The main purpose of this study is to predict daughters' somatization. In detail, the first purpose of this study was to examine the association between mother psychosomatization and daughter psychosomatization. The second one was to investigate the association between mentalization impairments of mothers and daughter somatization. The last aim of this study was to examine the potential role of mothers' mentalization as a moderator. Thus, a Multiple Stepwise Regression analysis was conducted to predict daughter somatization. The list of predictors tested, as outlined above, included mothers' somatization, mothers' certainty of mental states, mothers' interest and curiosity, daughters' hypermentalization, daughters' hypomentalization, daughters' age and the presence of a physical diagnosis for the daughter.

Table 3.3.

Model Summary of Stepwise Regression Analysis

Model	R	R ²	Adj. R ²	SE of the Estimate	Change Statistics				
					R ²	F	df1	df2	Sig. F
					Change	Change			Change
1	.389 ^a	.151	.140	5.18652	.151	13.550	1	76	<.001
2	.478 ^b	.229	.208	4.97687	.078	7.538	1	75	.008
3	.533 ^c	.284	.255	4.82786	.055	5.701	1	74	.020
4	.570 ^d	.325	.288	4.71979	.041	4.428	1	73	.039

a. Predictors: (Constant), Daughters' Physical Diagnosis

b. Predictors: (Constant), Daughters' Physical Diagnosis, Mothers' Somatization

c. Predictors: (Constant), Daughters' Physical Diagnosis, Mothers' Somatization, Daughters' Hypomentalization

d. Predictors: (Constant), Daughters' Physical Diagnosis, Mothers' Somatization, Daughters' Hypomentalization, Mothers' Certainty of Mental States

Further, in order to test the third hypothesis expecting an interaction between mothers' somatization and mentalization, two interaction terms of somatization and certainty, and somatization and interest and curiosity were included. Given that the interaction terms were included in analysis, centered scores

were used. The general summary of the models generated by the stepwise regression was shown in Table 3.3.

At step one, the presence of a Physical Diagnosis entered the model, accounting for the 15% of the variance in daughters' somatization. At step two, in addition to the daughter's physical diagnosis, Mothers' Somatization entered the model, explaining an additional variance of 8%. At the third step, Daughters' Hypomentalization was added and at the last step, Mothers' Certainty of Mental States entered the model, accounting for 5.5% and 4% of the variance in daughters' somatization, respectively. The final model with the four predictors explains 32.5% of the variance. The standardized and unstandardized regression coefficients of significant predictors were presented in Table 3.4.

Table 3.4

Coefficients of the Final Model of Stepwise Regression Analysis

	Unstandardized		Standardized	t	Sig.
	Coefficients		Coefficients		
	B	SE	Beta		
(Constant)	9.612	.637		15.098	<.001
Daughters' Physical Diagnosis	4.575	1.174	.375	3.898	<.001
Mothers' Somatization	.211	.093	.221	2.255	.027
Daughters' Hypomentalization,	.363	.152	.231	2.384	.020
Mothers' Certainty of Mental States	-.879	.418	-.205	-2.104	.039

Having a physical diagnosis of daughters was found to have the strongest predictive power as indicated by the highest beta. Having a physical diagnosis increased the level of somatization by 4.575. It is followed by Daughter's Hypomentalization, as a one unit increase in Hypomentalization increases somatization by .363. Mothers' Somatization also positively predicts Daughters' Somatization with a quite close predictive power to their own Hypomentalization. As mothers' level of somatization increases by one unit, daughters' somatization level increases by .211. Lastly, the sole negative predictor in the model is the Mothers' Certainty of Mental States, with a slightly weaker predictive power. In

this model, a one unit increase in mothers' certainty, decreases somatization by .879.

The results of the regression analysis of the model formulated on the basis of hypotheses and preliminary analyses demonstrated that mothers' somatization significantly positively predicts daughters' somatization, as expected by the first hypothesis.

On the other hand, findings were inconclusive for the second hypothesis that mentalization impairments of the mother did not positively predict daughters' somatization. As described in preliminary analyses and as confirmed by the model, certainty of the mothers about the mentalization did not increase but decrease daughters' somatization. On the other hand, impairments such as hypomentalization or pre-mentalizing functioning of the mother were not related to daughters' somatization, whereas their own hypomentalization did predict it positively. This finding will be discussed in the next section as to the construct's cultural connotations as well as the psychometric properties of the instruments.

The findings failed to support the third hypothesis expecting an interaction between mothers' somatization and mentalization. Even when considering certainty as a reparative factor instead of an impairment, the interaction term did not significantly predict daughters' somatization.

3.2. FINDINGS OF THE QUALITATIVE STUDY (STUDY 2)

In this section, the results of the analysis based on the interviews with 6 mother-adult daughter dyads were presented. The narratives of the participants are presented with quotations analyzing with the method of Thematic Analysis. Before presenting and discussing the themes below, the somatic complaints of the participants will be addressed.

In this study, the headache was the most reported somatic complaint among mothers and daughters. Half of the participants (4 daughters, 2 mothers) were suffering from headaches. Of these 6 participants who experienced headaches, 4 had a diagnosis of migraine. Secondly, three participants were suffering from the

skin-reactions like eczema, psoriasis, and mouth sore. Also, while two participants had experienced a bowel activity problem, the other two participants had experienced indigestion problems. The other prominent complaints among the participants were gastralgia and body aches.

The issue of whether these somatic complaints were due to a physical health issue is an important point. To illustrate, while rheumatoid arthritis is characterized by body aches in several areas of the body, thyroid disease is characterized by chronic fatigue. In this sample, two mothers had a diagnosis of rheumatoid arthritis and three mothers, and a daughter had thyroid disease. Since it is not possible to make a clear distinction between medically diagnosed disease and somatic complaints, the complaints and medical diseases of the participants were evaluated on the axis of psychosomatization in line with the discourses of the participants.

Five main themes came forward in line with the interviews. These are: Triggers of Psychosomatic Complaints, Effects of Somatization, Dealing with Emotions, Relationship with the Mother, and Intergenerational Transmission. These main themes and their subthemes were presented in Table 3.5 as organized by the sub-sections they will be presented in.

Table 3.5

The Themes of the Qualitative Study

3.2.1.	Triggers of Psychosomatic Complaints
3.2.1.1.	Sadness
3.2.1.2.	Fatigue
3.2.1.3.	Stress and Anxiety
3.2.2.	Effects of Somatization
3.2.2.1.	Weakness
3.2.2.2.	Functionality
3.2.3.	Dealing with Emotions
3.2.3.1.	Shared vs Unshared Emotions
3.2.3.2.	Difficulty in Making Sense of Emotions
3.2.3.3.	Coping Ways with the Emotions
3.2.4.	Relationship with the Mother

-
- 3.2.4.1. Close and Positive Relationship
 - 3.2.4.2. Conflicting Themes
 - 3.2.4.3. Mothers' Motherhood from Daughters' View
 - 3.2.5. Intergenerational Transmission
 - 3.2.5.1. Transmission of Tendency to Withhold Negativity
 - 3.2.5.2. Transmission of Somatization Tendency
-

3.2.1. Triggers of Psychosomatic Complaints

It was thought that triggering factors have an important place in understanding the somatic complaints of the participants in a deep way. For this reason, it was inquired when the bodily complaints of the participants got worsened. In line with the evaluation of the interviews, three sub-themes related to the triggers of somatic complaints came forward: (1) sadness, (2) fatigue, and (3) stress and anxiety.

3.2.1.1. Sadness

It has been noticed that sadness was a highly triggering emotion in the manifestation of somatic complaints. When the narratives of the participants were evaluated, it was noticed that nine of the twelve participants (5 mothers, 4 daughters) had physical complaints when they were sad.

I noticed that my aches increased during my father's illness. When I'm sad, I become introverted. I cannot do anything, and I fall asleep. In short, I can say my aches get worse when I'm upset. (Mother B)

When I am very upset about something, my migraine starts immediately. It's usually nervous. (Mother D)

When I feel sorry for someone and listen to their troubles, I feel stuck and bad. After, my heart palpitation increases. (Daughter E)

Two mother participants described their sadness and grief with their physical sensation of inability to swallow. The mother participant, who lost a loved one mentioned that there was something stuck in her throat, and she could not swallow. It might be an indication of having difficulty in processing her loss emotionally. Swallowing is something related to the function of the digestive system. In this sense, it was thought that these participants who had difficulty in swallowing might have difficulty metabolizing their experiences emotionally. It had been deduced that the feeling that cannot be put into words remains as a lump in the throat.

I have difficulty swallowing... For example, when I eat something, I have difficulty swallowing or I feel as if there is something there as if something has remained. I feel like something remained there after my loss. There is an emptiness inside of me. While eating, it's like it stays here and doesn't go away. As if there is a logjam there. (Mother F)
When I'm sad, I get sick. I cannot swallow, I have sores in my mouth. (Mother A)

The participant who experienced skin reactions stated that the exacerbation of psoriasis depends on her mood. This participant had difficulty expressing and sharing her feelings. It was deduced that she was expressing her accumulated feelings with the skin reactions in her body.

The emergence of my skin reactions changes depending on my mood. When I feel happy, I feel very healthy. When I am unhappy, my body seems to give an alarm at certain times. Either I have a disease on my skin, or I have sores in my mouth. Since I am not a person who can show my emotions very well, my body reacts with the skin reactions. (Daughter B)

One of the participants, who had difficulty swallowing, became constipated when sad. The problem experienced by the participant both in swallowing and in the functioning of the bowels indicated difficulty in the functioning of the digestive system. However, the mother participant, who hide her feelings, mentioned that she could not cope with both her physical complaints and intense emotions. It was

deduced she had difficulty metabolizing her intense emotions like she had difficulty digesting and metabolizing what she ate.

I feel down when I think about something. My aches get worse when I'm sad. On the contrary, when I feel good, I do not have physical breakdowns. I get sores on my palate when I'm sad and distressed. I'm constipated, and I could not go to the toilet for days. (Mother A)

On the contrary, another participant said that when she experienced intense sadness, her bowels deteriorated. It was deduced that the intense discharge of this participant with the movement of the bowels might be an indicator of the feelings that are difficult to carry in the psyche.

I will explain with an example. Last day, I got bad news. Then, my stomach came on to ache. My intestines came on working too much and I went to the toilet 4-5 times that day. It was such a terrible feeling.... I always have these complaints when I have a very intense emotion. (Daughter A)

Two participants mentioned that when they felt down, they had gas entrapment in their stomachs. This gas entrapment created difficulty for them to breathe.

When I'm down, my stomach over-swell like a balloon and I need to outgas, but I cannot. (Mother D)

When I'm stressed, anxious, or sad, I feel a tightness in my stomach. I would describe it as such a gas compression. I feel like I'm relieved if I eat something. But even if I ate at those moments, that unpleasantness in my stomach continues. (Daughter A)

Participants who associated bodily complaints with psychological dimensions were aware that they experience difficulties because they have difficulty verbalizing. Although these participants, who try to hear and understand the sounds coming from their bodies, emphasized the importance of expressing their emotions at the conscious level, they cannot express their emotions in the reality.

I do not see people who can tell their troubles, people who can express themselves get very sick. Also, I do not see that carefree people get sick a lot. It is the reason why I have diseases. I force myself to make things better. (Daughter B)

I cannot tell my problems. I think the reason I have these complaints stems from I can't express my experiences. Even if I tell it, it does not cure anyone. The people I will share cannot cure me either. (Mother D)

When I cannot express my anger enough, my headache is more. (Daughter F)

One of the participants mentioned her transformation process. Daughter F, who suffered from chronic headaches during her sad and tense times, mentioned that after years of getting psychotherapy, she began making sense of emotional experiences. With this change, her headaches began to diminish. It was seen that as she expressed her feelings and put them into words, the echoes that came from her body began to diminish.

According to me, my headaches were psychological. I used to get a lot of headaches when I argued with my mom during my adolescence period. I used to experience this intense ache especially when I was angry and nervous. Like when I cannot express my anger to that person fully when I cannot explain it with words, the ache in my head was irresistible. In the past, I could not make sense of it like this, but later I understood and tried to make sense of my experiences. (Daughter F)

3.2.1.2. Fatigue

One-third of the participants thought that the reason for their somatic complaints was related to fatigue.

I mostly feel an ache in my neck and back when I am very tired. I want to lean against the doors to rub my back. It's all due to fatigue and stress. (Mother B)

The common point of the two participants was that they had rheumatic arthritis and their daily lives were affected because of the disease. Mother E stated that her aches were completely hereditary, and she did not think that psychological processes might have any effect on her aches. She claimed that her aches intensified when the participant got tired.

The main source of my aches is rheumatoid arthritis. It is also inherited by many family members. It is triggered by doing a lot of work. I do not think it has a psychological effect on my aches. For example, it is not like 'I was very sad and my back hurt. My stress does not affect my aches. It happens when I tire myself too much when I make an adverse move... I can say that it depends on my movements. (Mother E)

In addition, another mother participant who had rheumatoid arthritis mentioned that various parts of her body ached, and these pains increased due to fatigue.

When I go to the doctor, the doctor says take care of yourself, do not lift heavy, but it is not so that you are the lady of the house... I try not to lift heavy, but still, it is cooking, cleaning, and laundry. We must do these. Sometimes happens that I cannot get up because of my hernia. (Mother C)

My husband, daughter, and relatives know about my aches. The doctor always tells me not to tire myself. But I do not listen to them. My daughter and husband always say do not tire yourself, but I get tired of myself, I do not listen to them. I do it even if it hurts. I have

had this disease for many years. That's why I know that whatever I do, my aches get worse, but I'm a housewife, and I have work to do at home. I do this deliberately (Mother E).

Contrary to Mother E, Mother C thinks that her aches might be related to her psychological experiences. She said that she knows her body and she can recognize to reappear of aches when she is depressed or distressed by something.

3.2.1.3. Stress and Anxiety

Stress and anxiety were the other factors that caused the emergence of somatic complaints. Seven participants (5 daughters, and 2 mothers) stated that the source of their physical complaints stemmed from stressful and anxious situations. In particular, many participants notified that headache was triggered by stress and anxiety. Mother and daughter participants who were diagnosed and not diagnosed with migraine emphasized that their headaches were exacerbated during stressful times.

My headaches all get worse especially when I'm stressed. (Mother B)

I have a headache when I feel stressed. I have two children, and I am tired of dealing with them. (Daughter C).

My headache is intensified during stressful moments (Daughter D).

I get a headache when I'm sad and nervous. (Daughter F)

It was seen that the participant with eczema unconsciously has scratched the top of her hand when she is stressed and realized that she is scratching her hand after seeing the redness on her hand.

When I try to solve a complex issue, I catch one hand over my other.

It happens when I'm stressed about something or when I'm worried about how it will happen. When I'm stressed about something, I start scratching my hands (Daughter E)

3.2.2. Effects of Somatization

In the previous theme, the triggers of the participants' somatic complaints and the situations in which these somatic complaints worsened were discussed. In this theme, the effect of the participants' somatic complaints on them was discussed. It was noted that almost all the participants felt weak and exhausted. In addition, it was noticed that the somatic complaints of the participants significantly reduced their functionality in their daily lives.

3.2.2.1. Weakness

Before examining the physical complaints of the participants, they were asked how they felt physically. There was a point that draws attention and was common in the narratives of almost all participants. They described themselves as physically tired and weak. While describing their fatigue, there were expressions in their narratives about their need for sleep and that they felt weak. In addition, 3 mother-daughter dyads described how they felt physically and gave clues about their emotional lives. It was noteworthy that the participants described their emotional experiences as a weight on their bodies.

My life is not going well right now. I don't feel well physically at all.

I'm tired, I'm not in a good mood. I want to sleep all the time. I can't raise my hand. It's not physical, I think it's psychological. I'm not sick, but I'm like sick. I have a strange situation that I can't explain. I constantly feel sleepy and want to lie down. (Mother A)

My life is going bad right now. I'm so tired, I feel 50 years old. (Mother B)

I feel tired. I feel like I'm 10 years older than my age. (Mother F).

The mother participant, who had a headache during stressful times, explained that she was tired while caring for her children and that she felt weak because of the headache. At times like these, she did not want to do anything. It was noteworthy that almost as if the headache she experiences left the participant

motionless. In particular, only one participant, who experienced physical weakness, mentioned the relationship between physical weakness and its psychological effects.

Sometimes I find it very difficult to get out of bed. Despite getting enough sleep, I have difficulty waking up and taking action. (Daughter A)

There is tiredness in me, I have a hard time getting up, especially in the morning. There is usually a weight on me. This weight is on me from time to time during the day. I don't feel pleasant and energetic. (Daughter F)

I feel very tired physically. Every part of my body is beating like a heart. (Daughter E)

3.2.2.2. Functionality

In general, the somatic complaints of the participants reduced their functionality. As an effect of somatization, the participants' feeling of weakness was seen as a factor that made it difficult for them to do their daily work. For example, 3 of these participants tended to sleep when they felt physically weak.

I do not do anything to deal with my distress. I'm just sleeping. (Mother A)

These complaints affect everything about me. My daily life, my order at home... I think of escape. Trying to get myself together with sleep (Mother B)

One of the participants explained that she made great efforts to prevent her physical complaints to not affecting her functionality. Even if she had a severe headache, she tried to fulfill many responsibilities during the day.

I try not to let my physical problems affect my life. Let's say I have a very bad headache today and my migraine got worse. I encourage myself to do something even though my head is about to explode. I cook my meals; I do the laundry. I prepare the table. (Mother D)

3.2.3. Dealing with Emotions

3.2.3.1. Shared vs Unshared Emotions

Difficulty in expressing and sharing their feelings was seen as the most striking common theme for the participants. Only one mother and one daughter participant stated that they had no difficulty in expressing their feelings. For the other participants, the emotions cannot be verbalized and even must be hidden.

I cannot express my feelings. I have always tried to solve my problems and feelings on my own. (Mother B)

You always see me happy. Nobody understands me. I always hide my feelings and keep them inside. (Mother C)

The most remarkable similarity was that while the participants shared their positive emotions, they did not share their negative emotions. While happiness, joy, and pleasure were seen as positive emotions by the participants, emotions such as anger, rage, and sadness are seen as negative emotions. Although mothers and daughters share their happiness, they cannot share their anger and sadness with anyone except 1 mother, and 1 adult daughter.

I share my happiness with others, but I cannot express my sadness. (Daughter D)

I am mostly able to show my happiness to everyone, ..., When someone angers me, I usually do not express my anger. I cannot show my anger, I cannot show my frustrations. (Daughter E)

I always inhabit my sadness inside and I do not share it with anyone. (Mother F)

Anger is seen by three participants as a very destructive emotion. The participants fear the destructiveness of this emotion. So, it is deduced that they have difficulty sharing this emotion.

I cannot express my anger or even want to express it. Anger seems like such a destructive and unsolvable emotion to me (Daughter A).

I fear when I am angry because it seems to me that I am someone else (Mother D).

3.2.3.2. Difficulty in Making Sense of Emotions

In this sub-theme, the emotions that the participants had difficulty making sense of were included. It was drawn attention that most of the participants were able to recognize and label their emotions like sadness, anger, worry, and happiness. However, it was observed that four mothers and four daughters had difficulty making sense of their feelings. It was seen that these participants have difficulty in holding the emotions they cannot make sense of and experience these emotions as very intense in their psyche.

I cannot name some of my feelings, I'm weird. I cannot describe it to you. I want to shout as much as I can, but I cannot. (Mother A)

Three mothers and two daughters that have difficulty in making sense of cannot distance themselves from their emotions. It was noticed that these participants had difficulty getting rid of the emotions they had difficulty carrying.

Sometimes there are moments when I cannot understand what I'm feeling... When an emotion is heavy on me, I cannot get out of that emotion. Even though I want to get away from that feeling, that feeling continues to come with me for a long time. (Daughter A)

I get very pessimistic sometimes. That pessimism sometimes makes me very happy and sometimes very unhappy. Either I hold the balloon and go all the way up, or I go all the way down. There are many times that I cannot understand my feelings. I ask myself a lot of questions about what I'm feeling right now, and why I'm feeling this way. (Daughter B)

Sometimes I cannot make sense of some of my feelings... I do not know how to console myself. Some people try to heal themselves; I cannot do that. I am hurting myself on purpose. Sometimes I push myself into depression. For example, today I was upset about something? Nothing

good happens during the day. Even if something goes right, that day is already over for me. (Mother E)

Contrary to these overthinking participants, the three of the participants who have difficulty in making sense of their emotions distance themselves from their emotions. Particularly, the mother participant appeals to the action-behavior ways in order not to touch her emotions like an escape.

Sometimes I feel inner distress and then I think about what to do. At such times, I do not want to think about it, I just go outside. (Mother C)

I experience my feelings on my own, but sometimes I do not understand. At such moments, I try to get out of that mood immediately. (Daughter C)

I try not to think too much in such moments that I could not make sense of my emotions. (Daughter D)

3.2.3.3. Coping Ways with Intense Emotions

This sub-theme was about how mothers and daughters cope with their emotions. Nearly half of the participants (4 mothers, and 1 daughter) described the most difficult emotion to deal with as loss and grief. For most of the participants, the most challenging thing was encountering the absence of the deceased. It was seen that they described their grief as deep pain and suffering. Another common emotion that was difficult to cope with was sadness and anxiety.

Sadness, pain, loss. (Mother A)

The loss of my loved one, the nonexistence of my loved one... these are something I cannot describe. (Daughter B)

Losing loved ones is such a pain for me. (Mother F)

It was observed that the methods of coping with the emotions felt by the participants varied. While some participants experience their emotions intensely, some participants try to get away from the intense emotion and take a distance. It was seen that three participants resorted to sleeping as an escape to get rid of the

emotion experienced as an intense. Especially when they had a destructive and strong emotion such as anger, falling asleep can be considered an expression of the death instinct (Allsopp, 2016).

It is very difficult for me to experience anger. I mostly prefer to sleep while angry. I want to close myself to life. (Daughter A)

Even if I am unhappy, I take my pillow and go to bed. I would like to sleep. I do not want to talk to anyone. When I get angry, I withdraw into myself. (Daughter E)

Two participants especially underlined that they could not cope with their emotions. It is noteworthy that the two mother-participants, who experienced their sadness intensely, did not have any coping way. In addition to these two mothers, 5 participants stated that they experienced their emotions very intensely. As a result, it was noticed that these participants resorted to crying as an expressive way or could not cope with intense emotion.

I cannot deal with my feelings; I feel a pang of grief. (Mother A)

In my sad moments, I cannot say that I should turn on music and be happy. I need to think about it for a long time... So, I cannot cope with my sadness. I can rarely get something out of my mind fast. (Daughter E)

If I'm upset, I want to cry intensely until I'm exhausted and then I just want to sleep. It's like it'll go away when you sleep (Daughter D)

Half of the participants stated that they did not receive support from anyone, and they were trying to cope on their own.

No, I do not get support from anyone. (Mother A)

I do not get support from my relative, I try to cope on my own. (Daughter A)

3.2.4. Relationship with the Mother

3.2.4.1. Close and Positive Relationship

Compared to the mother-participants, the daughter-participants mentioned more about the conflicts they experienced in relationships with their mothers, but still, all mother-participants and daughter-participants described their relationships as close and they highlighted having a good mother-daughter relationship. Three mother-daughter dyads stated they were like siblings or friends to each other. Especially, the daughter-participants emphasized that they could express their troubles to their mothers as if they were sharing them with their friends.

My relationship with my daughter is like a friend. (Mother B)

My mother has many qualities for me: mother, father, sister, and friend. It has all kinds of qualifications. (Daughter B)

We are like friends. I can share with my daughter what I cannot share with many of my friends. I trust her inner voice, thoughts, and feelings. (Mother D)

Our relationship is just like friends. For example, I can share things with my mother that I do not share with my sister. I can share easily with her. We both have a great time together. (Daughter D)

We are like sisters. Our relationship is very good, mashallah. (Mother E)

We are really like friends. My mother supports me in every matter, I can consult and get advice from her on any issue. (Daughter E)

Four mother-daughter dyads stated that they have similar tastes and get along well. It is a remarkable finding that most of the mother-daughter dyads defined each other based on their sameness, ignoring their individuality. This situation, which brings to mind the difficulty experienced in separating from each other, draws attention to the fact that mother-daughter couples defined their relationship as almost inseparable, referring to Winnicott's unit that is formed by mother and infant in the early period (Winnicott, 1960).

My mother and I are in harmony with each other and that's why we get along well. Our relationship is also good. Our ideas and tastes are similar... If we are going to do something together, we usually want to do similar things. (Daughter A)

I think that our characters resemble each other. We get along well, and we enjoy the same things... We are compatible with each other. (Mother D)

Our tastes, the things we want to do, and the places we want to go are all the same. We are so alike to each other. (Mother E)

3.2.4.2. Relational Conflicts

In this sub-theme, the relational conflicts of mothers and daughters were presented. The important and interesting point was that these conflicting issues differed according to the view of mothers and daughters. In general, mothers tended to describe their relationship with their daughters as an all-good relationship in a defensive way. On the other hand, it was seen that the unimportance of the mentioned conflicts was emphasized. In addition, if they shared any conflicting issues, they tended to complete their sentences by saying they had a good relationship. It was thought that this approach of the participants might be related to the fact that they are in an effort to compensate.

We do not have any problems with my daughter. Mashallah. (Mother B)

We often have conflicts about the house order and cleanliness. Other than that, we do not have any conflicts. (Daughter B)

I often have conflicts with my daughter over the care of my grandchildren. I cannot say that we do not have conflicts, but we do not have big problems. (Mother C)

Sometimes we have conflicts about my daughter's job. My daughter talks about her troubles at work. And I say to her, you must be patient a little bit, you must wait. She thinks I do not understand her when I

say that. Other than that, we have no conflicts. We do not have any problems at home either. (Mother E)

There used to be points where we had a lot of conflict with my daughter. I would not understand her, she would not understand me. I mean, we thought we could not understand each other. It feels like we've forgotten all about it now. Fortunately, we do not have such conflicts at the moment. (Mother F)

On the other side, while daughter-participants mentioned the interfering side of their mothers, mothers did not mention anything about their interference. Nearly all the daughter-participants shared that their mothers try to enforce their daughters to do something that their daughters do not want to do. It was deduced that the interfering side of these mothers might be a sign of the difficulties in the separation-individuation process. In a manner of speaking, it was noted that mothers do not give their daughters enough space for individualization. Even though their daughters became adults, these mothers had disposed to decide in the name of their daughters.

My daughter is not an insistent child. When I tell her that an outfit does not suit her, she never buys that outfit. She does not buy anything without showing it to me. My daughter is very obedient. She does not buy any clothes that I do not approve of. (Mother E)

My mother is a little bit obsessive and meticulous. For example, every object in the house has a specific place. If I need to explain with an example, even my mother's slippers have a certain place. When I do not do things the way my mother wants in the kitchen or the common areas, we have conflicts. Even the towel that I dry my hands with, I must put it as my mother wants. (Daughter E)

It can be said that in most mother-daughter relationships, the mother's desire is more important than the daughters. Regarding the discourses of mothers and daughters, it is noteworthy that while some daughter-participants were able to make their own decisions independently of their mothers, some of the daughter-participants were attuned to their mother's desires. For instance, Daughter B acts

according to her own desire despite her mother's intrusive attitude. However, she said that she still felt uneasy because she did not tune with her mother's desire. It was thought that this dilemma creates a great conflict in the inner world of Daughter B.

I have a lot of conflicts with my mother. My mom loves to make me do something I do not want to do. I used to do what my mother wanted, but now I do not. However, when my mother feels anxious, I am also unhappy. Sometimes I cannot balance. (Daughter B)

Similarly, Daughter A mentioned that her mother has an interfering and enforcing attitude. Daughter A, who experienced intense feelings, especially in the face of this enforcing attitude of her mother, stated that she felt stuck, and her freedom was restricted.

We do not have many conflicts with my mother. I usually get very angry and stubborn when my mom insists on something. I feel so overwhelmed and stuck when something I do not want is forced upon me. When my mom forces me to do something and I do not want to do it, then we argue. (Daughter A)

Another mother-participant mentioned that she wanted to choose her daughter's clothes herself accordingly to her own desire, but it was understood that she was not satisfied with this situation as her daughter did not allow it.

When my eldest daughter was a child, I used to dress my daughter very well and direct her. I couldn't lead my middle daughter when she was a kid. She always wanted to choose her own outfit. She dressed herself, but she dressed well. After she grew up, she did what she wanted again. (Mother D)

Among the daughter-participants, there was only one participant who was a 'mother' and was over 30 years old. The issue that this participant had a conflict with her mother was the way she cared for the children. The mother-participant interferes with her daughter's motherhood, which causes conflict.

We have a lot of conflict over the care of my children. My mother always wants her own will, she is intrusive. I do not want either. In times like these, we have conflicts. (Daughter C)

We often have conflicts over my grandchildren. I cannot say we do not have conflicts. (Mother C)

Another mother-daughter relationship can be divided into past and present. Both mother and daughter talked about a transforming process. Both of them said that they could not understand each other in the past and that's why they always had conflicts. They described that now their conflicts have decreased, and they can feel like mother-daughter.

When I argued with my mother in my adolescence, I would have severe pain in my head. When I was angry and nervous, when I could not say exactly what I said to my mother, I would experience this pain severely. This is no longer the case. I used to tell my mom all the time that you don't understand me. My mother also said that I did not understand her. In short, this was the main point of our conflicts. (Daughter F)

We had very big conflicts, very big conflicts. She did not understand me, I did not understand her. Now, we are not experiencing these conflicts, but we experienced a lot when my daughter was a teenager. (Mother F)

3.2.4.3. Mothers' Motherhood from Daughters' View

In this sub-theme, firstly how mothers were described by the daughters was presented and then the motherhood of mothers from the daughters' view was described.

Two daughter-participants described their mothers as overly anxious. It was deduced that these mothers both have difficulty in carrying their own anxieties and also have difficulty calming their daughters' concerns. Daughter A described her mother as fragile. She stated that her mother could not cope with negative emotions

and got sick when she was upset. On the other hand, Daughter E stated that her mother had too much anxiety to let her sleep at night.

From my point of view, my mother is fragile. She always tries to see the good ones... She cannot stay in negative emotions; she tries to avoid negativity. My mother is more worried than I am. Sometimes, we panic together. When there is a situation that worries her, she approaches me with anxiety. (Daughter A)

She experiences her anxiety by not sleeping at night because my mother is very anxious. I have seen my mother walking around the house many times at night. I think she experiences her anxiety at very extreme points. (Daughter E)

In contrast to these anxious mothers, three daughter-participants described their mothers as resilient. The common point of these mothers is that they seem happy on the outside and do not show what they feel to others. While Daughter C stated that she was angry that her mother did not share her feelings and troubles with her, Daughter D stated that she was angry that her mother was upset about the troubles of others.

My mother does not reveal what she is going through. She cannot cry and laugh easily. I think she thinks that the more she does not show her feelings, the more she will protect herself. (Daughter B)

I struggle within myself and always try to be strong. Also, I try not to show my feelings around. (Mother B)

She also hides her feelings a lot, you can never understand how she feels. Even if she is bad, she does not say that she is bad. She always seems strong. (Daughter C)

My mother does not share her troubles much. She usually tries to hide it. My mother is very self-sacrificing and that's why she listens to other people's problems as if she does not have any problems and worries about their problems. (Daughter D)

Three daughter-participants described their mothers as intrusive, dominant, and stubborn. It was noted that all three mothers have interfered with their daughters. It can be said that the described mothers have omnipotent features.

My mother likes to direct, she is intrusive. She can even force me to do something I do not want. (Daughter B)

My mother has her own truths, and those truths are hard to change... She thinks in a very detailed way. She takes great care of everything about me. I do not want her to be so interested in me. Sometimes I even wish I had one more sibling. (Daughter C)

She is very stubborn. She always wants what she wants. (Daughter E)

When the mentalization levels of the participants were evaluated, it was evident that all mother-participants tend to hypermentalize because of their certainty about the mental states of others in an omnipotent way. While some mother-participants explained it through motherhood, some mothers explained it through their intuitions.

There are moments when I am very sure of what the other is feeling. (Mother A)

I understand what my relatives are thinking. I understand my mother, my daughter, and my brother. I can decipher their feelings from their facial expressions. (Mother B)

I'm a connoisseur of human nature. When I talk to people, I already understand what they think. (Mother C)

I do not know if there is a sixth sense, but I trust my intuition. For example, I can understand my children's friends immediately. It is said mothers know and feel. Maybe it's something about motherhood. (Mother D)

I understand my daughter especially better. I can be surer of what my daughter is thinking. (Mother F)

The daughter-participants were asked how they would like their mothers to approach their bodily complaints. It is noteworthy that only two daughter

participants were satisfied with their mother's approach, while the other participants were dissatisfied with their mother's approach.

I do not think there's anything my mother can do more for my skin reactions (Daughter B)

She approaches me very protectively, and prickly. She dotes on me a lot. Also, she approaches me angrily. It's as if my illness was because of me as if I did it. For example, I got the flu, she immediately says it happened like this because you didn't pay attention. She says such things. If my kids got sick, my mom would definitely think I made them sick (Daughter C)

I am satisfied with my mother's approach. Even if she cannot find a treatment for my pain, it makes me feel comfortable because she makes me feel that she is with me. (Daughter D)

My mother is a very panicky person. Since I am usually the one who calms my mother down, I could not learn anything from my mother about it. When we experience something negative, such as illness, something wrong, or something out of the routine of life, my mother panics a lot, I usually calm her down. We get on the plane, I calm her down, or she gets a disease, I calm her down. Usually, I'm more of the comforting, calming one. My mom does not think of the best, she thinks the worst of everything. (Daughter E)

It was thought that these mothers did not have a container function. Mothers are unable to calm their daughters' anxiety and accompany their experiences. The prominent common feature of the three mothers is that they are overly anxious and cannot soothe their children. The daughter-participants wanted their mothers to have a different approach.

I always wanted her to approach me calmly. I wish she did not increase my anxiety, but my mother is very anxious and worried, so it has always been the opposite. (Daughter A)

I wish she was less accusatory. Maybe because my mother is approaching that way, I get very little sick, or I do not externalize what I've been through. (Daughter C)

I always tell her, that one should not think the worst of anything. I've been telling my mom for years, that you shouldn't think about the worst-case scenario. As people call evil, negative things happen to people. When something bad comes to mind, you must be able to remove it. One cannot live life by constantly thinking about the negative. When something negative comes to mind, I want her to distance herself from that thought, to break it off. (Daughter E)

"Let me be sick, mother", "If I am sick, I am sick, mother." I've said things like this many times. Why should we tend not to be sick? I expected her to understand me a little more, I expected her to accompany me. On the other hand, her calmness would do me good, she is not apprehensive. (Daughter F)

When it was examined how mothers handled their own motherhood, two mother-participants described their motherhood as calming. It was noted that especially when their daughters had a physical complaint, they approached their daughters in a guiding way.

I always told her to be calm. What will life bring before us? Who knows what will be faced in the future? The world... everybody's going through something. (Mother B)

I do not go to the doctor for the slightest thing, I do not have such a character. I try to figure things out by myself first. I resort to some old-fashioned methods, painkillers, drinking water, resting, or lying down... You must look at the level of that pain. I think this approach is transmitted to my children from me, they are just like me. (Mother D)

In addition, although Mother F has a calming approach, she avoids negative emotions, leaving no room for the possibility of her daughter becoming physically ill. Therefore, her daughter thought that her mother could not understand her. From

this point of view, it was concluded that although her mother had a calming approach, she could not soothe her daughter because she could not accompany her daughter's concerns.

I have always been positive. I say that it will pass, it is okay. But my daughter used to cry even when she had a pimple. She was very anxious, she would worry that something bad would happen, and she was always negative. We did not go to the hospitals much, thank God, but even if she had a pimple on her forehead, she would have wanted to be taken to the hospital. Even the people in line at the hospital would laugh at us wondering what we had to complain about. It would also be trouble to have an analysis done because in case the result is bad. However, she is not like that now, she has changed a lot. (Mother F)

My mother could stay calm when I had a physical complaint, but my mother would always say: 'Do not be sad, do not cry, do not stress'. There was no place for negative emotions in our lives, especially since my mother was always looking for affirmation. (Daughter F)

Only one mother-participant expressed that she was not satisfied with her current approach and said that she wanted to approach her daughter more resiliently. On the other hand, the other mothers said that they were satisfied with their current approach.

I wish I could get something more. I wish not to be weak and to be resilient. (Mother A)

I would like to approach her the same way (Mother C)

In the same way, I would like to approach my daughter by crying because when my daughter is sick, I cannot say to her "you are very well, come on, get up". My approach is as follows: "Are you too suffering from pain". I would approach her like that again because I am not calm. Some may calm their children, but I cannot. This is our relationship. It's very difficult what we did. But we are happy to be

like this. Some look at us strangely, but I also look strangely at those who are so disconnected from each other. (Mother E)

I was a positive mother when my children were little. In my opinion, when a mother screams, even if the child is not in pain, she screams more. When my child fell down, I would not shout, I would act very calmly. I think my children were calm because of this approach of mine (Mother F)

In the light of all the findings, it was noted that most of the mother-participants hide and did not share their feelings with the others, some of the mother-participants were defined as over-anxious and some had difficulties relating to negative emotions. Thus, it was thought that these approaches of mothers might have an impact on their daughters' difficulties in carrying, coping with, and expressing their emotions.

On the other hand, omnipotent characteristics of all mother-participants appear as a common finding. The mothers in question draw attention with their desires being at the forefront and imposing their desires on others. Besides, when the mentalization capacities of mothers are evaluated, it can be said that the hypermentalization tendencies of the mothers can be characterized as high based on the certainty in the statements of the participants about their daughters' mental states. Finally, in the face of these mothers who do not give their daughters the necessary space for individualization, it can be claimed that the daughter-participants were not satisfied with their mothers' approach and needed to be contained by their mothers.

3.2.5. Intergenerational Transmission

In the last theme, the discourses of mother-daughter participants were evaluated and interpreted together as a dyad to answer the question of whether mothers' feelings and physical complaints are transmitted to their daughters.

3.2.5.1. Transmission of Tendency to Withhold Negativity

Four mother-daughter dyads can share their positive emotions such as happiness, joy, and pleasure with each other, but they are not able to share negative emotions. They do not express their negative feelings to anyone and try to cope with these feelings within themselves. It can be said that these 4 mother-daughter couples also tend to avoid negativity.

We both live inside of us. My daughter endures in silence, and so do I. We are both sensitive. (Mother A)

When it comes to understanding and expressing emotions, neither of us can express our emotions very much... Neither my mother nor I can express our anger. (Daughter A)

There are times when I get angry and hurt. In these times, I want to express my anger, but I cannot. In general, I wreck my anger on myself, and keep inside on myself. (Mother B)

We have too many similarities with my mother. Neither of us expresses our feelings, but I can express my feelings more than my mother. The way we repress emotions is the same. It's like we both have a shell. We feel better when we get sucked into that shell. (Daughter B)

I do not tell anyone. I try to solve my problem inside myself... We both keep our feelings inside. (Mother C)

I suppress my emotions. Nobody understands my feelings. Even when I'm very angry, I behave as if nothing happened. People always see me happy. Nobody knows how I feel because I always hide my emotions and keep inside myself... Also, my mother is like me. We both deal with our problems by ourselves, without showing it to the outside. (Daughter C)

On the other hand, another mother-daughter couple can express their anger openly, while living their sadness inside. As an interesting finding, what is common in this mother-daughter couple is the expression of sadness with anger. While they

express their sadness with anger, the person in front of them thinks that they are angry, not upset.

When I am angry, I fear my anger. When my anger comes out of me, it's like someone else comes out. By the way, when I'm sad, I get angry.

(Mother D)

Sometimes when I am upset, I can express this by getting angry and the other person thinks that I am angry, not upset about it. But, at that moment I am very sad. Sometimes I do not get angry, but I do not express it, I try to pass it off. I share my happy moments directly. But I guess I just cannot express it when I'm sad. Actually, I express it, but I express it in anger. (Daughter D)

From this point of view, it can be said that the mother's failure to make room and express her feelings blocks the channels of her daughter's understanding and expression of her own feelings. Daughter-participants who do not share and express their feelings tend to keep their feelings a secret, just like their mothers. It can be said that the mother's way of expressing her feelings is largely transmitted to her daughter.

3.2.5.2. Transmission of Somatization Tendency

In line with the information obtained from the interviews, it was seen that all mother-daughter dyads were prone to somatization. In this sub-theme, somatization tendencies and specific complaints of mother-daughter dyads were discussed respectively.

It was noted that the first mother-daughter dyad was highly prone to somatization. In situations of sadness and stress, the mother specifically has difficulty swallowing, while her daughter suffers from gastroenterological problems. It should also be noted that both this mother-daughter dyad has both thyroid disease and intestinal problems in their sad moments and cope with it by sleeping.

My daughter has stomach problems the most. She has gas in her stomach when she is emotionally bad. Her sadness shows itself in her stomach. Apart from that, we both tend to sleep, but we both have thyroid disease, I attribute this to it (Mother A).

Frankly, we are very similar in that regard. By the way, we are both thyroid patients. The thyroid certainly has an effect, but we both react with our bodies when we are upset. I mostly sleep during those times or live with gas pains in my stomach. My mother's intestines do not work, she has the intestinal activity problem. Her stomach swells out like a balloon. She also becomes tired out and physically weak. She's getting sick. (Daughter A)

It was revealed that the second mother-daughter couple, who does not express and share their feelings, also experiences bodily complaints in their stressful and sad moments. It can be said that the skin reactions of Daughter B who has psoriasis increase during stressful and sad times. Similarly, Mother b, who has epilepsy, is seen to have epileptic seizures and migraine attacks when she is very stressed.

When she cannot stand the stress, she gets sores on her head. She has psoriasis. Mouth sores appear instantly. Other than that, while I express my sadness with my body aches, my daughter expresses it with her wounds. I feel so sorry for her, but I'm telling her to stay calm. But we cannot, we fail to stay calm. (Mother B)

My mom has seizures when she cannot deal with her stress and when she is really upset. She is triggered even although taking medication. In a word, my mother is suffering from seizures and migraine, I am suffering from skin reactions. I think our problems are intensified and triggered when we cannot deal with our emotions. (Daughter B)

It was seen that the striking common feature of the third mother-daughter couple was that: no matter what they experience, the emotions they both feel are not understood from the outside and they always seem pleasant. It can be said that neither of them shares any of their physical complaints with the other. Also,

Daughter C has almost no physical complaints other than a headache in stressful moments. On the other hand, her mother, who has RA, has chronic pain due to her illness, and the severity of these pains is affected by her mood.

My daughter never talks about her pain... She does not show much to me, she does not talk, but I understand. (Mother C)

I do not have many physical complaints, I do not remember much when I was sick, but my mother has more. She has pains. So, I cannot say many similarities in this regard. But I cannot say it exactly because neither of us told or expressed it. (Daughter C)

In the fourth mother-daughter pair, it was observed that there was a discrepancy between the statements of mother and daughters. While the mother participant mentioned that they both had stomach complaints and constipation problems, daughter-participant did not mention she had stomach complaints and constipation problems. It was seen that the daughter-participant, who associated migraine with her stress, stated that her psychological experiences did not affect her bodily complaints. On the other hand, the mother-participant emphasized the psychological dimension of the bodily complaints experienced by both herself and her daughter.

My daughter also has stomach complaints. I also say her from time to time, the reason for this is nervousness. If she was angry at something, if she was upset, it must have been because of it. Her condition is like mine. Otherwise, she also has a bowel problem. Both my daughter and I have intestinal problems, we are experiencing constipation. (Mother D)

I think that my work is affected especially because of my headache. For example, when I wear contact lenses, I suffer from headaches more but suffer from headaches less when I wear glasses. I honestly don't think it's psychological. (Daughter D)

In the fifth mother-daughter couple, it was noted that there was a difference between the mother's narrative and her daughter's narrative. The mother, who has RA, said that she did not think that the aches she experienced could have a

psychological dimension and that her aches were completely hereditary. On the contrary, her daughter stated that many of her mother's aches may be of psychological origin. Especially after some experiences, the increase in her mother's aches attracts the attention of her daughter. In addition, it was seen that Daughter E's eczema increases during stressful and sad times and she experiences physical complaints just like her mother.

It is also inherited in many family members. It is triggered by coercion due to doing a lot of work. I do not think there is a psychological reason for my pain. It's not like my back hurts when I'm so bored. The stress I've been through does not affect those pains. (Mother E)

I think everything about my mother may be of psychological origin. She always says she hurts somewhere. Her back hurts, and her neck hurts. I think it's all psychological. When she is upset about something, when she is stressed, she has a headache, cannot get out of bed, and has pain all over. (Daughter E)

Finally, in the sixth mother-daughter dyad, it was seen that mother F has stomach problems and swallowing difficulties, especially in her sad moments, while her daughter also suffers from severe headaches. It is noteworthy that both of their bodily complaints are of psychological origin. Talking about a transforming relationship throughout the interview, it was noticed that this mother-daughter couple changed their way of living and expressing their feelings compared to the past. Especially with Daughter F's making sense of and expressing her experiences, it can be said that she does not experience severe headaches as in the past. It is known that this mother-daughter dyad has been going to therapy for a long time. Thus, it can be claimed that their somatic complaints decreased as they found a channel where they could verbalize their experiences.

It increases in my sad and tense times. In my adolescence, when I argued with my mother, it would hit my head as a pain. I used to experience this intense pain especially when I was angry and nervous when I could not say exactly what I said to the person in front of me. When I cannot explain it with words, when I cannot express my anger

to that person exactly, it's like this anger growing and growing and attacking my head. But I realized later that I lived this way. I could not make sense of these at those times. (Daughter F)

In summary, in the light of all the interviews, it was observed that the mothers, who could not express their feelings and could only externalize them through their bodies, transmitted this to their daughters, and so their daughters also experienced their unexpressed emotions as a somatic symptom.

3.3. THE CONVERGING AND DIVERGING ASPECTS OF THE FINDINGS

Before discussing the study findings, the converging and diverging aspects of the quantitative and qualitative study will be briefly mentioned. In the qualitative part of this study, the mother's somatization was found to be a predictor of the daughter's somatization. Convergently, a somatization tendency was also noted in the qualitative study, which was transferred from mother to daughter. On the other hand, while the focus was on mentalization in the quantitative study, the issue of expressing and sharing emotions came to the forefront rather than mentalization in the qualitative study. In the qualitative study, it was seen that the participants did not make room for their feelings and had the tendency to withhold negativity as a common finding. However, the narratives of daughters about making sense of their own experiences and of what others think have given clues about mentalization.

In the qualitative study, it was noticed that daughter participants had difficulty making sense of emotions and experiences. This finding was compatible with the fact that daughter hypomentalization predicts daughter somatization in the quantitative study. On the other hand, when the way in which the daughter participants described their mothers in the qualitative study, it was remarkable that the daughter participants perceived their mothers as interfering, overprotective, and stubborn. This finding might point to the observation of Hypermentalization in the quantitative study.

In the qualitative study, the characteristics of stubborn and omnipotent mothers correspond to the certainty of the mothers in the quantitative study. However, while the daughters of mothers with high certainty in the qualitative study are prone to somatization, in the quantitative study, contrary to the hypothesis, the somatization levels of their daughters decrease with the increasing certainty of the mothers. This has been seen as a divergent point. For example, in a qualitative study, a mother said that her daughter never told her about her physical complaints, but she explained that she understood her without expressing her daughter, with the following words by Mother C, *“My daughter never talks about her pain... She does not show much to me, she does not talk, but I understand.”* At this point, the fact that the mother is very sure of what she knows indicates certainty.

On the other hand, while the subjective experiences of daughter participants are obtained mostly in the qualitative study, this part is missing in the quantitative study. For example, in the qualitative study, contrary to the mothers' description of an all-good relationship, it was observed that the perceived relationship of the daughter participants in the deeper parts of the interview was much different from that of their mothers. While mothers did not touch on their intrusive sides, many daughter participants mentioned their mothers' intrusive and omnipotent characteristics. These findings also offered a perspective on understanding the effects of the mother-daughter relationship, especially in the origins of somatization.

CHAPTER 4

DISCUSSION

Understanding a person's psyche from a psychoanalytic perspective requires investigating the relationship established with the mother at the beginning of life (Craig et al., 2004). The quality of this interaction between mother and child can be found in the literature on both psychosomatization (Gaddini, 1974) and mentalization (Fonagy & Target, 1997; Fonagy et al., 2002; Gubb, 2013; Rostad & Whitaker, 2016) which are the two main variables of this study.

When a baby is born, they do not have a psyche to process their own intrapsychic conflicts nor protect themselves against internal and external stimuli and meet their physical and psychological needs (Fonagy, 1991; 2001; Freeman, 2016). All interactions between mother and baby from birth have a very important place in the development of mentalization (Fonagy & Target, 1997). As the mother represents her child's feelings, desires, and intentions in her own mind, the child begins to discover their own inner experiences through their mother's representations (Slade, 2005). However, when emotions cannot be expressed and excitations cannot be discharged, psychosomatic symptoms might emerge. In other words, psychic problems might be felt physically in the body (Busch, 2013; Marty, 2012). In the literature, the occurrence of psychosomatic manifestations seems to be highly related to the mother's inadequate caretaking of her baby (Belot, 2013; Wenar et al., 1960).

In the light of theoretical literature, the hypotheses and research questions of this study were mainly obtained by pursuing the following questions: How does the mother's way of experiencing psychosomatic complaints affect the way her adult daughters experience psychosomatic complaints? How do the mother's mentalization impairments affect the child's adult life and what do the mentalization impairments of mothers make a road in their daughters' psyche? In other words, this study mainly aimed to investigate the psychosomatic complaints of adult daughters in depth, together with those transmitted from mother to daughter.

Owing to the convergent parallel design method adopted, the quantitative and qualitative findings will be compared and converged together in this section (Creswell & Clark, 2007). In the quantitative study, it was investigated daughter somatization with the association of mother somatization, mother mentalization and their interactions in terms of offering a solid ground a more representative picture of daughter somatization. In terms of the predicting daughter somatization, the research hypotheses were tested via Multiple Stepwise Regression. Additionally, in this study, the predictor of physical diagnoses of daughter participants was found to be compatible with the literature and was a control function in this study. The qualitative study, it was aimed to provide a deeper understanding of the daughter's somatization. In line with the analysis, 5 main themes were reached: Triggers of psychosomatic complaints, effects of somatization, dealing with emotions, relationship with the mother, and intergenerational transmission.

In short, the quantitative and qualitative studies had both converging and diverging points in this mixed-method study. Within the scope of this study, the findings of the study will be discussed, focusing on the impact of the mothers' somatization and mentalization on daughter somatization. First of all, the compatibility of the converging findings with the literature will be explained, then the contextual information obtained from the qualitative study will be presented.

All the findings will be handled in three headings within the scope of the research hypotheses and questions: Mothers' somatization and daughters' somatization, mothers' mentalization and daughters' somatization, and daughters' mentalization and daughters' somatization.

4.1. MOTHERS' SOMATIZATION AND DAUGHTERS' SOMATIZATION

The first hypothesis of the quantitative study was that the psychosomatic symptoms level of the mothers would predict the psychosomatic symptom level of their daughters. Parallel to this, the first question of the qualitative study addressed how mothers' psychosomatic complaints affected their daughters' psychosomatic complaints. Both the quantitative and qualitative findings supported the role of

mothers' somatization on daughters' somatization. In the quantitative step of the study, it was observed that mothers' somatization appeared as a strong predictor of daughters' somatization, following the presence of a diagnosed physical health issue in the daughter and with an almost equivalent predictive power with daughters' own mentalization impairment. In the qualitative step of the study, transmission of the tendency to somatize emerged as a theme along with the transmission of the tendency to withhold negativity.

As presented in the literature review section, there are several studies that investigated the relationship between mother somatization and child somatization (Craig et al., 2004; Glaus et al., 2022; Schulte & Petermann, 2011; Walker et al., 1991). Walker and his colleagues (1991) found that the high somatization scores of the family members are correlated with the high somatization scores in patients with Pediatric Abdominal Pain (Walker et al., 1991). Similarly, a study by Schulte and Petermann supported the significant predictor of parent somatization in child somatization. Craig and his colleagues (2004) supported that somatizing mothers showed less joint attention to their children's bids than healthy mothers in the study that explored the children's health of somatizing mothers. On the contrary, it was observed that somatizing mothers' attention increased and showed more interest while children were playing with the medical box (Craig et al., 2004). Glaus and his colleagues (2022) explored the intergenerational transmission of somatization in the context of physical, sexual abuse, or family violence in the consisting of mother-child couples. Their study supports the transmission of somatization from mother to child (Glaus et al., 2022). In another study, it was supported that exposure to ill parents as a child is a risk factor for adult somatization. It was emphasized that this study especially highlights that during parent and child interaction, the illness behaviors of somatizing mothers can create a model in their children and therefore increase the transmission of somatization (Craig, 2002). This study comes to the forefront of the impact of maternal somatization.

All these research findings indicate maternal somatization enhances the chances of somatization in the child by indicating intergenerational transmission as did the quantitative and qualitative observations of this study. The qualitative

findings further shed light on the relational context at which this transmission occurs, offering a glimpse into the subjective experience of the mother-daughter relationship.

4.1.1. The Mother-Daughter Relational Context

As a common finding, almost all mother-daughter participants described their relationship as close. Although the mother-daughter dyads in the study described their relationship as close, in the deepening parts of the interviews, it was noticed that the sharing of these mother-daughter couples with each other was quite limited. While many daughter participants received support from their mothers in coping with their somatic complaints, it was a remarkable finding that they did not receive support in coping with their emotional experiences and they tried to solve them on their own. The study by Stone and colleagues (2019) emphasized that mothers with chronic pain show more interest in bodily complaints rather than mental states (Stone et al., 2019).

Similar to the current study, a qualitative study by Bojczyk and colleagues (2010) explored the relationship between the mother and adult daughters in depth. Nearly both generations described their bond as a close. It was drawn to attention that in the study of Bojczyk and colleagues, the conflictual issues and especially maternal pressure are mentioned by the mother and daughters. However, in the current study, while daughter participants tended to mention their relational conflicts, mother participants tended to describe their relationship as an all-good. It was found meaningful that the mothers did not mention their conflicts with their daughters due to not making room for negativity. In addition to that, while nearly all daughter participants mentioned their mothers' omnipotent and interfering characteristics, mother participants did not mention these attitudes. It was thought that the mother participants are not aware of the difficulties their daughters are experiencing because of their interfering sides. When all of them are brought together, it could be suggested that the tendency of mothers to avoid negativity

caused them to describe their relationships as very good and it creates a barrier for them to see their intrusive side.

It is seen that these daughter participants do not receive support from their mothers. The reason might be that daughters see their mothers' weakness and inadequacy in emotional expressiveness. Some daughters described their mothers as overly anxious and weak. In addition to the mothers' being described as overly anxious and weak, many daughter participants described their relationship with their mothers using the adjectives 'like a friend-like a sister'. It might point out the uncontainment functions of these mothers from the perspectives of the daughters. In fact, the mother is not a friend or a sibling. In fact, one daughter participant, while talking about how worried her mother was, explained that she calmed her mother's anxiety, with the following words by Daughter E, *"My mother is a very panicky person. Since I am usually the one who calms my mother down, I could not learn anything from my mother about coping with my emotions."* It is seen that in this situation, contrary to her mother, the daughter participant tried to contain and soothe her mother's anxieties. In other words, this daughter provides the maternal function to her mother.

On the other hand, daughter participants described their mothers' motherhood from their own perspective. More than half of the daughter participants mentioned that their mothers are overly anxious and have difficulty holding the negativity. While these daughters mentioned the inability of their mothers to contain, on the other hand, they told their desire to be contained. For instance, Daughter A expressed her desire to be contained with these words, *"I always wanted her to approach me calmly. I wish she did not increase my anxiety, but my mother is very anxious and worried, so it has always been the opposite."*

In addition to that, it was thought that some daughters had difficulties in the separation-individuation process. To give an example, Daughter E, who has eczema, has a symbiotic relationship with her mother. Daughter E, who has difficulty separating from her mother, described their relationship with these words: *"We have a terrible relationship with my mother. We are very dependent on each other. We are together 24/7... I am with my mother in every aspect of my life. We*

did everything together. Our relationship is very tight, very close.” Symbiotic relationship basically means that living together and dependent on each other. In this context, Mother E's way of describing her mother's relationships almost answered the question of what a symbiotic relationship is: *“We are so attached, as if we are dependent on each other.”* It has been inferred that daughters' somatic complaints intensify especially when they try to concord to their mothers' desires. In addition, the gastrointestinal problems that Daughter A experienced in sad and anxious times were interpreted as a sign of her psychological distress.

Before this section is concluded, the following can be added both as a suggestion for future studies and to underline the possibility of change and transformation, from the physical to the mental: a mother-daughter couple mentioned that they have been going through individual therapy processes for a long time. This mother-daughter couple mentioned that while they had a very conflictual relationship in the past, their relationship is now improving compared to the past. The most crucial point was the reduction in the severe headaches of the daughter. It has been deduced that the burden of the processed, meaningful, and space-opening emotions on the body decreases. And as the emotions are expressed in words, the body almost recedes into the background.

4.2. MOTHERS' MENTALIZATION AND DAUGHTERS' SOMATIZATION

The second hypothesis of the quantitative study which claimed that mentalization characteristics of mothers would predict daughter somatization was supported. The study findings showed that maternal hypermentalization was found to be associated with daughters' somatization. Although this finding supports that maternal mentalization is a potential predictor of daughter somatization, it did not support the direction of expectation because contrary to hypothesized, increased maternal certainty which is described as a mentalization impairment predicts daughter somatization negatively.

The association between mentalization impairments and somatization has been supported by several studies (Ballespi et al., 2019; Bouteloup et al., 2020; Riem et al., 2018; Smadja, 2011; Preis et al., 2017) as will be discussed in the next section. On the other hand, there was only one study in the literature that directly investigated the relationship between maternal mentalization and their children's somatization with an infant sample. Belot and de Tychey (2015) assessed the mentalization levels of mothers in non-clinical and clinical groups with Rorschach tests and examined the relationship between the mentalization characteristics of the mothers and the somatic expressions of their infants. The findings showed that the infants of the clinical group mothers who have low-level mentalization presented somatic expressions (Belot & de Tychey, 2015). The theoretical literature also associates the mentalization impairments of the mother with also lower mentalization capacity and higher probability of emotional difficulties and psychopathology in their children (Fonagy et al., 1991; Fonagy & Luyten, 2018; Fonagy et al., 2002; Morel & Papouchis, 2015). However, the self-reports of the mothers and adult daughters in this study failed to support these observations.

The finding that increased maternal certainty is associated with decreased somatization in the daughter could be due to the validity of the certainty construct as measured by the existing instruments. In this study, it was observed that mothers' Certainty of Mental States as measured by PRFQ and both mothers' and daughters' Hypermentalization as measured by RFQ-8 were negatively correlated with daughters' somatization. Although theoretically unexpected, this finding is in line with other studies conducted via self-reports. These studies also reported negative associations of certainty with other measures of impairment and positive associations with signs of mental health in Turkey (e.g., Çuçülayef, 2020; Göktaş, 2021; Gör, 2021; Yayla, 2020). Similarly, some studies in other cultures also reported findings that were inconsistent with certainty as a construct, indicating questionable validity (e.g., Meulemeester et al., 2018, Müller et al., 2020, Slade et al., 2003, as cited in Göktaş, 2021). Thus, one reason for the observation that certainty of the mother acting as a protective factor against somatization might be that certainty indicates genuine mentalization, instead of a mentalization

impairment. The level of certainty captured by these self-report instruments, namely PRFQ and RFQ-8, might not reflect a state of being *too certain* as intended by their developers (Luyten et al., 2009; Fonagy et al. 2006). Rather, they might indicate a state of interest, effort, and ability to mentalize.

Furthermore, there might be a cultural aspect as to why mothers' mentalization negatively predicts their daughters' somatization as well as the instruments' failure to capture the state of being too certain. In Turkish society, certainty might define the predominant maternal parenting style. In the literature, Turkey is portrayed as having both individualistic and collectivistic qualities (Ayçiçeği-Dinn & Caldwell-Harris, 2011; Oyserman et al., 2002) that are reflected in a predominantly authoritative parenting (Filiz, 2011; Tunç & Tezer, 2006), specifically confirmed also for maternal parenting (Newman et al., 2015). This type of parenting involves more limit-setting when compared to the permissive parenting and more responsiveness when compared to authoritarian. Thus, the control is implemented via explanation in a context of recognition and nurturance. Similarly, Sunar's (2002) observations on three generations of families from Turkey, emphasize high levels of emotional closeness, especially in the maternal relationship, going together with low levels of conflict, flexibility as well as a tendency to refrain from strictness and coercion (as cited in Sunar & Fişek, 2005). This portrayal is consistent with the findings of the qualitative study that all mother-daughter dyads reported a close and positive relationship. Yet, it was also observable that many mothers have described their daughters' thoughts and feelings with the expression "mothers know" through the certainty and accuracy of their intuitions and they did not report any conflicts while their daughters did. The intrusive and interfering sides of the mothers were reported by many of the daughters. This depiction of a relationship in which the mothers fail to see the separateness and wishes of their daughters as well as their tendency to deny any conflicts, might suggest too much certainty, in other words hypermentalization. Nevertheless, the literature and the qualitative findings of this study indicate that this occurs in a mainly positive relationship and may represent the normative way of being parented by the mother, thus, might not necessarily indicate an impairment.

In the same way that the normative parenting styles of each culture might be different, their consequences in terms of children's development might also be different (Li et al, 2010; Newman et al., 2015), as might be seen in the negative association of maternal certainty with somatization of the daughter. Thus, although the literature suggests that certainty in the mother that encompasses projections of the mother's own desires and wishes onto her daughter results in separation-individuation difficulties and related developmental issues (Marriotti, 2012), the findings of this study suggests that in this cultural and relational context, the outcome might be different.

Lastly, mothers' pre-mentalizing or hypomentalization, which are considered to be more valid representations of a mentalization impairment (Slade et al., 2003), were associated with daughters' somatization in the expected direction, but this association was not significant. Additionally, the interaction of mothers' somatization and mentalization impairments were also not significant. Thus, mothers' inability to mentalize their daughters did not seem to be associated with daughters' somatization issues and also did not seem to moderate the transmission of maternal somatization. This might be due to the point that the mother sample of this study was non-clinical with high levels of interest and curiosity in their daughters' mental states. Likewise, any theme of mothers being unable to mentalize their daughters did not emerge in the analysis of the qualitative data. Instead, difficulties with dealing with emotions that were mostly at the awareness of the participants, and a theme of the transmission to withhold negativity emerged. Additionally, the emotional triggers of somatization were mentioned both by the mothers and daughters.

4.2.1. Emotional Triggers and Emotion Regulations

This section will be continued in the light of the question: "What kind of echoes do daughters' intrapsychic conflicts have on their psyches?" First of all, it is known that expressing the emotions in dyadic interaction is related to the child's growing understanding. When there is a climate in which the family expresses

emotions verbally, the child's emotion regulation skills and ability to convey emotion intensity increase (Morris et al., 2007; Thompson & Meyer, 2007). On the contrary, the qualitative findings show that there is atmosphere where the emotions are not verbalized and expressed. In this climate environment where there is no room for emotions, it is a big question mark how these children will make room for their own emotions.

The findings obtained from the interviews show that daughters have difficulty in sharing their feelings just like their mothers. Dunn and Brown's study (1994) shows that when mothers talk to their children about emotions, children can express their negative emotions, and expressing negative emotions also gives space to discuss emotions (Dunn & Brown, 1994). Relatedly, the findings from the qualitative study show that participants have difficulty in sharing and experiencing negative emotions while they can particularly share positive emotions. Especially anger is seen as an emotion that should not be experienced and avoided by many mother-daughter couples. In short, the mothers' failure to share and express their feelings is transmitted to their daughters. Because just like their mothers, these daughters also do not give room for their feelings. In other words, it has been commented that the mother's not expressing her feelings almost blocks her child's channels of expressing her feelings.

Additionally, most of the mother-daughter dyads in this study stated that they had difficulty in coping with their sadness, anxiety, and stress. Although some try to cope with it, almost none of them have been found to have inadequate coping methods as they do not share their feelings and do not receive support from anyone.

Emotions cannot be represented as symbolically, cannot be expressed with words, and go to the somatic pathway. It has been observed that their physical complaints increase especially when an emotion is too intense for them, and they have difficulty in carrying that emotion. Also, the findings of the current study show that mothers are highly prone to somatization, and emotional experiences that they do not express and verbalize create weightiness in their bodies. The study findings are compatible with the relevant literature. Özden's (2015) master's thesis study also supports the argument that the inability to cope with anxiety and sadness is highly

related to psychosomatic symptoms (Özden, 2015). In the qualitative study of Sibelli and colleagues (2017), it was indicated that somatizers do not express, and suppress their emotions because they do not want to worry others (Sibelli et al., 2017). It was also thought that their difficulties in representing their emotional experiences with mental states intensified this situation. It is considered that mothers' inability to contain and soothe both themselves and their daughters' anxieties and emotional experiences affect their ability to carry, cope with, and express their emotions. In this context, it can be said that many studies support the strong relationship between emotion regulation and somatization (Gilleland et al., 2013; Lily & Valdez, 2012; Waller & Schedit, 2006).

At the beginning of the discussion, the question of how the conflicts experienced by daughters resonated in their psyches were raised. The findings obtained from the interviews show that some daughters experience internal conflicts when they cannot express themselves to their mothers or do not fulfill their mothers' wishes, and these inner conflicts find expression in the bodies of daughters with various somatic symptoms. It was deduced that: the skin reactions experienced by Daughter B with psoriasis and the severe headaches experienced by Daughter F were thought to be bodily expressions of their internal conflicts. Kızılkaya's study (2018) supported that there is a significant relationship between the difficulties experienced in the separation-individuation and the number of skin reactions (Kızılkaya, 2018). The experience of Daughter B, whose skin reactions were intensified especially when her mother did not fulfill her wishes, was supported by the study findings of Kızılkaya.

4.3. DAUGHTERS' MENTALIZATION AND DAUGHTERS' SOMATIZATION

Given that the theoretical and empirical literature suggests strong links between the mentalization skills of the mother and their children, although not hypothesized, this study included daughters' mentalization in the models tested. As mentioned in the previous section, the Hypermentalization of the daughters

themselves also had a negative association with their somatization. Again, this finding points to the possibility of Hypermentalization as measured by these instruments reflecting a mentalization ability, instead of an impairment, especially in this culture. On the other hand, regarding Hypomentalization, the expected relationship was not found between mother's mentalization and daughter somatization, but a positive relationship was found between daughter hypomentalization and daughter somatization.

The positive relationship between hypomentalization and somatization is compatible with the literature. Gürkan (2020) found that hypomentalization is a significant predictor to understand somatic complaints in late adolescence (Gürkan, 2020). Additionally, Köksal's study shows that people with high levels of hypomentalization and attachment insecurity have more tendency to somatize (Köksal, 2017). Convergently, the qualitative findings in the current study supports this association between hypomentalization and somatization.

4.4. DAUGHTERS' HAVING A DIAGNOSED PHYSICAL DISORDER AND SOMATIZATION

In the preliminary analyses, as would be expected, daughters' having a diagnosed physical disorder reported more somatization symptoms. Thus, this was included in the models testing the prediction of other variables to identify its predictive power as well as to test the associations while controlling for a physical diagnosis. It is important to add that it is difficult to distinguish the origin of the existing symptom in terms of both the Somatization scale which was used to measure the somatization of the participants in this study and the diagnostic approach of the DSM. Compatible with these results, the qualitative study findings show that all daughters except one have a physical diagnosis. Additionally, it has been observed that all daughters who have physically diagnosed disease are highly prone to somatization, except for one daughter-participant who does not have a physically diagnosed disease. Köksal (2017) found that the current medical conditions are significant predictor of somatization. Especially, it was observed that

having a chronic disease rather than acute and childhood diseases was significantly correlated with the somatization level (Köksal, 2017).

4.5. LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

In the qualitative part of this study conducted with mother-daughter couples, it was observed that what is not expressed with words finds an expression on the body and this is transferred from mother to daughter. However, it was thought for future studies that conducting such a study with 3 generations (grandmother-mother-daughter) will contribute more to the literature, especially about the intergenerational transmission of somatization. It is believed that enriching these kinds of studies will enhance the understanding of the sources of psychosomatization. In the qualitative part, it was noted that a mother-daughter couple went to therapy. With the therapy process, the psychosomatic complaints of the daughter visibly diminished. It was thought that a longitudinal study with a population going to therapy would also add to the understanding the importance of the verbalizing and making sense of the emotional experiences of people who have psychosomatic symptoms.

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In addition to conducting such a study with three generations, it was thought that exploring the role of the father in the family system might give a clue about the big picture. This study included only mothers and daughters, but it was concluded that looking at the family system from a deeper perspective and investigating the role of the father would offer a richer perspective.

4.6. CLINICAL IMPLICATIONS

The mother's emotional and representative organization influences that of her daughter. From the beginning of life, there is a mutual interaction between mother and child verbally and nonverbally. Early unconscious dynamics in this interaction are transmitted from mother to daughter in the form of verbal and nonverbal patterns (Adelman, 1995). The findings of this study also support mother-to-daughter transmission. In this study, it was seen that both the way of experiencing and expressing emotions and the tendency of somatization were transferred from mother to daughter as a message. It should be pay sufficient attention to the mother-daughter interaction in terms of the importance of the intergenerational transmission. It is believed that especially mothers' making sense of their own experiences and strengthening their emotional regulation capacities can break the cycle which is transferred from mother to daughter where emotions are not expressed. In this context, it is thought that going to therapy, as a place where experiences are made sense and processed, will have a transformative effect on the next generations. From another point of view, features such as the mother's understanding and processing of her child's mental state and making sense of her experiences for her have an important place in the child's mentalization development (Fonagy et al., 1991; Fonagy & Luyten, 2018). When mothers who are incapable of providing this function cannot offer this to their children, children have difficulties in understanding and interpreting mental states just like their mothers. The bond between mental states and bodily complaints causes intergenerational transmission (Glaus et al., 2022). In this context, it was concluded

that this transferential relationship should be considered in terms of both emotion regulation, mentalization development, and somatization tendency.

Apart from this, it was an important finding in the qualitative study that somatic complaints increased after the loss of a loved one. Particularly, it was not possible for the participants, who had difficulties in making sense of and expressing their feelings, to mourn and process their loss. For this reason, it was as if their emotional pain had created a burden on their bodies. That is, grief should be considered in the triggers of somatization in the situations the person could not mourn.

Lastly, when it was thought that Turkish society's tendency to speak with their body, not their words, it was thought that offering psychoeducation to the people might be helpful in increasing the contact with the body and establishing a bond between emotional experiences and bodily complaints. It was thought that when a person can hear the voices coming from their bodies and make a bond between psyche and soma, a person can relate to their own body in a different way by trying to understand what is behind the symptoms.

CONCLUSION

In conclusion, this research is the first study aimed to investigate daughter somatization with the association of psychosomatization and mentalization of the mothers. The quantitative study findings revealed that as hypothesized, mother somatization significantly predicts daughter somatization. In addition, daughter physical diagnosis, daughter hypomentalization, mother age and daughter age appeared as the other significant predictors in understanding daughter somatization. Contrary to the expectations, mother hypermentalization predicted daughter somatization negatively. Further, the qualitative study findings supported the quantitative study's main hypothesis. The somatization tendency is transmitted from mother to daughter. Furthermore, the other remarkable finding is that mothers transmitted their tendency to withhold negativity to their daughters. The difficulty of the mother in making sense of her feelings and her failure to make a room for negative emotions have emerged as a striking pattern in her daughters as well. The burden of these unexpressed feelings in the psyche has found an expression in the body.

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APPENDICES

Appendix A: Informed Consent Form for Quantitative Study

Bilgilendirilmiş Onam Formu

Sayın Katılımcı,

İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Çağla Uçak'ın Dr. Öğr. Üyesi Alev Çavdar Sideris'in danışmanlığında yürütmekte olduğu tez çalışmasına katılımınızı rica ediyoruz.

Çalışmanın amacı katılımcıların ilişkilenme tarzları, duygusal farkındalıkları ve bedensel şikayetlerine dair bilgi toplamaktır. Ayrıca çalışmada, anne ve yetişkin kızları arasındaki etkileşimler ile bu etkileşimin doğurduğu sonuçların araştırılması hedeflenmiştir.

Çalışma; anne-kız çiftleri ile yürütülmektedir. Çalışma kapsamında annelerin ve kızlarının ayrı ayrı çeşitli anketleri doldurması istenecektir. Çalışmada yer alan soruları kızınızdan bağımsız bir şekilde yanıtlamanız beklenmektedir. Yaklaşık 10-15 dakika sürecek olan çalışmaya katılım tamamıyla gönüllülük temelinde olmalıdır. Ankette sizden kimlik belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak ve sadece araştırmacılar tarafından grup halinde değerlendirilecektir. 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 öngörülmemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz anketi yarıda bırakıp çıkmakta serbestsiniz. Araştırmamıza gönüllü katılım gösterirseniz, sizden ricamız soruları olabildiğince samimi ve eksiksiz yanıtlamanızdır.

Çalışma hakkında daha fazla bilgi almak için sorularınızı araştırmacıya iletebilirsiniz. Araştırmamıza katkıda bulunduğunuz için teşekkür ederiz.

☐ *Yukarıdaki bilgileri okudum. **Bu çalışmaya tamamen gönüllü olarak katılmayı ve verilerin bilimsel araştırma – yayın amacıyla kullanılmasını kabul ediyorum.***



Appendix B: Demographic Information Form for Mothers

Demografik Form: (ANNE)

Sayın Katılımcı,

Bu çalışma anne-kız çiftleri ile yürütülmektedir. **Anket formlarınızın başka formlarla karışmaması için sizden anne-kız olarak ortak bir rumuz belirlemenizi rica ediyoruz.** Anne ve kızlarının anket formlarını birlikte değerlendirmemiz için her anne-kız çiftinin aynı rumuzu kullanması gerekmektedir. **Anket formlarınızın başka formlarla karışmaması için sizden anne-kız olarak ortak bir rumuz belirlemenizi rica ediyoruz.**

Soruları kızınız ile konuşmadan yanıtlamanızı ve kızınızın da diğer linki tıklayarak ve aynı rumuzu kullanarak soruları yanıtladığından emin olmanızı rica ederiz.

Rumuz: _____ (örn: Güneş1, Turuncu3)

Kızınızın isminin ve kendi isminizin baş harfleri: _____ (örn: GD, DN)

A. Kişisel Bilgiler

1. Yaş:
2. Lütfen en son bitirdiğiniz okulu işaretleyiniz.

İlköğretim	
Lise	
Üniversite - Lisans	
Üniversite - Yüksek Lisans/Doktora	
Diğer:	

Çalışıyor musunuz? _____

Çalışıyorsanız, mesleğiniz nedir? _____

3. Kendinizi aşağıdaki gelir seviyelerinden hangisinde değerlendirirsiniz?

Alt	
Alt-Orta	
Orta	
Orta-Üst	
Üst	

4. İlişki durumunuzu belirtiniz.

İlişkim yok	
Sevgilim var	
Sözlüyüm/Nişanlıyım	
Evliyim	
Diğer: (belirtiniz)	

5. Şu anda kiminle yaşıyorsunuz?

Anne/Baba/Kardeş	
Eş ve/veya çocuklar	
Arkadaş/Akraba	
Yalnız	
Diğer: (belirtiniz)	

6. Kaç çocuğunuz var? _____

7. Araştırmaya birlikte katıldığınız kızınız doğum sırasına göre kaçınıcı çocuğunuzdur? _____

B. Sağlık Bilgileri

1. Tanı almış herhangi bir hastalığınız var mı?

Evet	Hayır
------	-------

Evet ise, lütfen belirtiniz _____

Evet ise, bu sağlık problemi ile ilgili tedavi alıyor musunuz?

Alıyorum	
Aldım, bitti	
Almadım	
Diğer: (belirtiniz)	

Evet ise, bu sağlık probleminin günlük hayatınızı ne oranda etkilediğini değerlendiriniz:

1 Hiç etkilemiyor	2	3	4	5	6	7 Çok fazla etkiliyor
-------------------------	---	---	---	---	---	--------------------------------

2. Tanı almamış bir hastalığınız ve/veya fiziksel bir sağlık şikâyetiniz var mı?

Evet	Hayır
------	-------

Evet ise, lütfen belirtiniz _____

Evet ise, bu sağlık şikâyetinizin günlük hayatınızı ne oranda etkilediğini değerlendiriniz:

1 Hiç etkilemiyor	2	3	4	5	6	7 Çok fazla etkiliyor
-------------------------	---	---	---	---	---	--------------------------------

3. Psikolojik/psikiyatrik bir hastalığınız/şikâyetiniz var mı veya daha önceden oldu mu?

Evet	Hayır
------	-------

Evet ise, lütfen belirtiniz _____

Evet ise, bu konuda bir yardım alıyor musunuz/aldınız mı?

Alıyorum	
Aldım, bitti	
Almadım	
Diğer: (belirtiniz)	

Evet ise, bu psikolojik/psikiyatrik bir hastalığınız/şikâyetinizin hayatınızı ne oranda etkilediğini değerlendiriniz:

1 Hiç etkilemiyor	2	3	4	5	6	7 Çok fazla etkiliyor
-------------------------	---	---	---	---	---	--------------------------------

4. Gündelik hayatınızdaki stres düzeyini hangi seviyede değerlendirirsiniz?

1 Stressiz	2	3	4	5	6	7 Çok Stresli
---------------	---	---	---	---	---	---------------------

5. Genel olarak bugünlerde hayatınızdan ne kadar memnunsunuz?

1 Hiç memnun değilim	2	3	4	5	6	7 Çok memnunum
-------------------------------	---	---	---	---	---	----------------------

Appendix C: Demographic Form for Daughters

Demografik Form: (KIZ)

Sayın Katılımcı,

Bu çalışma anne-kız çiftleri ile yürütülmektedir. Anne ve kızlarının anket formlarını birlikte değerlendirmemiz için her anne-kız çiftinin aynı rumuzu kullanması gerekmektedir. **Anket formlarınızın başka formlarla karışmaması için lütfen başlamadan önce kendi ikilinize özel bir rumuz belirleyiniz. Soruları anneniz ile konuşmadan yanıtlamanızı ve annenizin de diğer linki tıklayarak ve aynı rumuzu kullanarak soruları yanıtladığından emin olmanızı rica ederiz.**

Rumuz: _____ (örn: Güneş1, Turuncu3)

Kendi isminizin ve Annenizin isminin baş harfleri: _____ (örn: GD, DN)

A. Kişisel Bilgiler

1. Yaş:
2. Lütfen eğitim seviyenizi işaretleyiniz.

İlköğretim mezunu	
Lise öğrencisi	
Lise mezunu	
Üniversite öğrencisi	
Üniversite mezunu	
Yüksek lisans / Doktora öğrencisi	
Yüksek lisans / Doktora mezunu	
Diğer	

Çalışıyor musunuz? _____

Çalışıyorsanız, mesleğiniz nedir? _____

3. Kendinizi aşağıdaki gelir seviyelerinden hangisinde değerlendirirsiniz?

Alt	
Alt-Orta	
Orta	
Orta-Üst	
Üst	

4. İlişki durumunuzu belirtiniz.

İlişkim yok	
Sevgilim var	
Sözlüyüm/Nişanlıyım	
Evliyim	
Diğer: (belirtiniz)	

5. Şu anda kiminle yaşıyorsunuz?

Anne/Baba/Kardeş	
Eş ve/veya çocuklar	
Arkadaş/Akraba	
Yalnız	
Diğer: (belirtiniz)	

B. Sağlık Bilgileri

6. Tanı almış herhangi bir hastalığınız var mı?

Evet	Hayır
------	-------

Evet ise, lütfen belirtiniz _____

Evet ise, bu sađlık problemi ile ilgili tedavi alıyor musunuz?

Alıyorum	
Aldım, bitti	
Almadım	
Diđer: (belirtiniz)	

Evet ise, bu sađlık probleminin g nl k hayatınızı ne oranda etkilediđini deđerlendiriniz:

1	2	3	4	5	6	7
Hiđ etkilemiyor						Çok fazla etkiliyor

7. Tanı almamış bir hastalığınız ve/veya fiziksel bir sađlık řik yetiniz var mı?

Evet	Hayır
------	-------

Evet ise, l tfen belirtiniz _____

Evet ise, bu sađlık řik yetinizin g nl k hayatınızı ne oranda etkilediđini deđerlendiriniz:

1	2	3	4	5	6	7
Hiđ etkilemiyor						Çok fazla etkiliyor

8. Psikolojik/psikiyatrik bir hastalığınız/řik yetiniz var mı veya daha  nce geđirdiniz mi?

Evet	Hayır
------	-------

Evet ise, l tfen belirtiniz _____

Evet ise, bu konuda bir yardım alıyor musunuz/aldınız mı?

Alıyorum	
Aldım, bitti	
Almadım	
Diğer: (belirtiniz)	

Evet ise, bu psikolojik/psikiyatrik bir hastalığınızın/şikayetinizin hayatınızı ne oranda etkilediğini değerlendiriniz:

1	2	3	4	5	6	7
Hiç etkilemiyor						Çok fazla etkiliyor

9. Gündelik hayatınızdaki stres düzeyini hangi seviyede değerlendirirsiniz?

1	2	3	4	5	6	7
Stressiz						Çok stresli

10. Genel olarak bugünlerde hayatınızdan ne kadar memnunsunuz?

1	2	3	4	5	6	7
Hiç memnun değilim						Çok memnunum

C. Aile Bilgileri

1. Annenizin mevcut bir hastalığı ve/veya fiziksel bir sağlık şikâyeti var mı?

Evet	Hayır
------	-------

Evet ise, lütfen belirtiniz _____

Evet ise, annenizin yaşadığı sağlık şikâyeti günlük hayatını ne oranda etkilediğini düşünüyorsunuz?

1	2	3	4	5	6	7
Hiç etkilemiyor						Çok fazla etkiliyor

2. Çocukluk yıllarınızı düşündüğünüzde anneniz yaşadığı fiziksel sorunlardan (baş ağrısı, halsizlik, kalp çarpıntısı, mide ağrısı gibi) ne düzeyde şikâyet ederdi?

1	2	3	4	5	6	7
Hiç						Sürekli

3. Çocukluk yıllarınızı düşündüğünüzde, annenizin yaşadığı fiziksel şikâyetleri **sizi** ne düzeyde etkilerdi?

1	2	3	4	5	6	7
Hiç etkilemezdi						Çok etkilerdi

Appendix D: Somatization Scale (SS)

Somatizasyon Ölçeği

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

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

19. Soğuk günlerde bile kolayca terlerim.		
20. Çoğu zaman yorgunluk hissederim.		
21. Hemen her gün mide ağrılarından rahatsız olurum.		
22. Tekrarlanan mide bulantısı ve kusmalar yaşarım.		
23. Çoğu zaman bütün vücudumda bir halsizlik duyarım.		
24. Son birkaç yıl içinde sağlığım çoğu zaman iyi idi.		
25. Çok defa sabahları dinç ve dinlenmiş olarak uyanırım.		
26. Çoğu zaman bana kafam şişmiş ya da burnum tıkanmış gibi gelir.		
27. Çoğu zaman başım sıkı bir çember içindeymiş gibi hissederim.		
28. Kalp ve göğüs ağrılarından hemen hemen hiç şikayetim yoktur.		
29. Hayatımda hiçbir zaman kendimi şimdiki kadar iyi hissetmedim.		
30. Kalbimin hızlı çarptığını hemen hemen hiç hissetmen ve çok seyrek nefesim tıkanır.		
31. Hiç felç geçirmediğim ya da kaslarımda olağan üstü bir halsizlik duymadım.		

Appendix E: Reflective Functioning Questionnaire (RFQ-8)

Yansıtıcı İşeyiş Ölçeği

Lütfen aşağıdaki cümleleri dikkatlice okuyunuz. Her bir cümle için, cümleye ne kadar katıldığınızı ifade etmek üzere 1 ile 7 arasında bir numara seçip cümlemin yanına yazınız. Lütfen hiçbir soruyu boş bırakmayınız ve sorular üzerinde çok durmadan ilk aklınıza gelen derecelendirmeyi yapınız.

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

1	2	3	4	5	6	7
Kesinlikle						Kesinlikle
Katılmıyorum						Katılıyorum

1. İnsanların düşünceleri benim için bir bilinmezdir.	
2. Neyi neden yaptığımı her zaman bilmem.	
3. Sinirlendiğimde, neden söylediğimi gerçekten bilmediğim şeyler söylerim.	
4. Sinirlendiğimde, sonradan pişman olacağım şeyler söylerim.	
5. Eğer güvensiz hissedersen, diğerlerini sinirlendirecek şekilde davranırım.	
6. Bazen neden yaptığımı gerçekten bilmediğim şeyler yaparım.	
7. Ne hissettiğimi her zaman bilirim.	
8. Güçlü duygular genellikle düşüncelerimi bulanıklaştırır.	

Appendix F: Parental Reflective Functioning Questionnaire (PRFQ)

Ebeveyn İçsel Düşünme İşlevselliği Ölçeği

Aşağıda siz ve çocuğunuz hakkında birtakım ifadeler yer almaktadır. Her maddeyi lütfen dikkatle okuyunuz ve her maddeye ne derecede katılıp katılmadığınızı belirtiniz. Cevaplarınızı maddelerin yanındaki sayıları seçerek gösteriniz.

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

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

1. Kızımın beni sevdiğinden yalnızca o bana gülümsediği zaman emin olurum. (PM)	
2. Kızımın ne istediğini her zaman bilirim.	
3. Kızımın duygu ve davranışlarının altındaki sebepleri anlamak isterim.	
4. Kızım yabancıların yanında beni mahcup etmek için ağlardı.	
5. Kızımın aklından geçenleri tamamıyla okuyabilirim.	
6. Kızımın ne düşündüğünü ve hissettiğini çok merak ederim.	
7. Kızımın evcilik, doktorculuk ve benzeri oyunlarına aktif bir şekilde katılmakta zorlanırdım.	
8. Kızımın ne yapacağını her zaman tahmin edebilirim.	
9. Kızımın nasıl hissettiğini genellikle merak ederim.	
10. Kızım bazen yapmak istediğim şeyden beni alıkoymak için hasta olur.	
11. Kızımın yaptıklarını bazen yanlış anlayabiliyorum.	
12. Olaylara kızımın gözünden bakmaya çalışırım.	

13. Kızım mızmızlandığı zaman bunu beni kızdırmak için yapar.	
14. Kızımın neyi neden yaptığını her zaman bilirim.	
15. Kızımın neden yaramazlık yaptığını anlamaya çalışırdım.	
16. Çoğu zaman, kızımın davranışları çaba göstersem de anlaşılamayacak kadar karmaşıktır.	
17. Kızımın davranışlarının sebebini her zaman bilirim.	
18. Kızımın ne hissettiğini tahmin etmeye çalışmanın bir işe yaramadığına inanıyorum.	

Çalışmamıza katıldığınız için çok teşekkür ederiz.

Anne-kız ilişkisi ile ilgili ilerleyen dönemlerde yapılacak farklı çalışmalara katılmak isterseniz aşağıya yazmış olacağınız iletişim bilgisinden sizinle iletişim kurulacaktır. Eğer katılmayı düşünmezseniz iletişim bilgisi kısmını boş bırakıp, görüşmeyi sonlandırabilirsiniz.

İletişim bilgisi: _____

Appendix G: Informed Consent Form for Qualitative Study

Yarı Yapılandırılmış Görüşme için Onam Formu

Sayın Katılımcı,

İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Çağla Uçak'ın Dr. Öğr. Üyesi Alev Çavdar Sideris'in danışmanlığında yürütmekte olduğu tez çalışmasına katılımınızı rica ediyoruz.

Çalışmanın amacı katılımcıların ilişkilenme tarzları, duygusal farkındalıkları ve bedensel şikayetlerine dair bilgi toplamaktır. Ayrıca çalışmada, anne ve yetişkin kızları arasındaki etkileşimler ile bu etkileşimin doğurduğu sonuçların araştırılması hedeflenmiştir.

Çalışma; anne-kız çiftleri ile yürütülmektedir ve tamamen gönüllülük esasına dayanmaktadır. Bu çalışmaya anne-kız olarak katılmayı kabul ettiğiniz takdirde sizinle ayrı ayrı yaklaşık 45 dakika sürecek olan yarı yapılandırılmış görüşmeler yapılacaktır. Araştırma sırasında sizden alınacak bilgiler gizli tutulacak ve sadece araştırma amaçlı kullanılacaktır. Görüşme boyunca ses kaydı alınacak ve bu kayıtlar araştırmacının bilgisayarında şifreli bir bilgisayar programı ile saklanacaktır. Deşifre edilen ve şifreli bir bilgisayar programı ile saklanacak verilerde kimlik bilgileriniz yer almayacaktır. Birtakım ifadeleriniz araştırma kapsamında alıntı şeklinde kullanılabilir ancak hiçbir şekilde kimlik bilgileriniz yer almayacaktır. Araştırmaya katılımın katılımcıya herhangi bir zarar vereceği öngörülmemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz görüşmeyi yarıda bırakıp sonlandırmakta serbestsiniz. Böyle bir durumda vermiş olduğunuz bilgiler silinecektir.

Çalışma hakkında daha fazla bilgi almak için sorularınızı araştırmacıya iletebilirsiniz. Araştırmamıza katkıda bulunduğunuz için teşekkür ederiz.

☐ Arařtırmacı tarafından bana ekte iletilen bilgilendirilmiş onam formunu okudum ve anladım. Bu alıřmaya tamamen gönüllü olarak katılıyorum ve istediđim zaman arařtırmadan ekilebileceđimi biliyorum. Arařtırma süresince ses kaydı alınmasına ve elde edilen verilerin bilimsel arařtırma ve yayın amacı ile kullanılmasına izin veriyorum.



Appendix H: Semi-Structured Interview Questions for Mothers

Yarı Yapılandırılmış Görüşme Soruları:

Rumuz: _____

Anne-kız ikilisinin isimlerinin baş harfleri: _____

1. Nasılsınız? Genel olarak hayatınız nasıl gidiyor?
2. Fiziksel olarak kendinizi nasıl hissediyorsunuz, fiziksel sağlık durumunuzu nasıl tarif edersiniz? Kronik ya da sık tekrarlayan bir sağlık sorunuz var mı?
3. Geçmişte olan ve/veya halen daha süren bedensel bir sıkıntınız / şikâyetiniz var mı? Varsa detaylı bir şekilde tarif edebilir misiniz?
 - i. Bu şikâyetinizin fiziksel bir kaynağı / açıklaması var mı? Psikolojik olduğunu ya da ruh halinize göre değiştiğini düşünüyor musunuz?
 - ii. Sizce hangi zamanlarda artıyor veya azalıyor olabilir? Nasıl dönemlerde kötüleşiyor?
 - iii. Böyle bir şeyi yaşıyor olmanızın nedeni ne olabilir?
 - iv. Yaşadığınız bu sıkıntı hayatınızı nasıl etkiliyor?
 - v. Bu sıkıntıyla baş etmek için neler yapıyorsunuz? Çevrenizden destek alabiliyor musunuz? Kızınızdan destek alabiliyor musunuz?
4. Duygularla aranız nasıldır?
 - i. Yaşadığınız duyguların adını koyabiliyor musunuz? Bazen ne hissettiğinizi anlayamadığınız olur mu?
 - ii. Duygularınızı ifade edebiliyor musunuz? Duygularınızı nasıl ifade edersiniz?
 - iii. Hangi duyguları yaşamak sizin için daha zordur?
 - iv. Çok yoğun bir duygu yaşadığınızda ne yaparsınız, bu duygunuzla nasıl başa çıkarsınız?

- v. Başkalarının ne hissettiğini anlayabildiğinizi düşünüyor musunuz? Ötekilerin ne hissettiğinden çok emin olduğunuz anlar oluyor mu? Ötekilerin ne hissettiğini hiç anlamadığınız anlar oluyor mu?
5. Kızınızla ilişkiniz nasıldır? İlişkinizi nasıl tarif edersiniz?
- i. Kızınız duygularını nasıl yaşar, nasıl ifade eder?
- ii. Kızınızla ne tür çatışmalar yaşarsınız?
6. Duyguları anlama ve ifade etme konusunda kızınızla benzerlikleriniz ve farklılıklarınız neler?
- i. Kızınızın kendi duygularını anlama ve ifade etme konusunda nasıl bir etkiniz olmuş olabilir?
- ii. Kızınızın kendi duygularıyla baş etmesi konusunda nasıl bir etkiniz olmuş olabilir?
7. Psikolojik kökenli olabilecek bedensel şikayetler yaşamak konusunda kızınızla benzerlikleriniz ve farklılıklarınız neler olabilir?
- i. Bedensel şikayetleriyle baş etmesi konusunda kızınıza neler öğretmiş olabilirsiniz?
- ii. Kızınızın bedensel şikayetlerine nasıl yaklaşırsınız?
- iii. Kızınızın bedensel şikayetlerine nasıl yaklaşmayı isterdiniz?
9. Bu çalışmaya katılmak ve bu soruların üzerine düşünmek sizin için nasıldı?
- iv. Şu anda kendinizi nasıl hissediyorsunuz?
- v. Görüşme boyunca zorlandığınız anlar oldu mu?
- vi. Son olarak, burada konuşmadığımız ama sizin söylemek veya eklemek istediğiniz herhangi bir şey var mı?

Appendix I: Semi-Structured Interview Questions for Daughters

Yarı Yapılandırılmış Görüşme Soruları:

Rumuz: _____

Anne-kız ikilisinin isimlerinin baş harfleri: _____

1. Nasılsınız? Genel olarak hayatınız nasıl gidiyor?
2. Fiziksel olarak kendinizi nasıl hissediyorsunuz, fiziksel sağlık durumunuzu nasıl tarif edersiniz? Kronik ya da sık tekrarlayan bir sağlık sorunuz var mı?
3. Geçmişte olan ve/veya halen daha süren bedensel bir sıkıntınız / şikâyetiniz var mı? Varsa detaylı bir şekilde tarif edebilir misiniz?
 - vii. Bu şikâyetinizin fiziksel bir kaynağı / açıklaması var mı? Psikolojik olduğunu ya da ruh halinize göre değiştiğini düşünüyor musunuz?
 - viii. Sizce hangi zamanlarda artıyor veya azalıyor olabilir? Nasıl dönemlerde kötüleşiyor?
 - ix. Böyle bir şeyi yaşıyor olmanızın nedeni ne olabilir?
 - x. Bu sıkıntıyla baş etmek için neler yapıyorsunuz? Çevrenizden/Annenizden destek alabiliyor musunuz?
4. Duygularla aranız nasıldır?
 - xi. Yaşadığınız duyguların adını koyabiliyor musunuz? Bazen ne hissettiğinizi anlayamadığınız olur mu?
 - xii. Duygularınızı ifade edebiliyor musunuz? Duygularınızı nasıl ifade edersiniz?
 - xiii. Hangi duyguları yaşamak sizin için daha zordur?
 - xiv. Çok yoğun bir duygu yaşadığınızda ne yaparsınız, bu duygunuzla nasıl başa çıkarsınız?
 - xv. Başkalarının ne hissettiğini anlayabildiğinizi düşünüyor musunuz? Ötekilerin ne hissettiğinden çok emin olduğunuz anlar

oluyor mu? Ötekilerin ne hissettiğini hiç anlamadığımız anlar oluyor mu?

5. Anneniz nasıl biridir, onu nasıl tarif edersiniz? İlişkiniz nasıldır?

xvi. Anneniz duygularını nasıl yaşar, nasıl ifade eder?

xvii. Anneniz çok yoğun bir duygu yaşadığında bu duygusuyla nasıl başa çıkar, nasıl ifade eder?

xviii. Anneniz sizin duygularınıza nasıl yaklaşır?

xix. Annenizle ne tür çatışmalar yaşarsınız?

6. Duyguları anlama ve ifade etme konusunda annenizle benzerlikleriniz ve farklılıklarınız neler?

xx. Başkalarının duygularını anlama konusunda annenizden neler öğrendiniz?

xxi. Duygularınızla baş etme konusunda annenizden neler öğrendiniz?

7. Psikolojik kökenli olabilecek bedensel şikayetler yaşamak konusunda annenizle benzerlikleriniz ve farklılıklarınız neler?

xxii. Bedensel şikayetlerinizle baş etme konusunda annenizden neler öğrendiniz?

xxiii. Anneniz bedensel şikayetlerinize nasıl yaklaşır?

xxiv. Annenizin beden şikayetlerinize nasıl yaklaşmasını isterdiniz?

8. Bu çalışmaya katılmak ve bu soruların üzerine düşünmek sizin için nasıldı?

xxv. Şu anda kendinizi nasıl hissediyorsunuz?

xxvi. Görüşme boyunca zorlandığınız anlar oldu mu?

xxvii. Son olarak, burada konuşmadığımız ama sizin söylemek veya eklemek istediğiniz herhangi bir şey var mı?

ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of this dissertation.

